Syllabus &

Syllabus & Proceedings Summary

Proceedings Summary

A DANCING BEAR SYMBOLIZES RENEWAL AND STRENGTH TO MANY NATIVE AMERICAN CULTURES

American Psychiatric Association
Annual Meeting • May 30 - June 4, 1998
Toronto, Ontario, Canada

FOR YOUR RECORDS

The Certificate of Attendance below is for your personal records.

This is to certify that

---

was a registered
participant at the
151st Annual Meeting of the APA,
Toronto, ON, Canada, May 30-June 4, 1998
President's Theme: New Challenges for Proven Values—Defending Access, Fairness, Ethics, Decency

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

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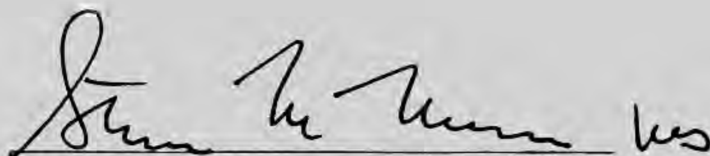
APA President



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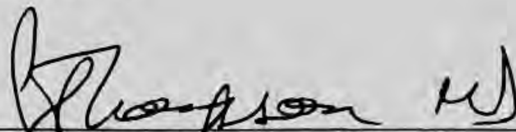

James W. Thompson, M.D.
Deputy Medical Director
Director, Office of Education

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

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

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

DAILY LOG FOR ATTENDANCE AT CME FUNCTIONS AT THE ANNUAL MEETING OF THE AMERICAN PSYCHIATRIC ASSOCIATION, May 30-June 4, 1998 Toronto, ON, Canada

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

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

The APA's Continuing Medical Education Requirement

The Requirement

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

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

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

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

Obtaining an APA CME Certificate

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

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

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

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

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

APA Report Form

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

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

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

Exemptions

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

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

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

CONTINUING MEDICAL EDUCATION
SYLLABUS
AND
SCIENTIFIC PROCEEDINGS

IN SUMMARY FORM

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

Toronto, Ontario, Canada

May 30-June 4, 1998

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FOREWORD

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

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

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

Daniel K. Winstead, M.D., *Chairperson*
Philip R. Muskin, 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.

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.

1998 ANNUAL MEETING
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2. Alcohol and Drug-Related Disorders
3. Anxiety Disorders
4. Cognitive Disorders (Delirium, Dementia, Amnestic, etc.)
5. Dissociative Disorders
6. Eating Disorders
7. Infant and Childhood Disorders
8. Premenstrual Dysphoric Disorder
9. Mood Disorders
10. Personality Disorders
11. Schizophrenia and Other Psychotic Disorders
12. Sexual and Gender Identity Disorders
13. Sleep Disorders
14. Somatoform Disorders
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18. Public Sector
19. University
20. Other

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24. Biological Psychiatry
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26. Child and Adolescent Psychiatry
27. Community Psychiatry and Prevention
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29. Cross-Cultural and Minority Psychiatry
30. Diagnostic Issues
31. Ethics
32. Forensic Psychiatry
33. Genetics
34. Geriatric Psychiatry
35. Neurobiology
36. Neuropsychiatry
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66. Stigma/Advocacy
67. Women's Issues
68. Drug Addiction—A Treatable Disease: A Special Research-Based Program Track

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

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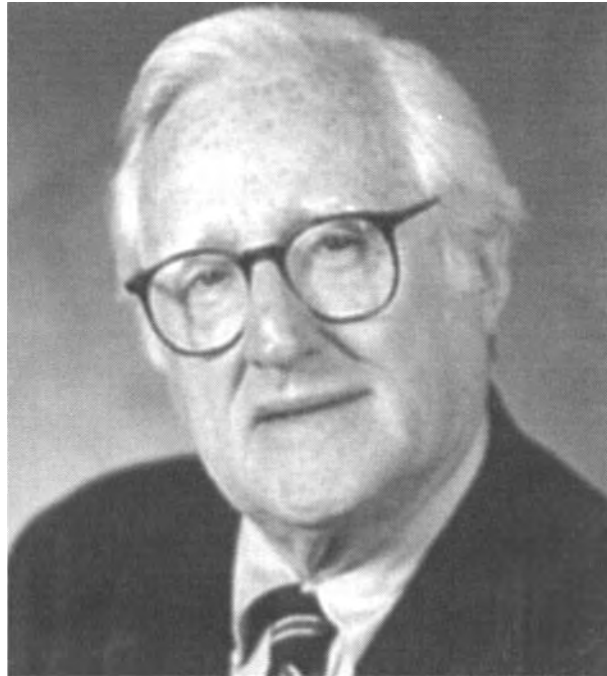

Herbert S. Sacks, M.D.

PAPER NO. 1: PRESIDENTIAL ADDRESS

New Challenges For Proven Values—Defending Access, Fairness, Ethics, Decency

Assuring access to care, treating patients with fairness, sustaining our ethical values, and caring for patients with decency and respect are irreproachable standards for American paychiatry. The logo for the Toronto Annual Meeting draws our attention to a standing bear, the bear symbolizes ***renewal and strength*** for the Innuit nation.

Future historians of medicine will be astonished by a decade of revolutionary scientific advances in psychiatry, illuminated by new findings in the neurosciences, psychopharmacology, and dynamic treatment modalities. These developments reflect our strength and our capacity for renewal. They speak to the creative work of our brilliant research establishment, which has given fresh hope to those in despair. As never before, we have an integrated, sophisticated view of how to help our suffering patients. Paradoxically, excellent patient care has been constrained by most profit-driven payment systems, without social accountability or responsibility to anyone but stockholders.

But there is a bright future ahead! A sea change of public opinion has compelled state and federal legislative action. Litigation, APA-sponsored, is beginning to show results. State attorneys general and insurance commissioners are moving with alacrity. And the President's Commission has generated a patient's bill of rights, which by Executive Order, now covers 40 percent of all Americans.

Psychiatry, the oldest medical specialty and the fourth largest, has led the counterattack against the inequities imposed upon our patients and our professionalism. We gather new allies, partners, and advocates each day.

Despite the changed environment, psychiatry is living and well. Our superb educational base and standard-setting groups are reshaping their missions; research funding over the past 13 years is up 470 percent in medical shools, second only to internal medicine.

Resolute and more determined than ever, we look to brighter days ahead, when the proven values of ***access, fairness, ethics,*** and ***decency*** will be vouchsafed for our patients in need.

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SCIENTIFIC AND CLINICAL REPORT SESSION 1—COMORBIDITY AND TREATMENT ISSUES IN PERSONALITY DISORDERS

No. 2
PERSONALITY IN DIFFERENT ANXIETY DISORDERS

James H. Reich, M.D., *2255 North Point Street, #102, San Francisco CA 94123*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation one should be able to better understand the strong relationship between the personality and the anxiety disorders. Included will be a knowledge of which personality disorders and combinations of Axis I symptoms appear most strongly related to personality pathology.

SUMMARY:

Objective: There has been increasing interest in the relationship between the personality and anxiety disorders. This paper presents comorbidity findings between DSM-III-R personality pathology and several DSM-III-R anxiety disorders and makes direct comparisons between anxiety groups. This is the most extensive comparison of this kind reported thus far.

Method: This report is on the first 475 anxiety patients who were recruited from multiple sites to take part in a naturalistic study of anxiety. All had a DSM-III-R diagnosis of panic, agoraphobia, social phobia, or generalized anxiety disorder (GAD).

Results: Previous studies that found high comorbidity between anxiety and personality pathology were confirmed, with significantly higher prevalence of personality pathology occurring with social phobia and GAD. Among our patients, all of whom had anxiety disorders, the presence of comorbid major depression was associated with an increase in the levels of comorbid personality pathology, as was previously described in the literature. The relationship between low social functioning and presence of personality pathology was confirmed; however, the relationship appears specific to certain areas of functioning, a new finding.

Conclusions: There is a clinically important relationship between PDQ-R personality pathology and anxiety disorders characterized by different prevalences of personality disorders in different anxiety disorders and specific areas of social dysfunction.

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1. Reich J: The epidemiology of anxiety. Journal of Nervous and Mental Disease 1986; 174:129-136.
2. Alnaes, R, Torgersen S: DSM-III personality disorders among patients with Major Depression, Anxiety Disorders, and Mixed Conditions. Journal of Nervous and Mental Disease 1990; 178:693-698.

No. 3
PERSONALITY TRAITS AND RESPONSE TO ANTIDEPRESSANTS

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EDUCATIONAL OBJECTIVE:

To learn about the frequency of comorbidity between depression and personality disorders and to assess whether the presence of deviant personality traits predicts response to antidepressants.

SUMMARY:

Objective: The efficacy of antidepressants in the treatment of major depression has been well established. However, various factors have been associated with better or worse antidepressant response. One confounding factor in the treatment of depressive illness is the presence of personality traits/disorders comorbid with major depression. It is the purpose of this paper to evaluate whether the presence of these variables predicted differential drug or placebo response to antidepressants for the treatment of major depression.

Method: Overall we evaluated 312 patients who entered one of six double-blind, placebo-controlled, antidepressant trials that were conducted over an eight-year course at the Foundation for Depression-Manic Depression (an outpatient affective disorder clinic associated with Columbia University). Prior to entry into the double-blind trial, the patients were evaluated using the Structured Interview for DSM-III Personality Disorders (SIDP). Based on patients' responses, dimensional personality traits were rated (on a 0–2 point score) for all of the 11 DSM-III personality disorders. In addition, patients were rated as to whether they met criteria for the individual disorders. These personality traits/disorders were correlated with response to drug or placebo treatment for major depressive disorder.

Results: In general, the greater the degree of dimensional traits for all 11 of the DSM-III personality disorders, the poorer the response to drug treatment. Patients meeting DSM-III criteria for any of the 11 personality disorders predicted a poorer response to drug. Dimensional personality and categorical diagnosis did not predict response to placebo.

Conclusions: Overall it appeared that the presence of deviant personality traits predicted a poorer response to drugs. The implications of these findings will be discussed. Though drug companies (Lilly, Smith-Kline Beecham) funded the efficacy studies for various studies above, the personality disorder aspect presented here was not funded.

REFERENCES:

1. Peselow ED, Fieve RR, DiFiglia C: Personality traits and response to desipramine. Journal of Affective Disorders 1992; 24:209-216.
2. Shea MT, et al: Personality disorders and treatment outcome in the NIMH treatment of depression collaborative research program. American Journal of Psychiatry 1990; 147:711-718.

No. 4
SCHIZOTYPY AND COGNITION IN BORDERLINE PERSONALITY

Rosemary Toomey, Ph.D., *Psychiatry 116A, Harvard Medical School, Brockton VAMC 940 Belmont St, Brockton MA 02401;* Michael J. Lyons, Ph.D., Rebecca Harley, B.A., Mary C. Zanarini, Ed.D., Stephen V. Faraone, Ph.D., Larry J. Seidman, Ph.D., Ming T. Tsuang, M.D.

EDUCATIONAL OBJECTIVE:

To recognize the difference between two groups (subjects with borderline personality disorder and symptomatic volunteers) on schizotypal symptoms and neuropsychological functioning.

SUMMARY:

Objective: Schizotypal (SPD) and borderline (BPD) personality disorders were both originally conceived as severe personality disorders that were on the "border" between neurosis and psychosis. Conceptualization of these disorders has evolved such that SPD is seen as part of the schizophrenia spectrum, while BPD is differentiated from SPD by affective symptoms. In this study, we sought to examine how subjects with BPD would compare with another putative schizotypal group on schizotypal symptoms and neuropsychological functioning.

Method: Subjects with borderline personality disorder (n = 19) were recruited from another study and all had been previously hospitalized, but were outpatients when enrolled in this study. Symptomatic volunteers (n = 29) were recruited from newspaper advertisements seeking subjects with schizotypal experiences. Subjects were evaluated with the Structured Interview of Schizotypy (SIS) and with a neuropsychological battery.

Results: The two groups did not differ significantly on age, sex, and number of subjects who met formal criteria for SPD based on the SIS. The symptomatic volunteers were significantly more educated that BPD subjects. Global symptom scores on the SIS revealed a pattern where eight ratings did not differ between groups (including all those ratings based on interviewer observation). Ten ratings were significantly more pathological in the BPD group, whereas two ratings were significantly more pathological in the volunteer group. Controlling for education, some aspects of neuropsychological functioning were significantly impaired in the BPD group, including tasks of conceptual flexibility and some aspects of visual processing.

Conclusion: Subjects with BPD exhibit many schizotypal symptoms in comparison with symptomatic volunteers, with the exception of the positive symptoms of magical thinking and illusions, which are more characteristic of the volunteer group. Neuropsychological impairment was observed in the BPD but not volunteer subjects. [Funding Source: NIMH]

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1. Bornstein RF et al: Schizotypal personality disorder in an outpatient population: Incidence and clinical characteristics. Journal of Clinical Psychology, 1988; 44:322-325.
2. Kendler KS, et al: Schizotypal symptoms and signs in the Roscommon family study. Archives of General Psychiatry, 1995; 52:296-303.

SCIENTIFIC AND CLINICAL REPORT SESSION 2—MOOD DISORDERS IN WOMEN

No. 5
PREVENTION OF POSTPARTUM EPISODES IN BIPOLAR WOMEN

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

EDUCATIONAL OBJECTIVE:

To develop a management plan for postpartum women with bipolar disorder.

SUMMARY:

Objective: Women with bipolar disorder are at high risk for recurrence postpartum. The objectives are to test the hypothesis that provision of valproate (VLP) immediately postpartum prevents episodes and to collect data about VLP use during breastfeeding.

Method: Pregnant women with bipolar disorder were offered two plans for postpartum management: (1) provision of VLP immediately as a preventative, or (2) weekly monitoring with rapid treatment for recurrence.

Results: Eleven women have completed the 20-week trial; five are enrolled and will deliver within the next few months. Seven of the women chose immediate postpartum VLP treatment. Two of these women suffered recurrences of depression (28%). In women who elected observation, three of four (75%) had recurrences: two developed hypomania and one a mixed state. Three VLP-treated mothers breastfed. Mother and infant serum levels of VLP were obtained. Maternal levels ranged from 40 to 74 mcg/ml, and infant serum levels ranged from 0.7 to 1.5 mcg/ml.

Conclusions: These preliminary data suggest that preventive VLP results in fewer episodes postpartum, and that treated women develop depression while untreated women develop hypomania or mixed states. Consistent with the sparse literature to date, breastfeeding during VLP therapy yielded low levels in infants.

REFERENCES:

1. Cohen LS, Sichel DA, Robertson LM, et al: Postpartum prophylaxis for women with bipolar disorder. Am J Psych 1996; 52:1641-1645.
2. Wisner KL, Perel JM, Findling RL: Antidepressant treatment during breastfeeding. Am J Psych 1996; 153:1132-1137.

No. 6
ALCOHOL DEPENDENCY AND AFFECTIVE ILLNESS AMONG WOMEN

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

EDUCATIONAL OBJECTIVE:

To recognize women of childbearing age who are at risk for having comorbid alcoholism and affective disorder.

SUMMARY:

Objective: We determined predictors of duration of alcoholism over five years among women with young children.

Method: Women who were pregnant and had children under the age of three were identified from computerized psychiatric emergency records. These women were contacted five years after their initial evaluation and asked to participate in a follow-up study. Among 231 women eligible, 117 participated. The women were interviewed and diagnoses were made according to Research Diagnostic Criteria. The course of illness was explored graphically on a time-line.

Results: Women who experienced a longer duration of alcoholism had concurrent episodes of a major mood disorder over the five years. This was the only predictor of duration. Women with comorbid mood disorders and alcoholism were more likely to have a history of affective illness, to have had their first psychiatric illness before age 15, and to have cyclical mood disorders compared with women with affective disorder only.

Conclusion: These data suggest that some women are at risk for developing alcoholism after an early onset of affective illness. The prevalence of 26% for this comorbidity among childbearing-aged women who presented for evaluation is similar to the rate for inpatient populations of alcoholic women.

REFERENCES:

1. Kessler RC, et al: Lifetime co-occurrence of DSM-III-R alcohol abuse and dependence with other psychiatric disorders in the National Comorbidity Survey. Arch Gen Psych 1997; 54:313-321.
2. Kendler KS, et al: The structure of the genetic and environmental risk factors for six major psychiatric disorders in women. Arch Gen Psych 1995; 52:374-383.

No. 7
DYSPHORIC MOODS IN WOMEN: MENOPAUSE OR MYTH?

Howard M. Kravitz, D.O., *Department of Psychiatry, Rush Medical College, 1725 West Harrison Street, Chicago IL 60612;* Joyce T. Bromberger, Ph.D., Lynda H. Powell, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to better understand the complexities involved in the menopause transition and the interrelatedness of physiological and psychological changes that occur during this phase of women's life cycle.

SUMMARY:

Objective: Fluctuations in reproductive steroid hormones, especially decreasing estradiol levels, have been associated with gender-specific mood syndromes across the life cycle. Some women experiencing natural and surgically induced menopause report depression and anxiety. With data from The Study of Women's Health Across the Nation's (SWAN) Cross-sectional Screening Survey we examined the association between estrogen status related to the menopause transition and the risk for dysphoric mood symptoms.

Method: Our multiethnic sample of 10,190 women aged 40–55 was categorized, using bleeding criteria, as premenopausal, early or late perimenopausal, postmenopausal, or surgically menopausal. We examined bivariate associations of menopausal status with dysphoric mood symptoms (blue/depressed, irritable/grouchy, tense/nervous, pounding heart) alone and in combination. Sociodemographic, health, psychosocial, and vasomotor symptom covariates were included in multivariate logistic regression models.

Results: Both univariate and multivariate analyses show that compared with premenopausal women, the odds for dysphoric moods among early perimenopausal women were significantly higher (OR = 1.17, 95% CI = 1.02–1.35) and among naturally menopausal women were significantly lower (OR = 0.82, 95% CI = .67–.99). In all models, vasomotor symptoms were an important correlate of dysphoric mood.

Conclusion: These data confirm the association between the menopause transition and developing dysphoric moods. Prospective SWAN data will examine endocrine bases of mood.

REFERENCES:

1. Matthews KA, Wing RR, Kuller LH, et al: Influences of natural menopause on psychological characteristics and symptoms of middle-aged healthy women. J Consult Clin Psychol 1990; 58:345-351.
2. Nicol-Smith L: Causality, menopause, and depression: a critical review of the literature. BMJ 1996; 313:1229-1232.

SCIENTIFIC AND CLINICAL REPORT SESSION 3—SUICIDE: CAUSES IN PATIENTS AND EFFECTS ON DOCTORS

No. 8
KEVORKIAN'S LIST: PSYCHOSOCIAL OR MEDICAL FACTORS?

Kalman J. Kaplan, Ph.D., *Department of Psychiatry, Michael Reese Hospital, 2959 S. Cottage Grove, Chicago IL 60616;* Flint Lachenmeier, M.A., Jyll O'Dell, M.A., Diana Caragacianu

EDUCATIONAL OBJECTIVE:

To examine empirically psychosocial versus medical factors in Kevorkian's patients, especially with regard to gender bias, and to identify public latitudes of acceptance/rejection of different instances of doctor-assisted suicide.

SUMMARY:

Objective: The "right to die" debate has begun to rage across America, spurred on by the assisted suicides conducted by Dr. Jack Kevorkian in Michigan. The objective is to understand the relative role of psychosocial versus biomedical factors underlying the decision to seek doctor-assisted suicide with Dr. Jack Kevorkian and to ascertain whether Kevorkian's patients share risk factors with more typical suicidal patients.

Method: An empirical comparison of Kevorkian's first 47 assisted suicides in terms of psychosocial versus biomedical factors including age, marital status, family history, precipitating disease, terminality, physical pain and incapacitation, psychological pain, disposition of body, etc. There will be an identification of gender difference in this regard, as well as latitudes of public acceptance/rejection toward hypothetical doctor-assisted suicides.

Results: Twice as many women as men came to Kevorkian. They were less likely to be terminal or in acute anatomically based physical pain than the men. The strongest risk factor across gender was fear of dependency. Finally, over 90% of Kevorkian's patients chose to be cremated, four times the overall cremation rate in Michigan and over two times the cremation rate for suicides.

Conclusions: Many of Kevorkian's patients, especially the women, resembled more typical suicidal patients in terms of being motivated primarily by psychosocial factors.

REFERENCES:

1. Kaplan KJ, Schwartz MW: A Psychology of Hope: An Antidote to the Suicidal Pathology of Western Civilization. Westport, Conn.: Praeger, 1993.
2. Kaplan KJ, DeWitt J: Kevorkian's list: gender bias or what? Newslink, 1996; 22:14.

No. 9
PSYCHOLOGICAL IMPACT OF PATIENTS' SUICIDE ON PSYCHIATRISTS

Charito V. Quintero, M.D., *Department of Psychiatry, University of Iowa, 200 Hawkins Dr. #1882 JPP, Iowa City IA 52242*

EDUCATIONAL OBJECTIVES:

This study was conducted to explore the prevalence of patients' attempted or completed suicide and their impact on faculty psychiatrists and trainees.

SUMMARY:

Objective: This study was conducted to explore the prevalence of patients' attempted or completed suicide and their impact on faculty psychiatrists and trainees.

Method: A survey was conducted of faculty and trainees at the University of Maryland. It included demographic data and used the Impact of Event Scale, a 15-item validated self-report.

Results: Of the 35 respondents, 29 (83%) had patients who attempted suicide and 16 (46%) had patients who completed suicide. The majority of patients were outpatients with diagnoses of depression and personality disorders. There were no significant differences in the respondents' age, gender, or marital status. Trainees had more difficulty dealing with the event. Respondents with patients who completed suicide had more intrusive thoughts and avoidance behaviors than those who had patients who attempted suicide. Of respondents with completed suicides, intrusive thoughts were positively correlated with the length of time they had treated the patients.

Conclusion: Patients' suicidal behavior is prevalent and can leave an impact an psychiatrists. A support system among psychiatrists, especially for inexperienced trainees, may be necessary to express the affect engendered by the patient's suicide whether attempted or completed.

REFERENCES:

1. Chemtob C, Hamada R, Bauer G, et al: Patients' suicides: frequency and impact on psychiatrists. Am J Psychiatry 1988; 145:224-228.
2. Rosowsky E: Suicidal behavior in the nursing home and a postsuicide intervention. Am J Psychotherapy 1993; 47: 127-141.

No. 10
COVARIATES OF SUICIDALITY IN DYSPHORIC MANIA

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to demonstrate knowledge of the clinical features most likely to accompany suicidality in bipolar patients and recognize the importance of assessing suicidality in bipolar patients relative to the presence of a full depressive episode.

SUMMARY:

Objective: Bipolar disorder carries a high risk for suicide and arises more often in dysphoric than pure mania. Yet little is known about which additional symptoms are most critical in defining the profile of suicidal bipolar patients. We assessed clinical covariates of suicidal ideation in a sample of dysphoric manic inpatients.

Method: Charts were reviewed for 107 DSM-III-R dysphoric bipolar I inpatients from 1991–1995 at the Payne Whitney Clinic. Data were obtained regarding affective and psychotic symptoms throughout the index hospitalization and analyzed in relation to current suicidality.

Results: 1) Suicidal ideation was present in 65% of the sample. 2) Concurrent affective symptoms observed most often included elevated or irritable mood (89%), depressed mood (84%), pressured speech (66%), insomnia or hypersomnia (61%), decreased appetite (60%), poor concentration (60%), psychomotor retardation or agitation (58%), decreased sleep (58%), and increased activity (52%). 3) Two-thirds of suicidal patients were psychotic during the index episode. 4) Feelings of worthlessness were more common among suicidal than nonsuicidal bipolars ($p<.05$). No other affective symptoms significantly distinguished suicidal from nonsuicidal bipolars.

Conclusions: Suicidality is a central feature of dysphoric mania that often arises in the absence of a full concurrent major depressive episode. The assessment of suicidality should not be minimized in acute manic patients when dysphoric mood is unaccompanied by a full constellation of depressive symptoms.

REFERENCES:

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

SCIENTIFIC AND CLINICAL REPORT SESSION 4—ADOLESCENT MENTAL HEALTH ISSUES

No. 11
PTSD IN ADOLESCENT SURVIVORS OF ETHNIC CLEANSING

Daniel F. Becker, M.D., *Menninger-SFBA, 1783 El Camino Real, Burlingame CA 94010;* Stevan M. Weine, M.D., Dolores Vojvoda, M.D., Thomas H. McGlashan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should understand some of the psychiatric sequelae of "ethnic cleansing" in adolescent Bosnian refugees—particularly with regard to PTSD symptoms.

SUMMARY:

Objective: To describe the psychiatric sequelae of "ethnic cleansing" in adolescent Bosnian refugees, via a one-year follow-up study.

Method: Subjects were 10 Bosnian adolescents who had been exposed to the traumas of the recent war in Bosnia-Herzegovina and who had been resettled with their families in Connecticut. All received a baseline psychiatric assessment within the first year after their resettlement and a follow-up assessment one year later. Assessments were conducted by clinicians in the Traumatic Stress Clinic at the Yale Psychiatric Institute. At baseline and at follow-up, subjects participated in systematic, trauma-focused, clinical interviews that included an assessment scale for posttraumatic stress disorder (PTSD) symptom severity.

Results: At baseline, three subjects met diagnostic criteria for (PTSD) at follow-up only. For the group, mean PTSD severity scores at baseline and at follow-up were 8.9 and 4.0, respectively. At baseline, reexperiencing cluster symptoms was occuring 43% of the time, avoidance cluster symptoms were present 33% of the time, and hyperarousal cluster symptoms were present 33% of the time; at follow-up, these proportions were 35%, 16%, and 18%, respectively.

Conclusion: Overall, rates of PTSD symptoms diminished during the one-year follow-up interval suggesting that they may be transient and not representative of enduring psychopathology. The frequencies of the PTSD diagnosis in our group of adolescent Bosnian refugees are lower than those found in adult Bosnian refugees and also lower than those found in adolescent refugees from Cambodia. This finding may reflect the relative resiliency of adolescents, as well as a variety of factors that facilitated adaptation in our refugee group.

REFERENCES:

1. Kinzie JD, Sack WH, Angell RH, et al: A three-year follow-up of Cambodian young people traumatized as children. J Am Acad Chold Adolesc Psychiatry 1989; 28:501-504.
2. Weine S, Becker DF, McGlashan TH et al: Adolescent survivors of "ethnic cleansing": observations on the first year in America J Am Acad Child Adolesc Psychiatry 1995; 34:1153-1159.

No. 12
PATHOLOGICAL GAMBLING AMONG LOUISIANA ADOLESCENTS

James R. Westphal, M.D., *Department of Psychiatry, LSUMC-Shreveport, 1501 Kings Hwy/PO Box 3932, Shreveport LA 71130;* Jill A. Rush, B.S., Lee Stevens

EDUCATIONAL OBJECTIVE:

To recognize the extent of gambling behavior problems among Louisiana adolescents; to understand the significance of gambling behavior problems and the need for intervention and prevention programs.

SUMMARY:

Objectives: To determine the prevalence of gambling problems among Louisiana adolescents; to identify the age of onset; and to make recommendations on gambling prevention programs

Method: The survey instrument contained demographic and substance use questions along with the South Oaks Gambling Screen, Revised for Adolescents (SOGS-RA). Researchers selected a target population of 2,000 adolescents per grade (6th through 12th grades). The number of adolescents registered in Louisiana schools was determined for each grade, per parish. Cluster sampling by classroom was used to randomly select 3.5% of adolescents. Survey packets were mailed between 4/14/97 and 5/30/97 and administered in a classroom testing environment.

Results: A total of 12,066 Louisiana adolescents voluntarily participated. Eighty-six percent admitted having participated in gambling activities. The prevalence of increased risk factors for problem gambling behavior was 16% (SOGS-RA ≥2). The adolescent population meeting the adult criteria for pathological gambling was 5.6% (SOGS≥4). The average age of onset of gambling behavior was 13 years.

Conclusion: By the sixth grade Louisiana adolescents demonstrate a significant prevalence for problem gambling behavior. Early onset of gambling behavior and high prevalence of gambling disorders among Louisiana adolescents support the establishment of middle school prevention programs.

REFERENCES:

1. Shaffer H, Hall M: Estimating the prevalence of adolescent gambling disorders: a quantitative synthesis and guide toward standard gambling nomenclature. Journal of Gambling Studies, 1996; 12(2): 193-214
2. Derevensky J, Gupta R: Risk taking and gambling behavior among adolescents: and empirical examination. Paper presented at the Tenth National Conference on Gambling Behavior, 1996; Chicago, IL.

No. 13
DEPRESSED MOOD IN CONDUCT-DISORDERED INPATIENTS

Dwain C. Fehon, Psy.D., *Yale Psychiatric Inst., P.O. Box 208038, New Haven CT 06520;* Carlos M. Grilo, Ph.D., Steve Martino, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants should be able to recognize potential important predictors of co-occurring depressed mood among conduct disordered adolescents who are psychiatrically hospitalized.

SUMMARY:

Objective: To identify predictors of depressed mood among psychiatrically hospitalized adolescents with conduct disorder (CD).

Method: Seventy-six inpatients assigned with a DSM-IV Axis I diagnosis of CD were administered a battery of psychometrically well-established psychological self-report instruments. Level of depressed mood was assessed using the Beck Depression Inventory (BDI). Other measures, chosen based on their conceptual and empirical properties, included the Hopelessness Scale for Children (HSC), Adolescent Depressive Experiences Questionnaire (DEQ-A), Impulse Control Scale (ICS), Adolescent Drug and Alcohol Screening Test (DASTA), Rosenberg Self-Esteem Scale (RSES), and the Millon Adolescent Clinical Inventory (MACI).

Results: As expected, the HSC (r=.64), ICS (r=.44), RSES (r= –.70), SRS(r=.76), PFAV (r=.41), and DEQ self-critism (r=.65) were significantly correlated with level of depressed mood (p<.001). Multiple regression analyses were performed to ascertain the independent and joint contributions of these measures to the prediction of depressed mood. Accounting for 68% of the variance (F (7, 68)=20.1, p<.0000), significant independent contributions to the prediction of depressed mood were made by the HSC, DEQ self-criticism, and a reported history of childhood abuse.

Conclusion: These findings suggest that hopelessness, self-criticism, and a history of childhood abuse may predict the presence of depressed mood among hospitalized adolescents with CD.

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1. Ben-Amos B: Depression and conduct disorders in children and adolescents: A review of the literature. Bulletin of the Menninger Clinic, 1992; *56*: 188-208.
2. Biederman J, Faraone S, Mick E, Lelon E: Psychiatric comorbidity among referred juvenile delinquents with major depression: Fact or artifact? Journal of the American Academy of Child and Adolescent Psychiatry, 1995; 34:579-590.

SCIENTIFIC AND CLINICAL REPORT SESSION 5—CHANGING PATTERNS OF MENTAL HEALTH PRACTICE

No. 14
COUNTY FUNDING OF MENTAL HEALTH SERVICES

Barbara M. Rohland, M.D., *Department of Psychiatry, University of Iowa, 200 Hawkins Drive 2887 UPP, Iowa City IA 52242;* James E. Rohrer, Ph.D.

EDUCATIONAL OBJECTIVE:

To recognize demographic, economic, and cultural factors that influence county funding of mental health services; to appreciate the relationships that exist between county and state funding, particularly when restructuring one of one of the systems occurs; to anticipate the effects that funding reorganization may have on the local availability of services

SUMMARY:

Objective: To identify factors that are associated with variation in county funding for mental health services in a rural state.

Method: Indicators of county spending for services to persons with mental illness in FY1994 were used as dependent variables, and factors likely to influence county spending (county wealth, political activism within the county, service need, cultural factors, and policymaker attitude) were used as independent variables to determine predictors of county funding using logistic regression methods.

Results: The county population and proportion of persons receiving Medicaid explained 96% of the variation in funding for mental health services between counties. Counties with fewer people, lower proportions of college-educated residents, higher proportions of rural and elderly residents, higher rates of poverty, and higher proportion of farm income spent less on mental health services; counties where AMI advocacy was present spent more.

Conclusion: The number of people in the county and proportion of persons receiving Medicaid explains most of the variation in county spending for mental health services. Higher populations and proportions of residents receiving Medicaid predict more county funding. Characteristics associated with rural location and advocacy also appear related to county funding.

Funding Source: SAMHSA/Iowa Department of Human Services

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No. 15
RESULTS OF CAPITATED BEHAVIORAL HEALTH CARE IN A PRIMARY CARE BASED ACADEMIC HEALTH SYSTEM

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EDUCATIONAL OBJECTIVES:

To understand basic principles of managed care and capitation; to understand the clinical, educational, administrative, and economic factors that are crucial to the viability of academic departments of psychiatry and to managing primary care patients.

Increasingly, mental health services are being provided to patients by mental health groups that receive a fixed per member per month (PMPM) payment. The PMPM payment varies according to the patients served, type of insurance, degree of managed care penetration, and the intensity of utilization management. PMPM rates for mental health range between $2–$6 nationally and $1.5–$3 in California. In the UC Davis Health System, a Behavioral Health Center (BHC) was developed to manage the capitated mental health care patients. The BHC receives a $2.16 PMPM. For outpatient services, UC Davis internal providers (faculty and multidisciplinary trainees) were paid under case rate methodologies (receiving a fixed amount of money to provide services over a specified time). External or community providers were paid via a discounted fee-for-service system. A 12-month analysis revealed 20.6 hospital days per 1000 patient lives. These results compare favorably with Milliman and Robertson's rates in an aggressively managed care system of 18 hospital days per 1000 patient lives. The center reported 28.1 outpatient cases and 1.3 partial hospital admissions per 1000 patient lives. Patients used only 70% of outpatient cases that were authorized in response to primary care physician requests; to our knowledge, this is the first report of these data. Outpatient care was provided by internal providers (76%) and external providers (24%). For internal providers, trainees provided 65% of care for commercial lives and 94.8% of care for Medicaid lives. The average number of outpatient visits was 4.3 for commercial lives and 4.9 for Medicaid patients.

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No. 16
PRACTICE PROFILE OF CANADIAN PSYCHIATRISTS

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EDUCATIONAL OBJECTIVE:

The participants will be able to recognize the nature of the practice of Canadian psychiatrists and how these patterns resemble and differ from those of American psychiatrists.

SUMMARY:

The Practice Profile Survey is a national survey of psychiatrists that was commissioned by the Canadian Psychiatric Association. Conducted in Spring 1997, it assessed one 24-hour day (with a replacement date for nonresponders). Participants gave general information about the 24 hours and details about one random hour (including the first patient seen) and the most severely ill patient seen that day. Domains assessed included services rendered; patient demographics, diagnosis, and impairment; and reimbursement source. The response rate was 4.4% (n = 1621) with 20% on holiday or absent from their practice. Of the remainder, 40% were on call (75% for eight hours plus); 50% of those on call provided no direct or indirect services, while 25% provided more than five hours and 10% more than eight hours of direct care. An average of nine to 10 patients were seen during the day, with 80% of professional time spent on clinical activities. For patients seen during the random hour, 99% had at least one Axis I diagnosis, 33% at least two, and 44% a comorbid Axis II diagnosis. As expected, the most severely ill patients were considerably more impaired. This is a unique dataset providing useful information on the nature of psychiatric practice in Canada.

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SCIENTIFIC AND CLINICAL REPORT SESSION 6—NEUROLEPTICS: COSTS AND BENEFITS

No. 17
HALOPERIDOL VERSUS CLOMIPRAMINE IN AUTISTIC DISORDER

Leon Sloman, M.D., *Clarke Institute, 250 College Street, Toronto, ONT M5T 1R8, Canada;* Gary Remington, M.D., Mary Konstantareas, Ph.D., Kathryn Parker, B.A.

EDUCATIONAL OBJECTIVE:

To postulate mechanisms of action of clomipramine and haloperidol in autistic disorder; to summarize differential effects of haloperidol and clomipramine in autistic disorder.

SUMMARY:

Objective: The study employs a double-blind, placebo-controlled, crossover design to examine the relative effectiveness and side effects of haloperidol and clomipramine in the treatment of autism. It was hypothesized that clomipramine would be superior to haloperidol for ritualistic and compulsive behaviors.

Method: 34 subjects, age range 6-30 with diagnosis of autistic disorder, were randomly assigned to one of three treatment regimes as part of a latin square design. Duration of each trial was seven weeks, each trial was preceded by a one-week, single-blind, placebo washout period (with the 7th week used for drug tapering). Medication was gradually increased to a maximum dose of 150mg of clomipramine and 1.5mg of haloperidol. Instruments to measure clinical improvement included the

1) NIMH Clinical Global Impression Scale;
2) Behavior Observation Scale for Autism-modified;
3) Childhood Autism Rating Scale (CARS); and
4) Aberrant Behavior Check List.

Scales to assess drug induced side effects were

1) Treatment Emergent Symptoms Write-In Scale;
2) Treatment Emergent Symptoms Scale;
3) Extrapyramidal Symptoms Rating Scale;
4) Clomipramine Monitoring Scale.

Results: Haloperidol and clomipramine show a significant difference from baseline on irritability, while haloperidol also was superior to both clomipramine and placebo on the CARS. Clomipramine shows significantly more side effects than haloperidol and placebo particularly with regards to tremor.

Conclusions: Data indicated that haloperidol proved superior to clomipramine, both in terms of clinical efficacy and side effects, for the treatment of autism. At odds with the original hypothesis, clomipramine was not more efficacious in treating ritualistic and compulsive behaviors. Results are discussed in terms of clinical implications as well pathophysiologic mechanisms involved in autism. (Study was funded by the Ontario Mental Health Foundation).

REFERENCES:

1. Gordon CT, State RC, Nelson JE, et al: A double-blind comparison of clomipramine, desipramine and placebo in the treatment of autistic disorder. Archives of General Psychiatry, 1993; 50:441-7.
2. Sanchez LE, Adams PB, Uysal S, et al: A comparison of live and videotape ratings: clomipramine and haloperidol in autism. Pscyhopharmacol Bull. 1995; 31:371-8.

No. 18
COST OF OLANZAPINE TREATMENT COMPARED WITH HALOPERIDOL FOR SCHIZOPHRENIA: RESULTS FROM A RANDOMIZED CLINICAL TRIAL

Susan Hamilton, Eli Lilly and Company, *Lilly Corporate Center, Indianapolis IN 46285;* Dennis Revicki, Ph.D., Laura A. Genduso, Gary D. Tollefson, M.D.

EDUCATIONAL OBJECTIVE:

SUMMARY:

Objective: The evaluation of effectiveness and costs of novel agents is necessary to determine their place in the treatment of schizophrenia. This prospective, double-blind, randomized study was designed to evaluate the efficacy and associated costs of olanzapine versus haloperidol among patients with schizophrenia.

Method: Patients with DSM-III-R schizophrenia received either olanzapine (n = 551) or haloperidol (n = 266) 5 to 20 mg/day for six weeks. Responders were eligible to enter a 46-week double-blind maintenance phase. Two outcome measures were analyzed: responder days (BPRS improvement ≥40% or final BPRS ≤18) and BPRS-based minimal symptom days (BPRS ≤18). Medical resource use was also collected, and costs were assigned using standard prices. Medical costs and outcomes were analyzed using ordinary least squares regression.

Results: Acute phase mean total medical costs for the olanzapine-treated patients averaged $431 per month less than those of the haloperidol-treated patients (p = 0.026). During the first six weeks of acute therapy, the olanzapine-treated patients achieved significantly more responder days (3.3 additional days, p = 0.004) and BPRS-based minimal symptom days (2.8 additional days, p = 0.017) than their haloperidol counterparts. Mean total medical costs during the maintenance phase for olanzapine responders were $345 per month lower than those of the haloperidol responders (p = 0.16). Olanzapine responders demonstrated numerically more responder days and more BPRS-based minimal symptom days during maintenance treatment (20.1 and 23.3 additional days, respectively) than haloperidol responders.

Conclusions: Both acute and maintenance treatment of schizophrenia with olanzapine resulted in greater treatment effectiveness and a cost-benefit advantage over haloperidol.

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No. 19
NMS AND CATATONIA: COMPARATIVE FEATURES

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

EDUCATIONAL OBJECTIVE:

To recognize the similarities and differences between neuroleptic malignant syndrome (NMS) and catatonia (CAT) and to appreciate the associated underlying theoretical issues.

SUMMARY:

Objective: To compare and contrast the epidemiological, clinical, and laboratory features of neuroleptic malignant syndrome (NMS) and catatonia (CAT).

Methods: We have prospectively studied 40 consecutive cases of NMS (14M, 26F; × age = 46.3, SD = 20, range 17-93) and 112 episodes of catatonia (59M, 53F; × age = 44.2, SD = 21, range 44-88) over a 12-year period. All patients met strict diagnostic criteria for CAT and NMS. Detailed information was obtained regarding: 1) underlying diagnoses, 2) clinical features, including autonomic function, 3) associated laboratory and EEG findings, and 4) course of illness and response to treatment.

Results: 1) Affective disorder was the most frequent underlying diagnosis in both NMS (64%) and CAT (41%). 2) The majority of patients in both groups were immobile and mute; distinguishing clinical features included fever (NMS: 100% of cases vs. CAT: 5%) and altered consciousness (NMS: 100% of cases vs. CAT: <10%). 3) Differentiating laboratory features included: leucocytosis (NMS: 75% of cases vs. CAT: 12%); CPK and low serum iron (NMS: 96% of cases vs. CAT: <20%); EEG evidence of encephalopathy (NMS: 100% of cases vs. CAT: 10%). 4) NMS typically resolved in all instances with conservative treatment within hine days; 10% of CAT episodes resolved without treatment. Benzodiazepines were robustly effective in 85% of the remaining cases.

Conclusions: While NMS and CAT share clinical features, only NMS is regularly associated with evidence of an acute phase response.

REFERENCES:

1. Rosebush, et al. Catatonic syndrome on a general psychiatric ward: frequency, clinical presentation and response to lorazepam. Journal of Clinical Psychiatry 1990; 51:9:357-362.
2. Rosebush PI, Stewart T: A prospective analysis of 24 episodes of neuroleptic malignant syndrome. American Journal of Psychiatry 1989; 146:6:717-725.

SCIENTIFIC AND CLINICAL REPORT SESSION 7—CHALLENGES IN DIAGNOSIS

No. 20
INCARCERATION: WHAT DOES IT DO TO PSYCHIATRIC DIAGNOSIS?

Balbir S. Coshal, M.D., *Columbia Area MHC, 1618 Sunset Drive, Columbia SC 29203*

EDUCATIONAL OBJECTIVE:

To recognize the pitfalls in the psychiatric diagnosis in the incarcerated juvenile population and how to avoid them in order to reach a more accurate diagnosis.

SUMMARY:

Objective: This paper presents four case studies of adolescent inmates of the Department of Juvenile Justice (DJJ) who were admitted to the inpatient unit for stabilization of the acute phase of their Axis I mental illness. The diagnoses for which they were referred were not confirmed in the hospital setting. A hypothesis for this phenomenon is suggested.

Method: Medical records including notes from referring psychiatrists from DJJ were reviewed. When indicated medication prescribed

by the referring psychiatrists were carefully withdrawn during their hospital stay. Observations from team members, who included a child and adolescent psychiatrist, psychologist, social worker, nurses, activity therapist, and mental health workers, were pooled. Final diagnosis was reached by a consensus of the team.

Results: In all four cases the acute Axis I diagnoses for which they were referred were not confirmed. Their original diagnoses were bipolar disorder, schizophrenia, and schizoaffective disorder. The diagnoses that we arrived at included attention deficit hyperactivity disorder, and adjustment disorder to being incarcerated. Malingering was considered but it did not explain the whole picture.

Conclusion: It is suggested that the symptoms of agitation, insomnia, paranoia, hallucinations, and suicidal and homicidal ideation presented by the inmates in the DJJ environment are a reaction to the specific stresses they face at DJJ. These stresses include physical and sexual abuse by their bigger peers as well as staff who are supposed to protect them. These stresses probably induce changes in the neurotransmitter systems, notably noradrenergic and adrenocortical systems, giving rise to the symptoms of agitation, insomnia, hallucinations, paranoia, and depression. The safe and nurturing milieu of the hospital removed these stresses, consequently their symptoms abated. This is a retrospective study, thus it has the limitations that can be eliminated in a prospective research design. Further systematic research will be needed. All the same these findings have implications in the differential diagnosis in the incarcerated youth as well as in their rehabilitation. No funding was received in preparation of this paper.

No. 21
PSYCHIATRIC DIAGNOSIS IN CLINICAL PRACTICE

Mark Zimmerman, M.D., *Department of Psychiatry, Rhode Island Hospital, 235 Plain Street Ste 501, Providence RI 02905;* Jill I. Mattia, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation participants should be able to understand that diagnostic comorbidity is often missed during the routine clinical evaluation, and they should become more aware of which disorders are most often overlooked.

SUMMARY:

Objective: The recognition of comorbidity has important clinical significance because comorbidity predicts poorer outcome for patients with depressive and anxiety disorders. In routine clinical settings, an unstructured clinical interview is typically used to assess patients. Unstructured interviews, however, may result in missed diagnoses, with potential negative clinical consequences.

Method: Axis I diagnoses derived from structured and unstructured clinical interviews were compared in two groups of psychiatric outpatients seen in the same practice setting. Five hundred individuals presenting for an intake appointment to a general adult psychiatric practice underwent a routine unstructured clinical interview. Subsequent to the completion of the first study the method of conducting diagnostic evaluations was changed and 500 individuals were interviewed with the Structural Clinical Interview for DSM-IV disorders (SCID).

Results: The two groups had similar demographic characteristics and scored similarly on symptom questionnaires. Individuals interviewed with the SCID were assigned significantly more Axis I diagnoses than individuals who were assessed with an unstructured interview. More than one-third of patients interviewed with SCID received three or more disorders in contrast to fewer than 10% of the patients assessed with an unstructured interview. Fifteen disorders were more frequently diagnosed in the SCID sample, and these differences cut across mood, anxiety, eating, somatoform, and impulse-control disorder categories.

Conclusions: The results suggest that in routine clinical practice clinicians underrecognized diagnostic comorbidity. The anxiety, somatoform, and not otherwise specified (NOS) disorders were the most frequently underdetected disorders. The implications of underdiagnosis for treatment outcome will be discussed.

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1. Mezzich JE, Fabrega H, Coffman GA: Multiaxial characterization of depressive patients. J Nerv Ment Dis. 1987; 175:339-346.
2. Brown TA, Barlow DH: Comorbidity among anxiety disorders: implications for treatment and DSM-IV. J Consult Clin Psychol. 1992; 6:835-844.

No. 22
THE EVALUATION PROCESS IN OBSTRUCTIVE SLEEP APNEA

Milton Kramer, M.D., *Sleep Center, Bethesda Hospital, 619 Oak Street, Cincinnati OH 45206*

EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, the participant should recognize the problems in evaluating and treating the major sleep problem obstructive sleep apnea.

SUMMARY:

The clinical effectiveness of the evaluative process in somnology remains a topic of high interest. This report reviews the diagnostic and treatment process for all patients seen in our center between August, 1984 and December, 1995 who had a diagnosis of obstructive sleep apnea (OSA) by intake history. During the 11-year period, 8500 patients were seen and 82.6% (7025) had a diagnosis of OSA. Of these 7025 patients with the diagnosis of OSA by history, 75% (5270) had at least one clinical polysomnogram. (CPSG)

The diagnostic accuracy of the medical history for OSA was 68%. Some 3584 of the 5270 patients with a history of OSA had their OSA confirmed by CPSG, while 1686 (325) did not. Table I describes the disposition of the 3584 patients who had a diagnosis by history of OSA that was confirmed by CPSG.

Table I: Disposition of 3584 Patients Who Had OSA on CPSG

Nasal continuous positive air pressure (NCPAP) titration	1946	(54.3%)
No treatment at the center	921	(25.7%)
Surgery—uvulopalatopharyngoplasty (UPPP)	347	(9.7%)
Medication	291	(8.1%)
Intraoral devices	41	(1.1%)
Weight loss	38	(1.1%)

We had 1946 patients who had an NCPAP trial (adjustment) in the laboratory. Some 1401 (72%) tried the NCPAP at home, while 545 (28%) rejected the NCPAP based on their one-night trial in the laboratory. The current status of the 1401 patients who tried the NCPAP at home is summarized in Table II

Table II: Status of 1401 Patients Who Tried NCPAP at Home

Still on NCPAP	412	(29.4%)
Stopped NCPAP	294	(21.0%)
Status unknown	695	(49.6%)

We have an effective but burdensome treatment or OSA. Utilization of the treatment remains an enormous problem. The diagnostic and treatment process in somnology remains at the clinical level and needs to be more carefully and systematically scrutinized.

REFERENCES:

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2. Krieger J: Long-term compliance with nasal continuous positive airway pressure (CPAP) in obstructive sleep apnea patients and non-apneic snorers. Sleep. 1992; 15:542-546.

SCIENTIFIC AND CLINICAL REPORT SESSION 8—SEX, ADDICTION, AND ETHICS OF TREATMENT

No. 23
SEXUAL ABUSE BY CLERGY: CLINICAL AND FORENSIC ISSUES

Diane H Schetky, M.D., *PO Box 220, Rockport ME 04856*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant should be able to describe the problems of sexual abuse by the clergy including liability issues and PTSD.

SUMMARY:

The problem of sexual abuse by the clergy is discussed as is the impact on victims, drawing from forensic evaluations done on 11 plaintiffs by the author. Typically, victims did not questions the authority of the offending priests and some viewed them as agents of God. Victims' disclosures were met with disbelief from the congregation and parents as well. Some felt shunned by the church and lost the support of both family and the church in their time of need. Rarely did the church offer any support to the victim; rather, it often adopted a stone-walling posture and relocated the alleged perpetrator to another parish. Conflicts around sexual identity, sexual problems, loss of faith, social withdrawal, and PTSD were common among victims. Liability issues include negligent hiring, retention, and supervision. Obstacles to bringing about a successful suit include statutes of limitation, statutes that limit the liability of charitable organizations, and the need to overcome disbelief on the part of jurors.

REFERENCES:

1. Sipe AW: Sex, Priests and Power. NY: Brunner/Mazel, 1995
2. Berry J: Lead Us Not Into Temptation. NY: Image Book, 1994

No. 24
SEXUAL ADDICTION: AN INTEGRATED UNDERSTANDING

Aviel Goodman, M.D., *MN Inst of Psychiatry, 1347 Summit Ave, St. Paul MN 55105-2219*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to diagnose sexual addiction; to recognize the differential diagnosis and epidemiology of sexual addiction; to understand the relationship between sexual addiction and other addictive disorders; and to describe an approach to treating sexual addiction.

SUMMARY:

Objective: This paper proposes an integrated theoretical framework for understanding sexual addiction.

Method: A condition is identified in which a person's sexual behavior is driven and maladaptive, causing either subjective distress or significant functional impairment. Alternative classifications and designations for this condition are considered. A definition of and a set of diagnostic criteria for this condition are presented, after which its differential diagnosis and epidemiology are briefly addressed. The relationship between this condition and other similar disorders is discussed. An approach to treating individuals who suffer from this condition is then outlined.

Results: This condition is found to be most suitably classified as an addictive disorder and designated as "sexual addiction." Sexual addiction is defined as a condition in which some form of sexual behavior is employed in a pattern that is characterized by two key features: recurrent failure to control the behavior and continuation of the behavior despite significant harmful consequences. Sexual addiction shares with other addictive disorders a large number of clinical findings and epidemiological relationships, and it is hypothesized also to share with other addictive disorders an underlying biopsychological process.

Conclusion: Sexual addiction is a prevalent condition that can be defined, diagnosed, understood, and treated.

REFERENCES:

1. Goodman A: Sexual addiction: diagnosis, etiology, and treatment. In: Lowenstein JH, Millman RB, Ruiz P, Langrod JG, eds. Substance Abuse: A Comprehensive Textbook, Third Edition. 1997; Baltimore: Williams & Wilkins, pp. 340-354.
2. Goodman A: Sexual Addiction: An Integrated Approach. 1997; Madison, CT, International Universities Press.

No. 25
ETHICS IN THE PRACTICE OF PSYCHIATRY IN SOUTH AFRICA

Christopher P. Szabo, M.D., *Department of Psychiatry, Witwatersrand University, 7 York Road, Johannesburg 2193, South Africa;* Robert Kohn, M.D., Alan L. Gordon, M.D., Itzhak Levav, M.D., George A. Hart, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, the participant should have an awareness of ethical considerations in the practice of psychiatry, with specific reference to the South African situation.

SUMMARY:

Objective: The study was part of a multicenter international survey of ethics in the practice of psychiatry. Decision-making patterns regarding the use of involuntary treatment were examined as was awareness of potential abuses within psychiatry. No such investigation has previously been conducted in South Africa.

Methods: The study employed a case-vignette method, with emphasis on the gender and race of the patient as potential modifying variables in their management. Open-ended questions pertaining to potential abuses were included. Questionnaires were mailed to all psychiatrists in 1993 and 1994 during the post-apartheid transition.

Results: A 40% (n = 80) response rate was obtained. Race and gender of the patient did not influence diagnosis or have a marked impact on treatment. Family pressure placed on the psychiatrist did alter their management decisions, as did the psychiatrists' age and gender in some instances. Racial discrimination, sexual misconduct, and economic abuse were the most frequently cited areas of observed abuses within the South African psychiatric system.

Conclusions: The results demonstrate that in general, the practice of psychiatry in South Africa is characterized by objectivity and awareness of ethical considerations in decision making. With the demise of the apartheid system, South African psychiatry has an opportunity to contribute to the increasing emphasis on the protection of human rights.

REFERENCES:

1. Kohn R, Flaherty JA, Levav I: Cross-cultural psychiatric ethics and abuse, Symposium 142nd Annual Meeting of the American Psychiatric Association, San Francisco, 1989.

2. Kulgren G, Jacobsen L, Lynoe N, et al: Practices and attitudes among Swedish psychiatrists regarding the ethics of compulsory treatment. Acta Psychiatrica Scandinavia 1996; 93:389-396.

SCIENTIFIC AND CLINICAL REPORT SESSION 9—DEPRESSION: OUTCOMES AND COMORBIDITIES

No. 26
MATCHED VERSUS MISMATCHED TREATMENT FOR DEPRESSED INPATIENTS

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

EDUCATIONAL OBJECTIVE:

To have a better understanding of the efficacy of different treatments for depressed inpatients.

SUMMARY:

Objective: To investigate the efficacy of different treatments for depressed inpatients.

Method: 121 inpatients with major depression were randomly assigned to treatment conditions that were matched or mismatched to the patient's pretreatment levels of cognitive distortion and family functioning. The treatment conditions included: a) pharmacotherapy alone, b) cognitive therapy + pharmacotherapy c) family therapy + pharmacotherapy or d) combined treatment (pharmacotherapy + cognitive therapy + family therapy). Treatment began after discharge and continued for six months.

Results: There were no significant differences between matched and mismatched conditions. However, there was a significant difference according to treatment condition subjects in the combined condition having lower rates of discontinuation because of increased symptoms or suicidality than subjects in the pharmacotherapy group. There was also a tendency for the combined group to have higher improvement and response rates; however, this effect was partially mediated by pretreatment Beck Depression Inventory score, such that patients with lower BDI scores responded equivalently in the combined and pharmacotherapy conditions, while patients with more severe BDI scores responded significantly better in the combined condition.

Conclusions: Although this study did not find support for matching algorithm tested, it did find evidence for severity of depression predicting response to combined treatment vs. pharmacotherapy.

REFERENCES:

1. Miller IW, Keitner GI: Combined pharmacological and psychosocial treatment for mood disorders. Psychiatric Clinics of North America, 1996; 19:151-171.
2. Miller IW, Norman WH, Keitner GI: Cognitive-behavioral treatment of depressed inpatients: 6 and 12 month follow-up. American Journal of Psychiatry. 1989; 146:1274-1279.

No. 27
SOCIODEMOGRAPHIC AND CLINICAL PREDICTORS OF LIFETIME HISTORY OF ALCOHOL AND DRUG ABUSE IN DEPRESSED OUTPATIENTS

John J. Worthington III, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 815, Boston MA 02114;* Bronwyn R. Keefe, B.A., Andrew A. Nierenberg, M.D., Jonathan E. Alpert, M.D., Joel Pava, Ph.D., Jerrold F. Rosenbaum, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVE:

To understand which factors may predict a history of either alcohol or substance abuse/dependence in outpatients with major depression.

SUMMARY:

Background: Alcohol/substance abuse comorbidity is commonly observed among patients with major depressive disorder (MDD). Data from the Epidemiologic Catchment Area study showed that among subjects with a history of unipolar major depression, 17% met DSM-III criteria for a lifetime prevalence of alcohol abuse and/or dependence (AAD) and 18% had a lifetime prevalence of substance abuse and/or dependence (SAD).

Objective: We assessed the relationship between sociodemographic and clinical variables and a history of either AAD or SAD in depressed outpatients.

Method: Eligible subjects were adults who met DSM-III-R criteria for MDD as determined by the Structured Clinical Interview for DSM-III-R-Patient Edition. Patients with a lifetime history of AAD or SAD were required to have been in full remission for at least the 12 months preceding entry into the protocol. Demographic information and data concerning the patients' illnesses were collected.

Results: Of the 329 patients, 107 (33%) had a lifetime history of AAD and 81 (25%) had a lifetime history of SAD. There were no statistically significant differences between subjects with and without AAD or SAD in terms of ethnicity, education, marital status, presence of atypical features, number of episodes of MDD, and comorbidity with any anxiety disorder. Statistical significance ($p < .01$) was seen in gender, with more men (41%) than women (26%) having a history of AAD. There was also a trend ($p < .1$) towards significantly more men (30%) than women (20%) having a history of SAD. Depressed subjects with a history of SAD were significantly ($p < .02$) younger (mean age 37 ± 8 years) than subjects without (mean age 40 ± 11 years) a history of SAD.

Conclusions: With the exception of gender, and to a lesser degree age, no sociodemographic or clinical variables predicted a history of either AAD or SAD.

REFERENCES:

1. Reiger DA, Farmer ME, Rae DS, et al: Comorbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiologic Catchment Area (ECA) study. JAMA 1990; 264:2511-2518.
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No. 28
A SYSTEMATIC REVIEW OF THE MORTALITY OF DEPRESSION

Lawson R. Wulsin, M.D., *Department of Psychiatry, University of Cincinnati, 231 Bethesda Avenue (ML 559), Cincinnati OH 45267-0559;* George E. Valliant, M.D., Victoria E. Wells, M.D.

EDUCATIONAL OBJECTIVE:

To understand the evidence for and against a relationship between depression and mortality; to identify the research needs for future studies of the mortality of depression.

SUMMARY:

Objective: To assess the literature on the mortality of depression with respect to five issues: 1) strength of evidence for increased mortality, 2) controlling for confounders, 3) the contribution of suicide, 4) variation across sample types, and 5) possible mechanisms.

Method: We searched all relevant English-language databases from 1966-96 for reviews and studies that included a formal assessment of depressive symptoms or disorders, death rates or risks, and an appropriate comparison group.

Results: We found 45 studies; 16 (36%) were positive, eight (18%) negative, and 21 (46%) mixed. Eighteen studies (40%) studies ranked among the better studies on our strength of evidence scale, but they do not provide a sound estimate of mortality risk. Only seven studies control for two of the four major confounders; six control for smoking and five control for alcohol. Suicide accounts for less than 20% of the deaths in psychiatric samples, and less than 1% in medical and community samples.

Conclusion: The data linking depression and early death are mostly mixed and poorly controlled. The better studies suggest that depression substantially increases the risk of death by unnatural causes and cardiovascular disease, but not by other causes.

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SCIENTIFIC AND CLINICAL REPORT SESSION 10—TREATMENT ISSUES IN DEPRESSION

No. 29
BIRTH OUTCOMES FOLLOWING PRENATAL EXPOSURE TO FLUOXETINE

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EDUCATIONAL OBJECTIVE:

To enhance understanding of factors that may contribute to obstetrical outcome following prenatal exposure to psychotropics; to clarify the putative safety of fluoxetine when used during labor and delivery; and to describe treatment guidelines that may include use of fluoxetine through labor and delivery to minimize risk of puerperal worsening of mood.

SUMMARY:

Recent investigations suggest high rates of relapse in pregnant women who suffer from recurrent mood disorder and who discontinue maintenance antidepressant treatment proximate to conception. For those women who may elect to maintain treatment with antidepressants such as tricyclics or fluoxetine during pregnancy, delineation of risk for perinatal toxicity associated with use or these agents during labor and delivery is critical.

Methods: Neonatal and obstetrical outcome was assessed in 31 newborns whose mothers used fluoxetine during pregnancy. Information was gathered regarding (1) intensity of fluoxetine exposure, (2) timing of exposure: early (trimester I) and/or versus late (trimester III to delivery), (3) age, (4) parity, (5) method of delivery, (vaginal versus caesarean), (6) duration of active labor, and (7) delivery at a tertiary versus comunity hospital. Outcome variables of interest included (1) five-minute APGAR score, (2) birthweight, (3) gestational age at delivery (preterm ($\leq$ 37 weeks), (4) presence of poor neonatal adaptation, and (5) admission to special care nursery.

Results: Neonatal complications* and APGAR** scores at five minutes were associated with total *duration* of fluoxetine exposure during pregnancy (*p = .06, **p = .05). Nine infants who were exposed to fluoxetine proximate to delivery were admitted to the special care nursery (SCN), though admission to the SCN was most strongly associated with hospital type (tertiary versus community) in which mother delivered (chi square, p = .0028). The clinical significance of SCN admissions seemed limited and no newborn failed to be discharged with mother within the extremely short duration of the perinatal hospital stay.

Conclusions: Multiple factors including but not limited to prenatal exposure to psychotropic and nonpsychotropic drugs may contribute to obstetrical and neonatal outcome as well as acute disposition of the newborn, i.e. the special care nursery. Antidepressant discontinuation proximate to labor and delivery is best avoided and may actually place women at heightened risk for postpartum worsening of psychiatric disorder.

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No. 30
VENLAFAXINE IN THE TREATMENT OF POSTPARTUM DEPRESSION

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EDUCATIONAL OBJECTIVE:

To understand the role of venlafaxine for the treatment of postpartum major depression; to delineate apparent dosage range to which most patients who suffer from postpartum major depression respond as well as frequently reported side effects.

SUMMARY:

Introduction: Several studies describe a prevalence of nonpsychotic postpartum major depression approximating 10%. Despite the significant morbidity associated with puerperal mood disturbance, postpartum depression remains underrecognized and undertreated. To date, few treatment studies have been performed to establish efficacy of specific antidepressants this population of women.

Methods: Twenty women meeting criteria for major depression with onset during the first three months postpartum were accessioned into an open-label trial of venlafaxine. Women were accessioned during the first postpartum year, but onset during the first three puerperal months was required for inclusion. Patients were treated with venlafaxine on a flexible dosing schedule to a maximum of 225mg/day over an eight-week period. The Structured Clinical Interview for Diagnosis (SCID-IV) was administered at baseline. The Hamilton Depression Rating Scale (HDRS) and Beck Depression Inventory (BDI) were administered every other week during the study. The Social Adjustment Scale was also administered at each visit during the course of the study.

Results: Interim analysis revealed a mean Ham-D score of 25.79 (S.D. = 5.16) for the first 14 patients who completed the study. All but one patient demonstrated a reduction in Ham-D score to below diagnostic threshold for MDD. Mean Ham-D score at endpoint was 5.79 (S.D = 7.56). Side effects included symptoms of nocturnal sweating, nausea, and dry mouth and were typically transient. No

patient discontinued treatment because of side effects during the eight-week trial.

Conclusion: Venlafaxine appears to be an effective antidepressant for the treatment of postpartum major depression. Treatment-emergent side effects do not appear to limit therapy. Like sertraline and fluoxetine, venlafaxine appears to be effective for the treatment of puerperal mood disturbance. Replication of these preliminary data in a placebo-controlled study are necessary to confirm these findings. Data on the balance of the cohort (n = 6) will be presented as will psychosocial characteristics of the population.

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No. 31
CHANGES IN INSOMNIA DURING THE TREATMENT OF DEPRESSION

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should recognize that the majority of patients with high baseline insomnia show significant improvement in their insomnia by week 2 of treatment and that predictions regarding the likelihood of treatment tolerability cannot accurately be made on the basis of baseline insomnia level.

SUMMARY:

Introduction: We examine the effects of fluoxetine (''nonsedating'') treatment on insomnia symptoms in patients characterized as having high or low baseline insomnia.

Method: We analyzed data from seven double-blind clinical trials including 2456 patients with major depression randomly assigned to fluoxetine or placebo treatment. Baseline HAMD insomnia score (total of Items 4, 5, and 6) was used to categorize patients as having low insomnia (<4) or high insomnia (≥4). Baseline-to-endpoint reduction in insomnia score was used as a measure of improvement. The frequency of treatment-emergent insomnia (appeared or worsened during treatment) was also determined.

Results: Compared with placebo, fluoxetine-treated patients with high baseline insomnia experienced significant reductions in insomnia score (fluoxetine, –2.132; placebo, –1.632; p < .05). Patients with low baseline insomnia showed a slightly decreased insomnia score in both treatment groups (fluoxetine, –0.243 and placebo, –0.272). Frequency of treatment-emergent insomnia was greater in fluoxetine- vs. placebo-treated patients in both insomnia categories (low insomnia; 15.7% vs 5.8%, p < .001 and high insomnia; 16.0% vs 11.5%, p = .02).

Conclusion: Compared with placebo, fluoxetine-treated patients with high baseline insomnia showed significant improvement in insomnia, and patients with low baseline insomnia evidenced numerical improvement from baseline in both treatment groups. The frequency of treatment-emergent insomnia for fluoxetine-treated patients was virtually identical in high and low baseline insomnia groups.

Research funded by Eli Lilly and Company

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SCIENTIFIC AND CLINICAL REPORT SESSION 11—THE SPECTRUM OF SUBSTANCE ABUSE: RESEARCH FROM THE BRAIN TO THE STREETS

No. 32
PSYCHOPATHOLOGY AND THE RISK OF HOMELESSNESS

Collaborative Presentation with the National Institute on Drug Abuse

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the role of substance and mental disorders as risk factors for homelessness when severe mental illness is not present.

SUMMARY:

Objective: How important is psychopathology in the onset of homelessness when severe mental illness is not present? Prior research on risk factors for homelessness focused on subjects with chronic mental illness and long-standing homelessness, has not provided a clear answer to this question.

Method: We conducted a NIDA-funded case-control study of 200 newly homeless men and women selected from New York City municipal shelters, and 200 never-homeless men and women who were applicants for public assistance. The sample was stratified by gender, and homeless cases were matched with never-homeless controls on gender, age, and ethnicity. Subjects were excluded if they had ever experienced a psychiatric hospitalization or a psychotic disorder. Subjects who gave voluntary informed consent were interviewed with a battery of standardized assessments that included the Structured Clinical Interview for DSM-IV. We looked at the following disorders: bipolar disorder, major depression, dysthymia, substance-induced mood disorder, depressive disorder NOS, PTSD, antisocial personality disorder, alcohol abuse/dependence, and drug abuse/dependence.

Results: Homeless and never-homeless of both genders were quite similar with regard to lifetime and current bipolar disorder, dysthymia, depressive disorder NOS, and antisocial personality disorder. Homeless men were more likely than never-homeless men to have current diagnoses of major depression, substance-induced mood disorder, or PTSD. Homeless women were more likely than never-homeless women to have current PTSD. Although lifetime diagnoses of substance abuse/dependence were widespread in all groups, current diagnoses of substance abuse/dependence were significantly more common among the newly homeless.

Conclusion: Current substance abuse/dependence and certain mental disorders occur more commonly among the newly homeless compared with matched never-homeless controls, suggesting that specific aspects of psychopathology play an important role in the onset of homelessness.

REFERENCES:

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No. 33
ADDICTION PROFESSIONALS' PERCEPTION OF NICOTINE USE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will be able to understand how nicotine dependence is viewed by professionals treating other addictions; the factors contributing to their attitudes towards nicotine dependence; and proposed measures to increase their motivation to address this illness in substance abuse treatment programs.

SUMMARY:

Objective: To survey addiction professionals' willingness to address nicotine dependence while treating drug/alcohol addiction. How does the professional's own nicotine dependence, training, and perception of the impact of nicotine addiction treatment on the recovery process affect his or her willingness to address this illness concurrently while treating other addictions?

Methods: 24-item questionnaire administered to professionals at four addiction treatment programs in Southeastern Virginia. Responses were analyzed using frequency distributions and contingency tables.

Results: 57% of professionals believed that nicotine dependence should be treated concurrently with other addictions. Professionals who wanted to address it believed that nicotine dependence had a significant impact on recovery from other addictions. Forty percent of the responders were smokers; 75% of smoking professionals didn't want to address nicotine dependence. Training and smoking cessation increased the professional's motivation to address nicotine dependence.

Conclusion: Addiction professionals have different views regarding treating nicotine dependence. More emphasis on nicotine is needed when training addiction professionals. Professionals who don't use nicotine were more motivated to incorporate nicotine treatment in a patient's management and so were those who had recovered from nicotine dependence. More cohort studies are needed to examine the actual patient response to changing professionals' attitudes towards treating nicotine dependence.

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1. Hurt RD, Croghan IT, Offord KP Eberman, KM, Morse RM: Attitudes towards nicotine dependence among chemical dependency unit staff before and after smoking cessation trial. J. of Substance Abuse Treatment, 1995; 12:247–252.
2. Joseph AM: Nicotine treatment at the drug dependency program of the Minneapolis VA Center: a researcher perspective. J of Substance Abuse Treatment, 1993; 10:147–152.

No. 34
MU-OPIOID RECEPTOR BINDING DURING COCAINE ABSTINENCE

Collaborative Presentation with the National Institute on Drug Abuse

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EDUCATIONAL OBJECTIVE:

To understand the influence of cocaine use on brain mu-opioid receptor binding and its implications for treatment.

SUMMARY:

Objective: To evaluate the time course of upregulation of brain mu-opioid receptors (mOR) in cocaine addicts.

Method: Positron emission tomography (PET) scanning with 11C carfentanil in 12 chronic heavy cocaine users and 25 non-drug-using healthy controls. Cocaine users had 90 days of monitored abstinence on a closed research ward, during which they had five PET scans: #1 within 48 hours of last cocaine use, #2 and #3 about seven days later, #4 and #5 about 90 days later. Cocaine (80 mg intranasal) was given during scans #3 and #5 five minutes after IV carfentanil.

Results: Compared with controls, cocaine users had significant (– 20%) increases in mOR binding in putamen, cingulate, temporal, and frontal cortex at scan #1, which persisted through scan #4 except in temporal cortex. There was a significant positive correlation between plasma cocaine concentration and the change in regional mOR binding associated with cocaine challenge. There was also a significant correlation between the decrease in mOR binding between scans #2 and #4 and the time to relapse to cocaine use after ward discharge.

Conclusions: Increased brain regional mOR binding persists during prolonged cocaine abstinence and may influence relapse to cocaine use.

Supported by NIDA intramural funds and grant R01-DA 09479.

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SCIENTIFIC AND CLINICAL REPORT SESSION 12—COMPLICATIONS IN THE TREATMENT OF MOOD DISORDERS

No. 35
RELAPSE FOLLOWING DISCONTINUATION OF LITHIUM MAINTENANCE IN PREGNANT WOMEN WITH BIPOLAR DISORDER

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe the risk of relapse in discontinuing maintenance lithium treatment in pregnancy.

SUMMARY:

Introduction: Abrupt discontinuation of maintenance psychotropics can be followed by a high risk of early relapse. The risk is best quantified for the discontinuation of lithium therapy in bipolar disorder in which risk of mania, depression, and suicidal behavior may rise. However, women planning pregnancy must weigh the risks of continuing medications and prenatal exposure against risks of relapse in the setting of stopping their medications. For patients who

choose to stop medications, the risks of gradual or rapid discontinuation on the course of their bipolar disorder have not been quantified in this unique population.

Methods: We investigated the clinical course of 26 pregnancies in women with a history of DSM-IV bipolar I or bipolar II disorders. Time to first recurrence was assessed by Kaplan-Meier survival analysis. Relapse rates and clinical variables were assessed with contingence tables and ANOVA methods.

Results: Mean age at time of conception was 33.0 ± 4.6 years. Subjects discontinuing vs. continuing lithium did not differ significantly by diagnostic subtype, age, or number of previous affective episodes. In none of 11 pregnancies with lithium continued was there a relapse during pregnancy, but following lithium discontinuing shortly before or at the start of pregnancy, 10/15 cases became ill at a time to –50% relapse of 24 ± 7.7 weeks. There was a greater risk of relapse associated with a higher number of past episodes.

Discussion: These findings indicate a very high risk of affective illness during pregnancy in women with bipolar disorder who discontinue lithium maintenance treatment, but a powerful protective effect of continued lithium.

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No. 36
TRICYCLIC ANTIDEPRESSANT OVERDOSES: TIME TRENDS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand recent trends in tricyclic antidepressant overdoses and the possible relationship with prescribing patterns of selective serotonin reuptake inhibitors.

SUMMARY:

Objective: Safety in overdose distinguishes selective serotonin reuptake inhibitors (SSRIs) from tricyclic antidepressant (TCAs). This study examined changes in antidepressant overdoses since the introduction of the SSRIs in 1988.

Method: National data from 1986 through 1994 were obtained from the U.S. National Center for Health Statistics, the American Association of Poison Control Centers, the Drug Abuse Warning Network (DAWN), and pharmaceutical manufacturers. Oregon information from 1986 through 1995 also included medical examiner reports and health maintenance organization data on numbers of antidepressant users.

Result: Although use of SSRIs increased dramatically during the study period, TCA use did not decline and actually increased in Oregon. Nationally, hospitalizations for antidepressant overdose appear to have peaked in 1993 at 0.13% of discharges. No such peak was observed in Oregon where TCA overdoses currently account for about 0.19% of discharges. Analogous time trends were found for poison center calls. The DAWN data suggest that nationwide emergency room mentions of TCAs have declined since 1992.

Conclusion: SSRIs have not replaced TCAs. Nonetheless, national data suggest that TCA overdoses may be declining. However, in Oregon (where TCAs remain widely used) TCA overdoses persist.

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2. Kapur S, Mieczkowski T, Mann JJ: Antidepressant medications and the relative risk of suicide attempt and suicide. JAMA, 1992; 268:3441–3445.

No. 37
CLINICAL EFFECTIVENESS OF CITALOPRAN IN MAJOR DEPRESSION

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EDUCATIONAL OBJECTIVE:

The participant should be able to recognize that major depressive disorder is often a chronic illness requiring long-term treatment. Citalopram is effective in treating depression with significantly fewer side effects than traditional antidepressants, thereby improving safety and compliance.

SUMMARY:

Objective: The purpose of this study was to evaluate the clinical effectiveness and tolerability of citalopram in the treatment of depression. It is mainly because of the numerous adverse side effects of TCAs that SSRIs such as citalopram have been developed.

Method: Forty-seven depressed patients, 26 females and 21 males with a mean age of 38 years (range: 18–65), identified from five private outpatient clinics were treated with 20mg of citalopram daily for six weeks. Patients were administered HRSD (Hamilton) at baseline and weekly thereafter for six weeks, as well as the United Kingdom Undesirable (UKU) Side-Effects Rating Scale.

Results: HAM-D scores revealed a significant decrease of the mean baseline scores from 25 to a mean score of 14 after six weeks of treatment, indicating that by the end of the sixth week, 98% of the patients had a 50% reduction in the HAM-D score. The UKU revealed no major side effects in the dose range in this study. The adverse side effects encountered were transient and did not promote withdrawal.

Conclusion: The results of this study indicate that citalopram is effective in treating depression, minimizing side effects, and improving safety. The lack of side effects could only improve compliance leading to the adequate continuation of treatment.

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1. Montgomery SA, Djarv L: The antidepressant efficacy of citalopram. Int. Clin. Psychopharmacol., (suppl. 1) 1996; 11:29–33.
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SCIENTIFIC AND CLINICAL REPORT SESSION 13—THE SOMATIC SPECTRUM

No. 38
EFFECTS OF TRAUMA EVENTS IN GAD PATIENTS

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Ph.D., R. Bruce Lydiard, M.D., Naresh P. Emmanuel, M.D., Sarah W Book, M.D., Michael R. Johnson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant should be able to recognize the prevalence of trauma and trauma effects in patients with GAD.

SUMMARY:

There are growing data indicating a potential relationship between traumatic events and symptoms of anxiety disorders, such as panic disorder. However, little is known about the effects of traumatic events in patients with generalized anxiety disorder (GAD). We have recently reported significantly higher rates of traumatic events, specifically sexual and physical assault, in treatment-seeking DSM-III-R GAD patients compared with normals. To further examine the effects of trauma in GAD patients we evaluated 52 patients with DSM-III-R GAD (without other current Axis I disorders), using the SCID for DSM-III-R Patient Version, Trauma Assessment for Adults, and the Modified Post-Traumatic Stress Disorder (PTSD) Symptom Assessment Scale for DSM-IV (self report). Further, the 18 somatic symptoms (from the motor tension, autonomic hyperactivity, and vigilance/scanning categories) associated with GAD were evaluated using the SCID interview.

We found that almost all GAD patients (96%) had a history of at least one traumatic event in their lifetime. Traumatic events usually preceded (65%) the onset of GAD. However, study patients did not endorse frequently specific trauma-related symptoms of re-experiencing and avoidance, and only one patient met severity criteria for PTSD (using PTSD Symptom Scale). Interestingly, we found that a history of sexual assault between ages 13-18 years predicted endorsement of significantly less GAD-associated somatic symptoms, specifically motor tension and autonomic hyperactivity symptoms ($p=0.000$, $p=0.0026$, respectively). Additional analyses and the significance of study results will be presented.

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No. 39
CHRONIC PAIN DISORDER FOLLOWING INJURY

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EDUCATIONAL OBJECTIVE:

To recognize the distinctive features of somatoform pain disorder and understand potential pitfalls in treatment.

SUMMARY:

Objective: To compare the characteristics of those who develop chronic pain disorder (PD) after injury with those who do not.

Method: 47 cases of pain disorder, chronic, meeting both DSM-IV and DSM-III-R criteria were compared with 43 injured controls. All subjects received a lengthy semistructured psychiatric interview, and extensive medical records were reviewed. PD cases were similar to controls in time from injury to evaluation (31 vs. 32 months) and all demographic factors except gender (PD group had more females, $p<05$).

Results: The PD group had more distinct sites of pain (5.2 vs. 2.3), spread of pain beyond area of original injury (83% vs. 0%), and nonphysiological findings on physical exam (55% vs. 7%) (all $p<.001$). The PD group had higher daily narcotic (49% vs. 9%, $p<.001$) and benzodiazepine (34% vs. 5%, $p<.01$) use. History of child abuse was present in 21% of the PD group and 12% of controls (not significant). Depression was common in both groups, and antidepressants were frequently used, which helped depression but not pain. Compensation/litigation (measured by a reliable scale) influenced symptoms more in the PD group ($p<.001$).

Conclusions: Chronic PD has distinctive associated features. Psychotherapists often supported the patient's viewpoint that the pain was physical and to be endured.

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No. 40
A FAMILY STUDY OF FIBROMYALGIA

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EDUCATIONAL OBJECTIVE:

Participants will hear a review of the literature related to the association between fibromyalgia and psychiatric disorders, how family data can help elucidate this relationship, and what the data from this study contribute to what is known about fibromyalgia.

SUMMARY:

Background: Fibromyalgia is the most common cause of widespread body pain, with an estimated prevalence of 15%-20% in rheumatology clinics, yet it has no firmly established pathogenesis or treatment, and the diagnosis remains one of exclusion. Fibromyalgia has been associated with psychiatric illness, predominantly anxiety and depression, in at least half and up to 90% of patients who seek treatment for the disorder. This study is a preliminary effort to evaluate whether the relationship between fibromyalgia and psychiatric illness is a real association by comparing the first-degree relatives of patients with fibromyalgia with the first-degree relatives of patients with rheumatoid arthritis. If there is an association between fibromyalgia and psychiatric disorders, then there should be an increased prevalence of both fibromyalgia and psychiatric disorders in the first-degree relatives of fibromyalgia probands.

Methods: Structured interviews were administered to 40 probands and 40 controls to obtain lifetime psychiatric and functional somatoform disorder histories, as well as family history data related to fibromyalgia, psychiatric disorders, and functional somatoform disorders. A Structured Clinical Interview for DSM-IV-Nonpatient version (SCID) was administered to obtain lifetime psychiatric diagnoses as well as the Functional Somatoform Disorders interview. The Family Informant Schedule Criteria (FISC) was administered to probands to gather family history information. The Fibromyalgia Impact Questionnaire (FIQ) and the Illness Worry Scale (IWS) were administered to assess impact of pain, tendency to worry about illness, to be convinced that one is ill, and to feel more sensitive to pain and more vulnerable to illness than others. The NEO Personality Inventory (NEO-PI) was administered to assess personality dimensions and a SCID-II was administered to diagnose DSM-IV personality disorders. A self-administered questionnaire was be given to assess sexual and physical abuse as well as early childhood experiences.

Results: Psychiatric disorders occurred in significantly more probands with fibromyalgia than in control probands with rhuematoid arthritis. The probands with fibromyalgia had significantly more

personality pathology and history of physical and sexual abuse than control probands. The first-degree relatives of fibromyalgia probands had significantly more fibromyalgia and functional somatoform disorders by family history than the first-degree relatives of control probands. The first-degree relatives of fibromyalgia probands had significantly more psychiatric disorders that the first-degree relatives of control probands.

Conclusions: Fibromyalgia is associated with psychiatric disorders and a history of sexual and physical abuse in treatment-seeking patients. That finding was replicated in this study. In addition, fibromyalgia was found to be familial.

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SCIENTIFIC AND CLINICAL REPORT SESSION 14—RISK FACTORS FOR CHILDHOOD PSYCHOPATHOLOGY

No. 41
SOME LONG-TERM CONSEQUENCES OF ORPHANAGE CARE

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EDUCATIONAL OBJECTIVE:

To recognize that symptoms of emotional or physical distress in middle-aged patients may be the consequences of early affective deprivation and that publically available banks of survey data may obviate the need for costly recruitment of control subjects for studies of special populations, provided identical instruments are used.

SUMMARY:

Objective: To determine the very-long-term physical and psychological effects of being raised in an orphanage.

Method: 31 members of a self-help group (aged 45–65) of orphans were selected in alphabetical order from a list of 125 members. Most had been placed at birth and none had been adopted. The comparison groups consisted of all 446 people who participated in a province-wide community health survey who lived in the same area as the ex-orphans and were of the same age and income range.

Measurements: The index group responded to scales of well-being and of psychiatric symptoms and a checklist of chronic physical complaints. These measures were included in the community survey.

Results: Compared to the members of the comparison group with the lowest annual income (0-$10,000), the ex-orphans had significantly lower well-being scale scores and significantly higher scores on measures of psychological distress (median effect size = 1.27). In the group of illnesses that were judged to be potentially stress-related, significantly more ex-orphans had two or more.

Conclusions: There are discernable long-term negative physical and psychological effects of being raised in an orphanage. Larger, representative samples are needed to test the generalizability of the findings of this pilot study.

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No. 42
ATTACHMENT SECURITY OF MOTHERS AND ADOLESCENTS

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EDUCATIONAL OBJECTIVE:

To cite highlights from longitudinal studies of first-born infants and their parents, illustrating aspects of attachment, affect, and the self; to give clinical implications of these findings.

SUMMARY:

Objectives: To determine if a relationship exists between: 1) maternal perception of her one-month-old infant and the child's attachment security 18 years later; 2) the child's attachment security at age 18 years and the mother's attachment security assessed concurrently; 3) the maternal perception of her newborn and the mother's attachment security 18 years later.

Method: Prospective longitudinal follow up of 51 full-term, single, healthy firstborns recruited with their mothers at birth. At one month of age we assessed the mother's perception of her infant using the Neonatal Perception Inventories. Using a semistructured clinical interview of broad spectrum social and emotional functioning designed by Pilkonis (The Interpersonal Relations Assessment), we assessed attachment patterns of mothers and adolescents 18 years later.

Results: A positive correlation existed for each objective: 1) Children rated positively by mothers at one month of age were more likely to have secure attachment at age 18 years. (Sig@ P.000002; odds ratio-35:1); 2) Significant concordance existed between the child's and mother's security attachment determined 18 years after delivery (P.002; odds ratio-9.8:1). The child was more likely to have a secure attachment when the mother was securely attached; 3) Mothers with a positive perception of their newborn were 13.5 times more likely than those with a negative perception to have a secure attachment classification 18 years later (P.005).

Conclusion: The findings suggest a high degree of stability of inner organization over 18 years despite many life changes.

Funding sources: private foundations and the University of Pittsburgh.

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No. 43
SHYNESS AND BEHAVIORAL INHIBITION: RELATIONSHIP TO ANXIETY DISORDERS

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EDUCATIONAL OBJECTIVE:

To understand the potential relevance of childhood behavioral inhibition and shyness in the development of adult anxiety disorders.

SUMMARY:

Objective: Childhood behavioral inhibition (CBI) and shyness may be precursors of adult anxiety disorder. This study examines the degree of CBI and shyness in an anxiety-disordered population as well as investigating the relationship of these constructs to particular anxiety disorders.

Method: A sample of 280 SCID-diagnosed patients with a primary DSM-IV anxiety disorder diagnosis completed a battery of psychometric measures that included the Retrospective Self-Report of Behavioral Inhibition (RSRI), comprising a social-evaluative factor and a general fearfulness factor, and the Revised Shyness Scale (SHY).

Results: Shyness was strongly correlated with social phobic avoidance (r; eq .55), while being largely unrelated to agoraphobic avoidance (r = .21) and modestly related to self-reports of state anxiety (r = .34). The social-evaluative factor of the RSRI showed the same pattern of relationships as the shyness measure. The general fearfulness factor of the RSRI was unrelated to adult social phobic avoidance (r = .18) and self-report of state anxiety (r = .06), and was only modestly related to agoraphobic avoidance (r = .28). Shyness was most related to social phobia, and the social-evaluative factor of the RSRI showed the same relationship.

Conclusions: Childhood social evaluative shyness may be a developmental precursor of adult anxiety disorder, especially social phobia. Behavioral inhibition, as assessed by RSRI, may be associated with anxiety disorder symptomatology only because it indirectly assesses childhood social-evaluative shyness.

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SCIENTIFIC AND CLINICAL REPORT SESSION 15—MENTAL HEALTH DELIVERY ISSUES

No. 44
MAXIMIZING COMMUNITY RESOURCES IN A RURAL SETTING

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EDUCATIONAL OBJECTIVE:

To learn how one system of collaborative efforts works among health professionals; the importance of staying informed about each others needs—consumers, agencies, hospitals, legislators, and the state; the financial benefits of sharing resources; and about the impact of collaboration on legislation and managed care.

SUMMARY:

In order to address the multiple needs of long-term mental health consumers in our rapidly changing health care environment, innovative models of collaboration and partnership leading to resource sharing are needed. This presentation describes the successes of Northeast Networking and Support (NENS) in Maine, primarily a rural state.

Founded in 1993, NENS is a volunteer community collaborative network composed of 21 agencies representing state and local government, psychiatric hospitals, academic institutions, consumers, and family members in a four-county area. Functioning as both a "think tank" and technical support group, any mental health problem (clinical, administrative, and legal) is addressed. Guest speakers are invited to monthly meetings to discuss a broad range of topics including teenage alcoholism, housing, the RFP process, and the state's reorganization of the mental health system.

Through this ongoing collaboration, the group has increased interagency understanding and sharing of limited resources leading to 1) increased continuity of care for patients; 2) modification and strengthening of legislation such as insurance parity and long-term care of children and teenagers; and 3) increased academic training.

Serving as a model for partnership, NENS could be duplicated in any rural community to improve care for those with long-term mental health problems.

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2. Shortell SM, Gillies RR, Anderson DA, et al: Remaking Health Care in America: Building Organized Delivery Systems. San Francisco, Jossey-Bass Publishers, 1996.

No. 45
MANAGED CARE PRINCIPLES APPLIED TO INDIGENT MENTAL HEALTH CARE

F. Kevin Butler, M.D., *Depart. of Public Health, University of South Florida, 4023 N. Armenia Avenue ste 470, Tampa FL 33607*

EDUCATIONAL OBJECTIVE:

To demonstrate an enhanced understanding of how cost, access, and quality analysis can be used to assess the effectiveness of a managed behavioral health care program for the indigent; to recognize how politics and legislator attitude can affect the scope of a behavioral health care program for the indigent.

SUMMARY:

Objective: The Hillsborough County Healthcare Plan (HCHP) of Florida is a nationally recognized managed care health plan for the indigent. This study attempts to critically analyze the mental health components of the plan using cost, access, quality, and policy awareness as indicators.

Method: Analysis of HCHP financial data, level of care provided, and quality improvement information. Interview of HCHP administrators, county commissioners, and state legislators. Literature review of other health care plans for the indigent.

Results: Costs: Mental health care is 3.5% of the total indigent health care budget. Provider reimbursement is for short-term crisis intervention only. Access: Limited continuum of care is provided to psychiatric patients. Primary treatment access remains the E.R. Quality: Public access to clinical information makes peer review a difficult process. Most psychiatric patients are lost to follow up. Policy: County commissioners and legislators tended to be unrealistically concerned about the cost of mental health services.

Conclusions: Managed care principles appear to have been poorly applied to the mental health component of the HCHP. Fear of cost overruns and lack of legislative intent have resulted in limited interest in expanding mental health services.

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No. 46
INTEGRATING PHYSICAL REHABILITATION SERVICES INTO AN INPATIENT PSYCHIATRIC UNIT

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EDUCATIONAL OBJECTIVE:

To recognize the challenge of physical disability in psychiatric patients; to discuss the emerging concept of integrated psychiatric and physical rehabilitation; to cite data to support the efficacy of combining diverse specialties into a single treatment team.

SUMMARY:

Objective: The presence of psychiatric symptoms such as major depression, dementia, or delirium in physical rehabilitation patients often precludes meaningful participation in rehabilitation and achievement of therapy goals. Yet transfer of these patients to a psychiatric unit does not adequately address their physical disability. This paper describes the establishment and operation of an integrated inpatient psychiatric and physical rehabilitation unit and outcomes of this innovative treatment approach.

Method: We studied a consecutive sample of the first 89 patients admitted for simultaneous psychiatric and physical rehabilitation. Follow-up was obtained on 83 individuals an average of nine months post discharge. Length of stay, disposition, functional capacity, and psychiatric status upon follow-up are reported.

Results: Despite the complexity of this patient population, average length of stay for all admissions was less than 18 days. Individuals returned directly to their homes or prior residences in 55% of discharges. On follow-up 54% were in their homes or prior residences. Patients improved their mobility and self-care skills and maintained this improvement on follow-up. However they did not achieve premorbid status in either area.

Conclusions: Formal integration of a rehabilitation team into a psychiatric setting is an effective means of treating high-risk individuals with concurrent physical disabilities and psychiatric diagnoses.

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SCIENTIFIC AND CLINICAL REPORT SESSION 16—BIOLOGICAL STUDIES OF MENTAL ILLNESS

No. 47
PET ANALYSIS OF ANTIDEPRESSANT EFFECTS OF PAROXETINE

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EDUCATIONAL OBJECTIVE:

To know the effects of antidepressant treatment on brain metabolism.

SUMMARY:

Objective: Antidepressants typically require four to six weeks of continuous treatment before efficacy is achieved. In an effort to understand the underlying mechanisms of this delay, the present single-blind randomized exploratory study employed PET/FDG techniques to observe and compare the changes in brain activity subsequent to acute and chronic treatments with the specific serotonin reuptake inhibitor (SSRI) paroxetine.

Method: Thirty right-handed male patients diagnosed with major depression were randomly assigned to receive PET scans following placebo treatment (baseline) and either an acute treatment with paroxetine (15 patients) or following 42 days of continuous paroxetine treatment (15 patients). PET scans were conducted five hours after patients received their test dose of paroxetine in order to approximate t_{max}.

Results: Acute administrations of paroxetine produced little effect on brain metabolism or efficacy. In contrast, chronic paroxetine administrations produced strong, largely lateralized effects. Specifically, chronic paroxetine decreased metabolic activity in the right inferior frontal cortex and right anterior cingulate, and increased activity in the left medial frontal cortex, left anterior cingulate, and left inferior temporal cortex.

Conclusion: Results are consistent with the notion that brain compensatory mechanisms inhibit the initial brain response to antidepressant therapy.

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No. 48
ABNORMAL DIURNAL 5-HIAA WITH PREMENSTRUAL SYNDROME AND PREMENSTRUAL DYSPHORIC DISORDER

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EDUCATIONAL OBJECTIVE:

To recognize the pattern of diurnal 5-HIAA variation in normal subjects versus that seen in women with premenstrual symptomatology.

SUMMARY:

Fifteen women completed a study of the association between diurnal variation in 5-HIAA levels and symptoms associated with premenstrual syndrome (PMS) and premenstrual dysphoric disorder (PMDD). Each participant kept a daily log of 24 symptoms for two months. During two 24-hour admissions, one 48 hours prior to onset of menses and one 48 hours after onset of menses, participants had blood draws for 5-HT and 5-HIAA every 90 minutes. Each woman was assigned to one of three study groups based on symptom ratios: symptom scores for the premenstrual week divided by symptom scores for the midcycle week. Eight women (normal subjects) had symptom ratios less than 1.2 and few symptoms in the week preced-

ing onset of menses (mean symptom ratio=1.09; mean symptom rating=204); four women (PMS subjects) had symptom ratios greater than 1.2 and less than 1.4 and moderate symptoms in the week preceding onset of menses (mean symptom ratio=1.25; mean symptom rating=284), and three women (PMDD subjects) had symptom ratios greater than 1.4 and severe symptoms in the week preceding onset of menses (mean symptom ratio=1.65; mean symptom rating=389). These three groups of women differed in amount of 5-HIAA diurnal variation on postmenstrual measures (1.52, 3.67 and 4.20 ng/ml, respectively). The three groups were also differentiated by premenstrual levels of estradiol ($F(2,12)=5.35$, $p=.026$) and showed a trend to be differentiated by postmenstrual levels of LH and postmenstrual levels of prolactin. For estradiol and LH, levels increased from the nonsymptomatic group to the PMDD group. For prolactin (PRL), levels decreased from the nonsymptomatic group to the PMDD group. These preliminary findings suggest that sub-threshold (PMS) and threshold symptoms of PMDD are associated with increased diurnal variation of 5-HIAA, particularly postmenstrually.

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No. 49
EXPANDING VERSUS STATIC VENTRICLE SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVE:

To recognize the heterogeneous nature of the schizophrenias, and have insight into differences in the symptomatic course and antipsychotic response in two of the schizophrenic-like disorders.

SUMMARY:

Objective: The question of whether schizophrenic-like disorders are of neurodevelopmental or atrophic origin has been argued since the time of Kraepelin. The present paper seeks to clarify this presumed dichotomy.

Methods: To determine whether some psychoses result from an atrophic process, serial cerebral ventricular volumes of schizophrenic patients were measured with MRI. Demographic features, premorbid functioning, and neuroleptic response were assessed in each patient.

Results: The rate of change in patients' ventricular volumes over a period of 2.5 ± 0.8 years was not normally distributed: one subcluster (a putative neurodevelopmental psychosis) showed expansion of 0.9 ± 0.5 cc/year (comparable to controls). Another subcluster (a putative atrophic psychosis) showed ventricular expansion of 4.0 ± 1.0 cc/year ($p<0.001$ [vs. controls]). By adolescence the atrophic psychosis already showed progression of trait-like negative symptoms, which subsequently were poorly responsive to conventional neuroleptics, while positive symptoms evidenced a significant, though delayed (eight weeks) decline. In contrast, the nonexpanding ventricle psychosis was characterized by a paucity of negative symptoms, but with positive symptoms that were poorly responsive to neuroleptics.

Conclusions: These results provide evidence for the existence of two etiologically and clinically distinct psychoses within the rubric of schizophrenia, one atrophic and the other neurodevelopmental.

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2. Garver DL: The etiologic heterogeneity of schizophrenia. Harvard Review of Psychiatry 1997; 4:317-327.

SCIENTIFIC AND CLINICAL REPORT SESSION 17—INNOVATIONS IN PRIMARY CARE

No. 50
USE OF THE PRIME-MD IN A UNIVERSITY STUDENT HEALTH SERVICE

Elizabeth H. Rand, M.D., *Department of Psychiatry, University of Alabama, P.O. Box 870326, Tuscaloosa AL 35487;* Lee W. Badger, Ph.D., Scott Batey, M.S.W., Allison Winters, M.S.W., Julia Hartman, B.A., Marian Swindoll, B.A.

EDUCATIONAL OBJECTIVE:

To describe the frequency of mental disorders in a large public university student health service primary care clinic; to recognize the pros and cons of the PRIME-MD in this setting; to be aware of the low recognition rate of these disorders by physicians; to discuss the public health significance of the problem described.

SUMMARY:

Mental disorders are a major public health problem. Both the dysfunction associated with these disorders and the economic impact on society are substantial. Depression alone is currently the fourth most prevalent disorder worldwide and is predicted to be second by the year 2020. Since most mental disorders have their onset in the later teens and early 20's, their timely recognition and treatment should be a central task of primary care physicians treating this age group.

This pilot study reports on the use of the PRIME-MD in the primary care clinic of a large public university student health service. The PRIME-MD consists of a patient questionnaire (PQ) followed by a clinical evaluation guide interview. It yields 18 specific DSM-III-R diagnoses (nine threshold and nine subthreshold), and is known to be brief (8.4 minutes). All students visiting the clinic doctor during the three-month Thursday a.m. study period filled out the PQ. The CEG was then administered by a social worker to students who were PQ+. Frequency of PRIME-MD disorders was calculated based on CEG(+) results for the 381 students completing the study. The summary sheet with CEG results was attached to the front of the chart and available to the doctors at the time of the visit. Doctors' recognition of disorders was estimated through chart review. Students' stated reasons for coming to the clinic were correlated with doctors' recognition.

Results showed that 40% of the student population attending the clinic had a psychiatric disorder: 16% had a mood disorder, 18% an anxiety disorder, 19% a somatoform disorder, 9% probable alcohol abuse or dependence, and 1% an eating disorder. Also, 56% of students who were CEG(+) had only one disorder, with a mean of 1.9 and a range from 1 to 8, supporting the findings of the NCS. Co-occurrence rates among modules will be presented. Five proxies for physician awareness of these disorders were extracted from the record; together they yielded a recognition rate of only 32% even though the summary sheet was available to the doctors. Reasons students gave for coming to the clinic were grouped into categories according to the likelihood they might have a mental disorder. When CEG(+) students presented with a complaint more likely to represent a psychiatric problem, they were more likely to be recognized than

when their complaint was very specifically medical (64% vs. 24%). Comparison with Spitzer's data and demographic differences will be presented.

These results are similar though not identical to Spitzer's finding in a general medical clinic. The Eating Disorder and Alcohol modules may be less useful than the other three. Frequency of disorders is high, yet under-recognition and undertreatment are also high, as has been documented in many primary care settings. Because college is a time of high stress and also of onset of many mental disorders, it is critical that both preventive measures and interventions designed to improve recognition be implemented.

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2. Spitzer R, et al: Utility of a new procedure for diagnosing mental disorders in primary care: the PRIME-MD 1000 study. JAMA 1994; 272:1749–1756.

No. 51
TELEPSYCHIATRY IN GEORGIA: A MULTICHANNELED APPROACH

Rhonda G. Vought, M.D., *Department of Psychiatry, Medical College of Georgia, Telemedical Center EA100, Augusta GA 30912;* R. Kevin Grigsby, D.S.W., Laura N. Adams, B.S., Stewart A. Shevitz, M.D.

EDUCATIONAL OBJECTIVE:

To describe the multichanneled nature of the Telepsychiatry Project; to demonstrate an understanding of the obstacles to implementing a program this type; to describe findings related to providing telepsychiatry services; to access the Georgia Mental Health Network throught the World Wide Web.

SUMMARY:

Objective: To describe the creation of comprehensive mental health telecommunications to serve rural and/or isolated persons, resulting in more equitable distribution of mental health resources.

Method: GSAMS, the Georgia Statewide Academic and Medical System, is a comprehensive distance learning and telemedicine network. Its Georgia Statewide Telemedicine Program (GSTP) allows two-way audiovisual communication integrated with medical peripherals. Telepsychiatric consultation is not a new idea (Baer et al, 1997). However, integration of telemedicine with a state mental health system is unique. Additionally, the "distribution" of telepsychiatry through additional integrated telecommunication channels is relatively novel. Progress to date includes the establishment of two additional telemedicine sites including one at Gracewood State School and Hospital, the creation of the Georgia Mental Health Network on the World Wide Web, and the incorporation of "desktop" video.

Results: This presentation describes the history of the development of the MCG Telepsychiatry Project. Through the use of the Georgia Statewide Telemedicine Program, the World Wide Web, and other innovative technologies, a more equitable distribution of mental health resources is underway.

Conclusion: A functional multichanneled mental health infrastructure is necessary to assess the impact of telecommunication on the distribution of mental health resources.

Funding: University System of Georgia Board of Regents.

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No. 52
CARE MODELS GUIDE PRIMARY CARE PSYCHIATRY TEACHING

Elizabeth H. Rand, M.D., *Department of Psychiatry, University of Alabama, P.O. Box 870326, Tuscaloosa AL 35487;* Troy L. Thompson II, M.D.

EDUCATIONAL OBJECTIVE:

To utilize six educational models that may be successfully implemented to provide psychiatric education to primary care physicians and recognize how these parallel and may be tailored to six frequent clinical settings in primary care. Utilizing the corresponding clinical and educational models together may complement and improve the efficacy of each.

SUMMARY:

Objective: Psychiatrists involved in the education of primary care physicians should utilize a variety of clinical settings where different educational approaches could be most successful.

Method: We identified six frequent primary care delivery models that are often analogous to Strain's six basic models (consultation, liaison, bridge, hybrid, autonomous, and postgraduate specialization) of teaching psychiatry in primary care and elucidated how these clinical and educational models may complement each other if utilized in parallel. We also applied Stanfield's framework of health services to examine the focus, intensity, and specificity of these six models.

Results: A consultation model of care delivery and teaching may be most useful for patients with recognized conditions, a liaison approach for patients who are difficult for staff, a bridge model for improving detection of previously unrecognized patients, a hybrid model for instruction in collaborative care, an autonomous model for addressing certain common office problems, and a postgraduate specialization model for those with a strong interest in learning more psychiatry.

Conclusions: Since effective education has been demonstrated to improve the recognition and management of psychiatric disorders in primary care settings, psychiatrists should tailor educational programs to parallel the needs and structures of as many primary care clinical settings as possible. These tasks are critical because psychiatric disorders appear in many guises in primary care settings, often coincide with medical conditions, and medical-psychiatric comorbidity often leads to greatly increased severity and chronicity of both conditions.

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SCIENTIFIC AND CLINICAL REPORT SESSION 18—NEW ISSUES WITH ATYPICAL ANTIPSYCHOTICS

No. 53
OLANZAPINE VERSUS PLACEBO IN THE TREATMENT OF ACUTE MANIA

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Ph.D., Gary D. Tollefson, Ph.D., Susan McElroy, M.D., Michael G. Greaney, M.S., Verna Toma

EDUCATIONAL OBJECTIVE:

To educate meeting attendees about the use of olanzapine as a new atypical antipsychotic in the treatment of mania.

SUMMARY:

Background: Antipsychotic agents have been used commonly in the treatment of bipolar disorder. More recently, there has been an interest in using atypical antipsychotic drugs.

Methods: Olanzapine is a new atypical antipsychotic agent that has affinity to both 5HT2A and D2 receptors. In order to assess the efficacy of olanzapine in the treatment of an acute episode of bipolar disorder, manic or mixed, a double-blind, placebo-controlled study was conducted. Patients were randomized to either olanzapine (5 - 20 mg/day) or placebo during a three-week period. Patients were required to be hospitalized for a minimum of one week. The primary assessment tool was the Young-Mania Rating Scale (Y-MRS) and a minimum score of 20 was required for randomization. Efficacy was measured from baseline to endpoint in the Y-MRS. In addition, patients were dichotomized into responders and nonresponders, where responder was defined as a 50% or greater decrease in the Y-MRS from baseline to last measurement in acute treatment. Patients were also assessed with the Hamilton Psychiatric Rating Scale for Depression-21 Items (HAMD-21) and the Positive and Negative Syndrome Scale (PANSS).

Results: 69 patients were randomized to placebo and 70 patients were randomized to olanzapine. Olanzapine was statistically significantly superior to placebo in mean reductions of Y-MRS total (−10.3 vs −4.9 p = .019), PANSS total (−11.1 vs −3.1, p = .019), and PANSS positive scores (−4.7 vs −2.0, p = .040) from baseline to endpoint. In addition, there was a statistically significantly greater number of responders on olanzapine than placebo (48.6% vs 24.2%, p = .004).

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2. Tohen M, Sanger T, Tollefson G, McElroy S: Olanzapine vs. haloperidol in the treatment of schizoaffective bipolar patients.

No. 54
OLANZAPINE VERSUS RISPERIDONE AND HALOPERIDOL IN THE TREATMENT OF SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant should be able to describe the comparison between olanzapine and risperidone and olanzapine and haloperidol for efficacy exams, safety, quality of life, and resource utilization.

SUMMARY:

It is hypothesized that in stable patients early in illness, an improvement in clinical symptoms of schizophrenia can be accompanied by an improvement in cognitive dysfunction and can positively impact a patient's quality of life and resource utilization. In this multicenter, randomized, double-blind, parallel study, 65 stable patients in the first five years of illness were randomized to one of three treatment groups: olanzapine in the dose range of 5mg to 20mg per day, risperidone in the dose range of 4mg to 10mg per day, or haloperidol in the dose range of 5mg to 20mg per day. Patients were excluded from the trial if they exhibited baseline PANSS>90. After a one-month stabilization period and a one-week washout/screening period, patients were randomized and followed on therapy for 54 weeks. Dosing after the first week of therapy was carried out on a per-patient basis and at the judgment of the attending physician. Results comparing olanzapine to risperidone and olanzapine to haloperidol for efficacy (neuropsychological exams, PANSS), safety (ESRS, Barnes Akathisia), quality of life (QLS, SF-36), and resource utilization are presented. Tests of the primary measures are performed both for endpoint values and change-from-baseline at endpoint. In this select population, olanzapine shows marked benefits on cognition, especially compared with risperidone and haloperidol.

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No. 55
THE DIFFERENTIAL RISK OF TARDIVE DYSKINESIA WITH OLANZAPINE

Charles M. Beasley, Jr., M.D., *MC 541, Eli Lilly and Company, Lilly Corporate Center, Indianapolis IN 46285;* Gary D. Tollefson, M.D., Maryanne Dellva, M.S., Roy Tamura, Ph.D., William M. Glazer, M.D., Hal Morgenstern, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to learn about the risk of tardive dyskinesia with the atypical antipsychotic olanzapine compared with the conventional neuroleptic haloperidol.

SUMMARY:

Objective: The incidence of tardive dyskinesia (TD) was evaluated in 1714 patients with schizophrenia, schizophreniform disorder, or schizoaffective disorder treated with olanzapine or haloperidol for a period of up to 2.6 years in three randomized, double-blind, multicenter studies. It was hypothesized that olanzapine would be associated with a lower incidence of TD than haloperidol.

Methods: Baseline TD was assessed by the Abnormal Involuntary Movement Scale (AIMS) and the Schooler-Kane Research Diagnostic Criteria for TD (RD-TD) as modified by Glazer and Morgenstern. Kaplan-Meier survival analysis was used to estimate the risk of TD for each treatment group at various time points during double-blind therapy. Incidence rates of TD as well as rate ratios were estimated during follow-up.

Results: The estimated risk remained higher with haloperidol than with olanzapine throughout the follow-up period (p<.001). Considering both acute (≤6 week) and delayed onset cases, the estimated rate ratio for haloperidol compared with olanzapine was 3.69 (95% CI= 2.10, 6.50). Based on data following the initial six weeks of observation, the estimated one-year risk of TD was 0.52% with olanzapine and 7.45% with haloperidol. The estimated risk with haloperidol was higher than with olanzapine throughout the follow-up period (p=.002). The estimated rate ratio was 11.86 (95% CI=2.30, 61.14).

Conclusion: Results of multiple assessments of the incidence of TD indicated a substantially lower risk of TD with olanzapine than with haloperidol.

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SCIENTIFIC AND CLINICAL REPORT SESSION 19—GERIATRIC PSYCHIATRY

No. 56
CLINICAL RESPONSE TO VALPROATE IN GERIATRIC PATIENTS

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EDUCATIONAL OBJECTIVE:

To identify geriatric patients for whom valproate may be helpful, understand tolerability and safety of valproate in geriatric patients with significant medical comorbidity, and recognize possible factors suggestive of favorable response to valproate in the geriatric population.

SUMMARY:

The efficacy of valproate for the management of adults with bipolar disorder has been repeatedly demonstrated in several studies. Patients with mixed states, rapid cycling, and EEG abnormalities have been shown to respond favorably to valproate. Valproate is also being used in disorders with aggressive or agitated features, such as the behavioral disorders of dementia; yet few studies have documented the utility of valproate in geriatric patients. The need to document safe and effective pharmacologic agents to treat geriatric mood and behavioral disorders continues to increase with the growing elderly population.

We conducted a retrospective study of the use of valproate in consecutive patients over a five-year period. Thirty-nine patients over age 60 were identified and then categorized into non-, partial, and full responders based on Clinician's Global Improvement Ratings. Information on diagnosis, age, valproate dose and serum concentration, psychiatric symptoms, medical comorbidity, concurrent psychotropic medications, and side effects was collected. Results suggest that full and partial responders to valproate over the age of 60 were more likely to be female, younger, carry a diagnosis of bipolar disorder, and achieve higher serum valproate concentrations. Fewer full responders had psychotic symptoms but more displayed manic symptoms. The data of this study suggest the need for controlled clinical trials to clarify the utility and predictors of response to valproate in the geriatric population.

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No. 57
NORTRIPTYLINE FOR GRIEF-RELATED DEPRESSION IN ELDERS

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EDUCATIONAL OBJECTIVE:

The participant will become familiar with data comparing the efficacy of nortriptyline and placebo for bereavement-related depression in the elderly, and will become familiar with the clinical implications of these data including limitations and the need for further research.

SUMMARY:

Objective: To test the efficacy of nortriptyline (NT) for bereavement-related depression under double-blind, placebo-controlled, random-assignment conditions in elderly subjects.

Methods: Sixty-eight elders were recruited with essential inclusion criteria of (1) HRS-17 score of at least 17; (2) onset of depression within two years of the death of a significant other; and (3) medical clearance for a trial of NT. Subjects were randomly assigned to NT or placebo and followed weekly for at least eight weeks. A full remission is defined as a HRS-17 $\leq$ 7 for three consecutive weeks.

Results: A full remission was achieved in 23/36 (64%) of the NT group and 12/32 (38%) of the placebo group $X^2 = 4.72$ $p = .03$. Mean nortriptyline dose age was 66.8 (SD 20) mg. producing a mean blood level of 72.9 ng/ml (SD 35.4) after a mean elapsed time of 8.5 (SD 4.2) weeks. There was no difference between the groups in any demographic variables. The clinical implications of these data will be discussed.

Conclusion: NT appears to be superior to placebo for the treatment of bereavement-related depression.

This research is supported by MH 37869 and NARSAD.

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2. Jacobs SC, Nelson JC, Zisook S: Treating depression of bereavement with antidepressants: a pilot study. Psychiatric Clinics of North America, 1987; 10:501–510.

No. 58
TWO-YEAR OUTCOME OF PSYCHOTIC DEPRESSION IN LATE LIFE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that older patients with psychotic depression are at greater risk of relapse/recurrence than nonpsychotic depressed patients, and understand that further research is needed to determine the optimal long-term treatment of psychotic depression in late life.

SUMMARY:

Objective: This study examined whether elderly patients with psychotic depression differed in their long-term outcome from patients with nonpsychotic depression.

Method: Nineteen patients with psychotic depression who had responded to either electroconvulsive therapy (ECT) (N=15) or a combination of nortriptyline and perphenazine (N=4) were compared with 68 nonpsychotic depressed patients who had responded to nortriptyline. Both groups were maintained on full-dose nortriptyline and followed monthly for two years or until relapse or recurrence.

Results: Logistic regression and survival analyses demonstrated that psychosis was a significant independent predictor of relapse/recurrence. The cumulative probability of remaining well without a relapse or recurrence was 48.8% for the psychotic group compared with 82.1% for the nonpsychotic group. Before entering the study, none of the psychotic patients had received adequate treatment for

the index episode of depression, and so their poor outcome could not be attributed to prior treatment resistance.

Conclusion: Even when they achieved remission and were maintained on full-dose nortriptyline, older patients with psychotic depression were at greater risk of relapse/recurrence compared with their nonpsychotic counterparts. In particular, continuation/maintenance treatment with tricyclic monotherapy following response to ECT had limited efficacy in this group of patients. These findings raise important questions about the optimal treatment of psychotic depression in late life.

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SCIENTIFIC AND CLINICAL REPORT SESSION 20—CHALLENGING CLINICAL ISSUES IN SCHIZOPHRENIA

No. 59
SCHIZOPHRENIA: A LANGUAGE OR THOUGHT DISORDER?

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EDUCATIONAL OBJECTIVE:

Participants will be informed about controversies concerning basic features of schizophrenia and about new research exploring the link between different types of symptoms in schizophrenia.

SUMMARY:

Objective: The long-standing theoretical issue of whether schizophrenic thought disorder should be viewed as only a speech-language disorder has not been resolved or even studied empirically. A large sample of patients were assessed to provide data to help resolve this theoretical issue, which bears on the nature of schizophrenic symptoms and schizophrenic psychopathology.

Method: 209 patients including 62 schizophrenia patients, 61 other psychotic patients, and 86 nonpsychotic control patients were assessed at the acute phase and then followed up twice at 2 years and 4.5 years post hospital. Patients were assessed with standardized measures of thought disorder, were assessed for delusions (unrealistic thinking), and were evaluated with newly constructed measures that separate schizophrenic language from schizophrenic behavior and thinking.

Results: 1.) Schizophrenia patients with strange speech-language on the proverbs test also showed delusional ideas at several successive follow ups over a three period ($p<.01$). 2.) Schizophrenia patients with strange speech on the proverbs test also showed strange behavior on the object sorting test, tending to sort uncommon objects ($p<.05$). 3.) Schizophrenia patients who made illogical verbalizations also showed strange behavior in terms of sorting uncommon objects on the object sorting test ($p<.05$).

Conclusions: Data from a large sample of patients assessed over four to five years using two different types of tests and other evidence of delusions suggest that schizophrenia patients with disordered verbalizations on thought disorder tests also show strange behavior and unrealistic ideas. These data suggest that strange speech shown by many schizophrenia patients is not due just to a language disorder, but involves a broader constellation of gross reality distortions, strange ideas, and thought disorder.

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2. Lanin-Kettering I, Harrow M: The thought behind the words: a view of schizophrenic speech and thinking disorders. Schizophrenia Bulletin. 1985; 11:1-7.

No. 60
SUICIDE ATTEMPTS IN SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify major risk factors for suicide in schizophrenia, understand the demoralization model, and be aware of possible clinical implications of these findings.

SUMMARY:

Objective: This study examined Drake's model that patients with schizophrenia are at increased risk for suicidal behavior due to feelings of demoralization arising when they become aware of their illness and recognize the discrepancy between their premorbid and current functioning. It was therefore hypothesized that individuals with schizophrenia with good premorbid adjustment *and* insight into their illness are more vulnerable to becoming demoralized and suicidal. We also predicted that the psychological symptoms of depression would best differentiate attempters from nonattempters.

Method: 164 patients with DSM-III-R schizophrenia (N=115) or schizoaffective disorder (N=49) were assessed with standardized structured interviews for depressive symptoms, premorbid adjustment, insight, and suicide attempts.

Results: As predicted, the interaction between good premorbid adjustment and insight predicted number of depressive symptoms. While a history of major depression did not differentiate attempters from nonattempters, the psychological symptoms of depression (guilt, feeling like a failure, and concentration difficulties) were significantly more common in attempters than nonattempters.

Conclusions: The findings provide some support for the demoralization model and suggest that it may be the *quality* of depressive symptoms, rather than simply the presence or absence of major depression, that puts some individuals with schizophrenia at risk for suicidal behavior.

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2. Roy A: Depression, attempted suicide, and suicide in patients with chronic schizophrenia. Schizophrenia, 1986; 9:193-206.

No. 61
PREDICTORS OF SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVE:

To recognize biological and social risk factors for schizophrenia during pregnancy and childhood.

SUMMARY:

The objective of the study was to investigate the association between early developmental factors and adult schizophrenia. We have investigated a cohort of 12,058 unselected live births. Data have been collected prospectively from pregnancy up to age 28. Eighty-nine (59 men) fulfilled criteria for DSM-III-R schizophrenia. The following early life factors have been found to be linked to schizophrenia (rest of the cohort as reference): low birth weight (< 2500g; OR 2.6; 95% Cl 1.1-5.9; population attributable risk [PAR] 4.6%; 0.3-6.5), short gestation (< 37 weeks; OR 1.4; 0.6—3.4), and their combination (OR 3.4; 1.2-9.4). Six of the 125 babies (4.8%) who survived severe prenatal brain damage later developed schizophrenia (OR 7.5; 3.2-17.6; PAR 6.8%, 5.4%-7.4%). OR of schizophrenia after childhood viral CNS infection was 4.8 (1.6—14.0; PAR 4%, 1.9%-4.8%). The incidence of schizophrenia until age 23 was two-fold in the highest social class I. Future schizophrenics were delayed in developmental and educational milestones: among boys late to stand or walk the incidence of schizophrenia was higher. Late achievement of daytime continence or of potty training was associated with schizophrenia among girls. Boys destined to develop schizophrenia were between two and three times more likely to have been below their expected class, but their school marks were not lower than expected. Surprisingly, 11% of preschizophrenic boys had excellent school marks compared with 3% in rest of the cohort.

Our study confirms some known fetal and maternal risk factors during pregnancy but also presents new biological risks (prenatal brain damage, central nervous system viral infections during childhood) and associations (maternal depression, social class I, poor and excellent school performance). This suggests new hypotheses linking biological and social risk factors.

This work was supported by the grants from the Finnish Academy, Ahokas Found., Juselius Found, and the Theodore & Vada Stanley Found.

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SCIENTIFIC AND CLINICAL REPORT SESSION 21—PSYCHOPHARMACOLOGY

No. 62
OLANZAPINE: SAFE IN CLOZAPINE-INDUCED AGRANULOCYTOSIS

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EDUCATIONAL OBJECTIVE:

To recognize the efficacy of olanzapine in schizophrenic patients discontinued from clozapine treatment; to recognize that olanzapine does not appear to worsen clozapine-induced agranulocytosis or prevent its recovery.

SUMMARY:

Objective: To demonstrate that olanzapine is a safe and effective antipsychotic drug in patients who develop agranulocytosis while on treatment with clozapine.

Method: Two male patients, A and B, aged 46 and 53, who had been stabilized on clozapine monotherapy (patient A takes L-thyroxine 150 mg, od, for hypothyroidism) for six weeks, and 37 months, respectively, developed agranulocytosis confirmed by peripheral blood smear (granulocytes <0.5 × 10^9/litre) and bone marrow aspiration. Preagranulocytosis total PANSS scores were 70 and 75, respectively. When clozapine was discontinued, their psychosis relapsed (total PANSS score = 100 and 103, respectively). Olanzapine was instituted. In patient A, colony stimulating factor was used, in the second patient no stimulating factor was used.

Results: The peripheral blood picture gradually improved to within normal limits within three weeks in both cases. In addition, mental state and measures of psychopathology (PANSS, NOSIE) and disruptive behavior improved to within preagranulocytosis level, (PANSS score 68 and 72, respectively). Current dose of olanzapine in patient A is 40 mg, od and patient B 30 mg.

Conclusions: Olanzapine can be substituted for clozapine during recovery from clozapine-induced agranulocytosis. Olanzapine does not appear to worsen clozapine-induced agranulocytosis or prevent recovery from it.

REFERENCES:

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No. 63
SILDENAFIL FOR ERECTILE DYSFUNCTION: A ONE-YEAR STUDY

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the effectiveness and safety of oral sildenafil in the treatment of erectile dysfunction over a one-year period.

SUMMARY:

Objective: The present study assessed the efficacy and safety of oral doses of sildenafil, taken as required (not more than once daily), during a one-year period in men with erectile dysfunction (ED).

Method: A previous double-blind, placebo-controlled study recruited 233 patients with ED of no known organic cause; 202 of these patients elected to receive open-label sildenafil for one year; however, only 192 patients (mean age 54 range 19-71) were randomized to receive treatment. All patients started at 25 mg, with an option to reduce the dose to 10 mg or increase to 50 mg and then 100 mg, based on toleration and efficacy; where clinically indicated, an intermediate dose of 75 mg was also permitted. Patients were withdrawn from treatment if they derived no benefit from sildenafil or if safety concerns arose. Efficacy was measured by a self-administered sexual function questionnaire and global efficacy questions completed at the end of the study.

Results: A total of 172 (89.6%) patients completed the one-year study; only two (1.0%) patients were withdrawn due to lack of efficacy. Of six (3.1%) patients withdrawn due to adverse events, in only two (1.0%) patients were the adverse events ascribed to

sildenafil. The most frequently reported adverse events were flushing, dyspepsia, and headache. Of 10 serious adverse events reported, none was attributed to sildenafil.

Conclusion: In men with ED of no known organic cause, oral sildenafil is effective and well-tolerated during long-term treatment.

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No. 64
ADVERSE EVENT PROFILES ASSOCIATED WITH LONG-TERM FLUOXETINE TREATMENT

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should recognize that for patients who derive therapeutic benefit from fluoxetine treatment, early adverse events tend to resolve with continued treatment up to 26 weeks. All events common in early treatment decline and no event uncommon early in treatment becomes common late in treatment.

SUMMARY:

Introduction: The Agency for Health Care Policy and Research Guideline states that "most patients should receive the full therapeutic dosage of antidepressant drug for four to nine months of continuation therapy after symptom remission is achieved." We examined the safety of fluoxetine 20 mg/day in long-term treatment in a large, prospective trial and report a comparison of early and late adverse events (AEs) and the course of AEs over time.

Method: AEs were recorded at each visit in a uniform format by open-ended questioning, regardless of perceived causality. The frequencies of common new/worsened AEs reported in the first four weeks (early) or the 22nd-26th weeks of treatment (late) were compared using McNemar's test.

Results: 299 patients with major depressive disorder responded to 12 weeks of fluoxetine treatment and entered continuation therapy and 174 completed 26 weeks of therapy. All early events which occurred in $\geq 5\%$ of patients declined significantly ($p<.05$) over time and no events occurred significantly more frequently during continuation therapy.

Discussion: Common adverse events associated with initiating fluoxetine in depressed patients resolve in the majority of patients and are significantly less frequent with ongoing treatment. Overall, therapy with fluoxetine 20 mg daily is well tolerated over a six-month period.

Research funded by Eli Lilly and Company

REFERENCES:

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SCIENTIFIC AND CLINICAL REPORT SESSION 22—MENTAL HEALTH STRESSES IN CHILDREN

No. 65
PSYCHOLOGICAL FUNCTIONING AND CHILD ABUSE IN ADOLESCENTS

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EDUCATIONAL OBJECTIVE:

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

SUMMARY:

Objective: To examine psychological and behavioral correlates of childhood abuse in psychiatrically hospitalized adolescents.

Method: 300 adolescent inpatients were administered a battery of psychometrically well-established psychological self-report measures soon after admission. Childhood abuse was assessed using the Childhood Abuse Scale of the Millon Adolescent Clinical Inventory (MACI; Millon et al., 1993).

Results: Scores on the MACI Childhood Abuse Scale were significantly ($p<.005$) positively associated with scores on the following instruments: Beck Depression Inventory, Depressive Experiences Questionnaire for Adolescents, Hopelessness Scale for Children, Suicide Risk Scale, Past Feelings and Acts of Violence Scale, Impulsivity Scale, Alcohol Abuse Involvement Scale, and the Drug Abuse Screening Test, and significantly negatively correlated with the Rosenberg Self-Esteem Scale ($p < .009$). When depression level was controlled for, significantly lower self-esteem and significantly higher levels of dependency, suicidality, and drug and alcohol problems were associated with higher levels of self-reported childhood abuse.

Conclusions: In our sample of psychiatrically hospitalized adolescents, patients' reports of childhood abuse are associated with lower levels of self-esteem and higher levels of dependency, suicidality, and drug and alcohol problems. This constellation of symptoms observed after controlling for the effects of depression is consistent with borderline personality *in statu nascendi*. These data are consistent with a hypothesized association between childhood abuse and borderline personality disorder. The findings have implications for clinicians and researchers who work with psychiatrically hospitalized adolescents.

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No. 66
CLINICAL JUDGMENT IN REPORTS OF CHILDHOOD SEXUAL ABUSE

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Ph.D., Carl Thoresen, Ph.D., Bruce Arnow, Ph.D., David Spiegel, M.D.

EDUCATIONAL OBJECTIVE:

To recognize correlates that influence clinical treatment decisions and judgments in reports of childhood sexual abuse.

SUMMARY:

Objective: This study examined the effects that repression, type of memory, age of memory, and gender have on clinical treatment decisions and judgments regarding the veracity of childhood sexual abuse memories.

Method: Participants were a national random sample of 984 clinical and counseling psychologists; 650 (66%) responded to the survey. Fifty-one percent were female. The mean age was 49.3 years. A history of sexual abuse was reported by 12.5% of the sample. All participants completed self-report measures on credibility of sexual abuse, treatment decisions, sexual abuse prevalence, and demographics.

Results: Multiple regression analysis revealed that clinical judgment is influenced by evidence, ($R^2 = .11$; $F(5, 575) = 13.71$, $p < .0001$). Clinicians were more likely to believe that sexual abuse had occurred when the memory had not been repressed ($p < .001$), the age of the memory first recalled was greater than 2 years ($p < .0001$), the memory was concrete ($p < .01$), and the perpetrator was male ($p < .001$). Surprisingly, clinicians' credibility ratings were not influenced by the victim's gender.

Conclusions: Clinicians need to be cognizant of the role that evidence, personal beliefs, and gender have in clinical judgment and treatment decisions.

This Research was funded by the Institute for Research on Women and Gender, Stanford University

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No. 67
HOMELESS CHILDREN: STRESSORS AND MENTAL HEALTH PROBLEMS

Bonnie T. Zima, M.D., *Department of Psychiatry, UCLA-NPI, 300 Medical Plaza, Box 956967, Los Angeles CA 90095;* Regina Bussing, M.D., Marina Bystritsky, M.A., Mel Widawski, M.A., Thomas R. Belin, Ph.D., Bernadette Benjamin, M.S.C.

EDUCATIONAL OBJECTIVE:

To gain greater awareness of the high level of exposure to severe psychosocial stressors experienced by school-aged children living in emergency homeless shelters; to become familiar with how severe psychosocial stressors and social support relate to a homeless child's likelihood of having symptoms of depression and behavior problems.

SUMMARY:

Objective: To describe the level of exposure to severe psychosocial stressors among school-aged, sheltered, homeless children and to examine how exposure to stressors relates to residential instability and child depressive symptoms and behavior problems.

Method: A cross-sectional study of 169 children aged 6-12 years and 110 parents living in emergency homeless shelters in Los Angeles County.

Results: Almost two-thirds of the children (64%) had experienced a major loss or separation, 48% had been exposed to violence, and three-fourths (76%) had mothers who screened positive for a mental health problem. Children who experienced high residential instability were more likely to have been exposed to psychosocial stressors and to manifest depressive symptoms, and those who experienced a maternal separation or whose mother had a probable lifetime major mental illness were more likely to have behavior problems. Primary social support from an adult relative was associated with fewer childhood problems.

Conclusion: Sheltered homeless children experience a high level of exposure to psychosocial stressors that appears related to symptoms of depression and behavior problems.

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SCIENTIFIC AND CLINICAL REPORT SESSION 23—BRAIN IMAGING

No. 68
BASAL GANGLIA CHOLINE LEVELS IN TRUE DRUG RESPONSE

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EDUCATIONAL OBJECTIVES:

Participants will learn about the possible relationship between brain choline levels and true response to antidepressant treatment.

SUMMARY:

Background: A series of studies using pattern analysis have identified two types of response: while "true drug" response seems to be characterized by a two-week delay in onset followed by persistent improvement, "placebo" pattern of response appears to be characterized by early, transient, or nonpersistent improvement.

Objectives: The purpose of this study was to evaluate the relationship between basal ganglia choline levels, as measured by in vivo proton magnetic resonance spectroscopy, and "true drug" pattern of response to antidepressant medication. In addition, we wanted to assess possible changes in basal ganglia choline levels among patients with a "true drug" response pattern compared to those with either a "placebo" pattern or nonresponse.

Method: 42 drug-free depressed outpatients meeting DSM-III-R criteria for major depressive disorder, diagnosed with the Structured Clinical Interview for DSM-III-R, were evaluated before undergoing an eight-week treatment with fluoxetine 20 mg/day. All patients underwent in vivo cholinergic proton magnetic resonance spectroscopy (MRS), using a voxel of 8 cm^3 centered on the head of the left caudate and the putamen. MRS N-acetyl aspartate (NAA) and choline (Cho) concentrations were expressed as the ratios of peak areas over creatine and phosphocreatine (i.e. NAA/Cr and Cho/Cr). Fifteen of these 42 patients underwent the same MRS assessment at the end of eight weeks of treatment with fluoxetine 20 mg/day. "True drug response" was considered to be present when much or very much improvement was present only after two weeks of treatment and persisted until the end of the study, while nonresponse

or earlier/nonpersistent response was classified as "non true drug response".

Results: We found no relationship between true drug response and basal ganglia choline levels at baseline in our 42 depressed patients. However, there was a statistically significant difference in the degree of change in Cho/Cr ratios between true drug responders (n=8) and "non true drug responders" (n=7), with the former group having a 20% increase in choline levels, while the latter group had a 14% decrease in the same levels.

Conclusion: True drug response in depression appears to be associated with a distinctive increase in the choline/creatine ratio in the basal ganglia. Further studies are needed to confirm these preliminary findings.

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No. 69
NEUROANATOMY OF ATTENTION TO EMOTIONAL EXPERIENCE

Richard D. Lane, M.D., *Department of Psychiatry, University of Arizona, P.O. Box 245002, Tuscon AZ 85721;* Gereon Fink, M.D., Phyllis M. Chua, M.D., Raymond J. Dolan, M.D.

EDUCATIONAL OBJECTIVES:

To describe the role of the anterior cingulate cortex and related paralimbic structures in the representation of subjective emotional responses; to appreciate how variations in selective attention produce different patterns of brain activity when stimulus conditions are kept constant; and to understand how representation of emotion influences the capacity for self-regulation of behavior.

SUMMARY:

Objective: To identify the neural correlates of selective attention to emotional experience.

Method: Ten normal men were studied. Twelve picture sets were presented, each consisting of 30 pictures (pleasant, unpleasant, or neutral) from the International Affective Picture System. Every 3.0 seconds a picture was presented for 500 msec. Twelve measures of cerebral blood flow using positron emission tomography and O^{15}-water were obtained in each subject, one for each picture set. During half the scans subjects attended to their emotional experience (indicating whether the picture evoked a pleasant, unpleasant, or neutral feeling); during the other half they attended to spatial location (indicating whether the scene depicted was indoors, outdoors, or indeterminate). Across subjects, picture sets were counterbalanced across the two attention conditions.

Results: During attention to subjective emotional responses, increased neural activity was elicited in rostral anterior cingulate cortex (BA32) and medial prefrontal cortex ($Z = 6.74$, $p < .001$, corrected), right temporal pole, insula and ventral cingulate (all $p < .001$, corrected). Under the same stimulus conditions when subjects attended to spatial aspects of the pictures, activation was observed in parieto-occipital cortex bilaterally ($Z = 5.71$, $p < .001$, corrected).

Conclusion: The findings indicate a specific role for the anterior cingulate cortex and related paralimbic structures in representing subjective emotional responses.

Funded by MH00972 from NIMH and the Wellcome Trust.

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2. Lang PJ, Bradley MM, Cuthbert BN: The International Affective Picture System (IAPS): photographic slides. 1995; University of Florida: The Center for Research in Psychophysiology.

No. 70
ATROPHY AND METABOLITE ABNORMALITY IN MOVEMENT DISORDER

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand imaging progress in movement disorders.

SUMMARY:

Objective: Movement disorders in geriatric groups are difficult to characterize. Morphological and molecular functional tools were utilized to better understand movement disorders.

Method: Patients were studied by MRI and proton spectroscopy in a GE 1.5T Signa system. Subjects included: (1) 50 patients (age 55-90) with one or more suspected movement disorders clinically evaluated by AIMS, (2) a control group of 40 patients (age 50-75) without movement disorders but with depression or dementia, and (3) 10 normal subjects (age 50-65).

Results: Amygdala atrophy was a consistent, nonspecific finding in coronal MRI in 70% of patients with any kind of movement disorder. Abnormal CSF dynamics obtained by axial FLAIR MRI were present in 50% of cases with significant aqueductal closure. Putaminal signal loss due to hypothesized iron deposition was nonspecific and observed in only 20% of cases. Myo-inositol and lactate metabolite were found to increase moderately (50-80%) in one or more locations in the frontal or temporal lobes in 70% of cases with movement disorder without hepatic problems. All patients with Parkinson's showed mild to moderate broadening of spectral lines in the putamina.

Conclusion: Proton MRS is a valuable addition to routine MRI. Movement disorders appear to be characterized by neurometabolite abnormalities in addition to structural defects. Myo-inositol controls calcium insult to cells in ischemia. Current findings suggest that in movement disorder, microscopic ischemia mediated by myo-inositol may cause receptor death and related atrophy.

REFERENCES:

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SCIENTIFIC AND CLINICAL REPORT SESSION 24—BIPOLAR GROUP: AT-RISK POPULATION

No. 71
WHICH UNIPOLAR DEPRESSIVES ARE REALLY BIPOLAR?

Joseph F. Goldberg, M.D., *Department of Psychiatry, Payne Whitney Clinic, 525 East 68th Street, New York NY 10021;* Martin Harrow, Ph.D.

EDUCATIONAL OBJECTIVE:

To present new, clinically useful information from a prospective follow-up study regarding the frequency and long-term risk of developing mania or hypomania in patients originally diagnosed with unipolar depression; to familiarize participants with risk factors for subsequent bipolarity in patients who initially present with unipolar depression.

SUMMARY:

Objective: The longitudinal risk for unipolar depressed patients to develop mania or hypomania has been estimated at 5%-10%. In order to provide greater information on the conversion from unipolar to bipolar disorder, we prospectively followed-up a large cohort of young adults originally hospitalized for unipolar major depression.

Method: Seventy-four RDC unipolar depressed inpatients (mean age=23 ± 3.8 years) were assessed at index and again five times, at 2, 4.5, 7-8, 10, and 15 years. Standardized interviews were used to evaluate manic or hypomanic episodes at follow-up, medication use, and rehospitalizations during each follow-up interval.

Results: 1) By the 15-year follow-up, 26% of the sample met Research Diagnostic Criteria for hypomania, while 15% had at least one bipolar I episode; 2) 45% of those who developed full mania also had periods of hypomania, while only 21% of those with hypomania also had a full manic episode; 3) conversion from a unipolar to bipolar diagnosis was more common among those with melancholic or psychotic features at index ($p<.05$); 4) unipolars who became fully manic more often had bipolar I relatives compared with unipolars who converted to hypomania; 5) 21% of "switches" were clearly associated with antidepressant use.

Conclusion: The findings suggest that young depressed inpatients with psychosis or melancholia may be especially vulnerable to subsequent mania. Consistent with recent reports, patients who develop hypomania less often develop full mania. The risk for subsequent bipolarity continued throughout the follow-up period. Inpatients initially diagnosed with unipolar depression may convert to a bipolar diagnosis at a rate somewhat higher than previously reported.

REFERENCES:

1. Coryell W, Endicott J, Maser JD, et al: Long-term stability of polarity distinctions in the affective disorders. Am J Psychiatry 1995; 152:385-390.
2. Akiskal HS, Maser JD, Zeller PJ, et al: Switching from unipolar to bipolar II: an 11-year prospective study of clinical and temperamental predictors in 559 patients. Arch Gen Psychiatry 1995; 52:114-123.

No. 72
POSTPARTUM COURSE OF BIPOLAR ILLNESS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant should be able to demonstrate the results of the study on treatment of women with bipolar disorder during pregnancy and the postpartum period.

SUMMARY:

Objective: The postpartum period is typically considered a time of significant risk for women with bipolar disorder and has been associated with high rates of relapse, ranging from 20% to 50%. Several investigators have described the use of prophylactic lithium during the postpartum period and have demonstrated a reduction in risk for relapse. Our objective is to further characterize the course of bipolar illness during pregnancy and the postpartum period. These data will help identify women at highest risk for relapse and minimize potential exposure to psychotropic agents in women at lower risk for recurrent disease.

Methods: This historical cohort study describes the postpartum course of 30 women with bipolar disorder who were followed during pregnancy and the postpartum period. Patients were initially evaluated by the Perinatal Psychiatry Program either prior to conception or during the first trimester and were re-evaluated at six to 24 months postpartum using telephone interviews and chart review.

Results: Despite prophylaxis with mood stabilizers during pregnancy and through the puerperium, women with bipolar disorder who were euthymic during pregnancy remained at high risk for relapse during the postpartum period. Data will be presented regarding the rates of relapse and the characteristic pattern of relapse (i.e., mania vs. depression) in this population. Predictors of relapse will also be discussed.

Conclusion: The implications of these findings for the treatment of women with bipolar disorder during pregnancy and the postpartum period will be discussed in the context of low-risk and high-risk subgroups of women who may require different treatment strategies.

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1. Cohen LS, Sichel DA, Robertson LM, et al: Postpartum prophylaxis for women with bipolar disorder. Am J Psychiatry 1995; 152:1641-1645.
2. Reich T, Winokur G: Postpartum psychosis in women with manic depressive disease. J Nerv Ment Dis 1970; 151:60-68.

No. 73
TREATMENT OF BIPOLAR SPECTRUM SYMPTOMS

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EDUCATIONAL OBJECTIVE:

To recognize when to consider mood stabilizing medication for children or adolescents; to be able to determine the potential effectiveness of mood stabilizing medication for various symptoms; to recognize when to consider additional medication for bipolar spectrum symptoms.

SUMMARY:

Objective: To assess the efficacy of mood stabilizing agents for bipolar spectrum symptoms in children and adolescents.

Method: The authors conducted a retrospective study of 198 patients, aged 3 to 16, treated for bipolar spectrum symptoms. Data were collected on presenting symptoms, family history, past and present medication treatment, and degree of improvement.

Results: 86% of the patients had at least three of the following: mood lability, irritability, rage episodes, hyper-excitement, depressed and/or elated states. Associated symptoms included suicidal ideation (55%), concentration (68%), anxiety (48%), and/or psychotic (47%) symptoms. Most patients had positive family histories, a long duration of symptoms, and prior medication treatment by other physicians. All patients were on current medication at least six months, most longer than one year. Treatment with mood stabilizing medication, predominantly valproate or lithium, proved quite effective. Seventy percent of patients had remission of mood *and* associated symptoms with mood stabilizer treatment alone: the others required additions of antipsychotic, stimulant, or antidepressant agents for associated symptoms. Fifty percent of all patients demonstrated marked improvement, and another 39% showed moderate improvement.

Conclusion: Youth with bipolar spectrum disorders can achieve high degrees of improvement from mood stabilizing medication.

REFERENCES:

1. Geller B, Luby J: Child and adolescent bipolar disorder: review of the past 10 years. J Am Acad Child Adolesc Psychiatry 1997; 36:1168–1176.
2. Wozniak J, Biederman J, et al: Mania-like symptoms suggestive of childhood-onset bipolar disorder in clinically referred children. J Am Acad Child Adolesc Psychiatry, 1996; 34:867-876.

SCIENTIFIC AND CLINICAL REPORT SESSION 25—TREATMENT ISSUES IN ANXIETY DISORDERS

No. 74
COGNITIVE AND/OR BEHAVIORAL THERAPY IN SOCIAL PHOBIA

Jean A. Cottraux, M.D., *Department of Neurology, Anxiety Disorder University, 59 Boulevard Pinel, Lyon 69003, France;* Ivan Note, M.D., Eliane Albuisson, M.D., Sainan Yao, M.D., Nathalie Etkmedjian, M.D., Isabelle Jalencques, M.D.

EDUCATIONAL OBJECTIVE:

To demonstrate the effectiveness of cognitive-behavior therapy in social versus supportive therapy; to disentangle the cognitive from the behavioral components of cognitive-behavior therapy; to treat social phobia with a cost-effective short-term therapy with long-term effects.

SUMMARY:

Objective: A cognitive-behavior therapy (CBT) package demonstrated its effectiveness in social phobia (Heimberg, 1990). A meta-analysis found that CBT had no greater effect than exposure (Feske and Chambless, 1995). This study aims to disentangle the cognitive from the behavioral component of CBT.

Method: Sixty-seven DSM-IV social phobic patients (89% generalized subtype) were randomized into two groups. Group 1 received individual cognitive therapy (ICT) over six weeks followed by six weeks of social skills training in group (SST). Group 2 received supportive therapy (ST) over 12 weeks, then the same treatment as Group 1.

Results: Improvement was higher in ICT than ST (p=0.03) but there was no significant between-group difference in the rate of responders. After the addition of SST, improvement was larger and the rate of responders demonstrated a threefold increase (p=0.001). These effects were replicated on group 2 and stable at a 72-week follow-up. Compared to the usual drop out rate found in SST in the same settings (30%), compliance was higher as 82% of the sample completed the treatment.

Conclusion: This suggests that CBT is more effective than ST, SST is the critical component of CBT, and CT increases compliance.

Grant from the French Ministry of Health: PHRC 94020.

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2. Feske U, Chambless DL: Cognitive behavioral versus exposure only treatment for social phobia. Behavior Therapy, 1995; 26:695-720.

No. 75
THE ASSOCIATION BETWEEN SYMPTOM CHANGES AND CLINICAL OUTCOME IN PANIC DISORDER

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should recognize that although reduction in panic attack frequency is a component of fluoxetine's therapeutic effect, effects on phobic avoidance, anxiety, and depressive symptoms are also critical factors in clinical improvement.

SUMMARY:

Objective: Panic attacks account only partially for the morbidity of panic disorder, and frequency assessments are unreliable, but are typically the primary measure of improvement. We studied the efficacy of fluoxetine in panic disorder and measured the relative contributions of changes in multiple symptom domains to overall improvement.

Method: 243 patients with panic disorder were randomized to fluoxetine or placebo treatment. Assessments included the panic attack frequency, CGI, PGI, the PPDS, phobia ratings, HAMA, HAMD-21, and Sheehan Disability Scale. Correlations between outcome in each symptom domain and clinical outcome were determined.

Results: Reduction in panic attacks and CGI improvement were significantly greater in fluoxetine-treated versus placebo-treated patients (p=.015 and .040, respectively). Greater efficacy was also demonstrated in fluoxetine-treated patients in reducing illness-associated anxiety (HAMA, p=.004), depression (HAMD-21, p=.008), phobic symptoms (Phobia Rating Scale, p=.002), and improved functional outcomes (Sheehan Disability Scale, p=.025). Global improvement was most highly correlated with reductions in overall anxiety and phobic symptoms, and least correlated with reduction in panic attacks.

Conclusions: Fluoxetine treatment reduced panic attacks, phobic symptoms, anxiety, and depressive symptoms. Reductions in panic attack frequency were less closely related to clinical improvement than reductions in phobic avoidance, anxiety, depressive symptoms, and functional impairment, suggesting that outcome measures in this disorder should be more broadly based.

Research funded by Eli Lilly and Company

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2. Hollifield M, Katon W, Skipper B, Chapman T, et al: Panic disorder and quality of life: variables predictive of functional impairment. Am J Psychiatry 1997; 154:766-772.

No. 76
PLATELET AND PLASMATIC MAO IN ANXIETY DISORDERS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant should be able to demonstrate the relationship between anxiety disorders and the MAO value.

SUMMARY:

This study determined the activity of platelet and plasmatic monoamine oxidase (MAO) and the total phenylacetic acid concentration (PAA) in 105 nonmedicated patients who met the DSM-IV criteria for panic disorders with and without agoraphobia and social phobia. The values were compared with those of 25 normal controls and 24 schizophrenic patients. Both MAO's were determined according to a modification of the Mac Ewen et al. method, and the PAA with our own methodology.

In disagreement with the data of the literature, the values of the platelet MAO were normal or even inferior to the normal. On the other hand, the activity of plasmatic MAO was significantly increased in 97% of the patients with anxiety disorders. This is valid with panic disorder patients with or without agoraraphobia, as in patients suffering from social phobia. We have not found references to a similar finding in the searched papers. A meaningful number of anxiety patients (66%) presented values of low PAA (< 430 ng/ml). We consider low levels of plasmatic PAA as a marker of depression. These findings match with the frequent presence of secondary depression after anxiety disorders. We analyzed our clinical observations and their relationship with the laboratory data.

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1. Gorman J, Liebowitz MR: Platelet monoamine oxidase activity in patients with panic disorders. Biol Psychiatry 1985; 8:852-7.
2. Gudemann JE, Schatzberg: Toward a biochemical classification of depressive disorders: platelet MAO activity and clinical symptoms in depressed patients. Am J Psychiatry. 1982; 139:630-3.

SCIENTIFIC AND CLINICAL REPORT SESSION 26—DIAGNOSIS AND METHODOLOGY IN PERSONALITY DISORDERS

No. 77
DIVALPROEX FOR AGGRESSION IN PERSONALITY DISORDERS

Richard J. Kavoussi, M.D., *Dept of Psychiatry, Medical College of PA, 3200 Henry Avenue, Philadelphia PA 19129*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify target symptoms in personality disordered patients for treatment with medication, recognize the various medications that have been shown to be effective in treating impulsive aggression in these patients, and understand the use of valproate in treating impulsive aggression in these patients.

SUMMARY:

Objective: Valproate, an anticonvulsant and antimanic agent, has recently been studied for its antiaggressive effects in patients with brain injuries, dementia, and borderline personality disorder. Since patients with other personality disorders also exhibit impulsive aggressive behavior, we conducted a preliminary open-label trial of valproate as a treatment for impulsive aggression in patients with a variety of personality disorders.

Method: Nine patients meeting DSM-IV criteria for at least one personality disorder were treated with valproate in an eight-week, open clinical trial. All patients had failed at least one trial of a serotonin reuptake inhibitor. Valproate was increased as tolerated using a flexible dosing schedule. Clinician ratings for impulsive aggressive behavior and irritability were made biweekly using the Overt Aggression Scale-modified (OAS-M).

Results: Five of seven completers reported significant decreases in irritability and impulsive aggressive behavior. For the entire sample, improvement on OAS-M irritability and overt aggression scores were noted by the end of four weeks and continued to occur through week eight.

Conclusion: This study suggests that valproate is an effective treatment for impulsive aggressive behavior in some personality disordered patients who fail to respond to other antiaggressive agents. Controlled studies are needed to determine which patients are most likely to benefit from valproate and to evaluate the differential effectiveness of various agents in reducing impulsive aggressive behavior.

Supported by a grant from Abbott Laboratories

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2. Wilcox J: Divalproex sodium in the treatment of aggressive behavior. Annals of Clinical Psychiatry 1994; 6:17-20.

No. 78
INTERNAL CONSISTENCY AND OVERLAP OF DSM-IV PERSONALITY DISORDERS

Carlos M. Grilo, Ph.D., *Department of Psychiatry, Yale Psychiatric Institute, PO Box 208038/184 Liberty St., New Haven CT 06520;* Thomas H. McGlashan, M.D., Mary C. Zanarini, Ed.D., Charles Sanislow, Ph.D., Elayne Daniels, Ph.D., Robert T. Stout, Ph.D., Leslie C. Morey, Ph.D.,

EDUCATIONAL OBJECTIVE:

The participant should be able to recognize important psychometric aspects of the DSM-IV personality disorder diagnoses. Implications for clinical diagnosis and clinical research will be understood.

SUMMARY:

Objective: This study aimed to examine two aspects of construct validity of the DSM-IV personality disorder (PD) criterion sets: within-category cohesiveness and between-category overlap.

Method: Subjects were 300 adult patients (aged 18 to 45) participating in the Collaborative Longitudinal Study of Personality Disorders. The presence or absence of every DSM-IV-defined personality criterion was assessed with the semi-structured Diagnostic Interview for Personality Disorders-Version IV (DIPD-IV). Assessments were performed reliably by a trained and monitored research evaluation team.

Results: Within-category cohesiveness of the PD criteria was determined by Cronbach's alpha coefficient and by mean intercriterion correlations (MIC), which facilitate comparisons between criterion sets of different lengths. Alpha coefficients ranged from .53 to .88; only four PDs had alphas greater than .80, which is a typical convention indicating adequate internal consistency. Between-category criterion overlap was tested using intercategory mean intercriterion correlations (ICMIC) between pairs of PDs. ICMICs ranged from -.02 to .11. The low ICMIC values are desirable since they indicate limited between-diagnosis overlap. Moreover, ICMIC values were substantially lower than MIC values (range .14 to .41), which suggests adequate diagnostic homogeneity.

Conclusion: Although improved over internal consistency estimates for DSM-III-R-defined PDs, our results suggest modest within-category cohesiveness for DSM-IV-defined PDs. However, the DSM-IV PDs appear to have discriminative validity, i.e., acceptable homogeneity. Implications for future research will be discussed.

REFERENCES:

1. Morey LC: Personality disorders in DSM-III and DSM-III-R: convergence, coverage, and internal consistency. Am J Psychiatry 1988; 145:573-577.

2. Pfohl B, Coryell W, Zimmerman M, Stangl D: DSM-III personality disorders: diagnostic overlap and internal consistency of individual DSM-III criteria. Compr Psychiatry 1986; 27:27-34.

No. 79
IDENTIFYING PERSONALITY DISORDERS: TOWARDS THE DEVELOPMENT OF A CLINICAL SCREENING INSTRUMENT

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should have increased knowledge of how to screen for patients with personality disorder.

SUMMARY:

Objective: To identify a set of personality disorder (PD) criteria from the DSM PD diagnostic sets that can be used to detect subjects with an increased likelihood of having a PD diagnosis.

Method: Stepwise logistic regression identified 45 criteria as discriminating for their specific PD in 221 outpatients evaluated systematically in two waves for every criterion item for 12 DSM-III-R PDs. Selected for further analysis to assess their ability to discriminate for *any* PD, 15 of the 45 are identified. Receiver operating characteristic (ROC) analysis is used to evaluate their discriminating power in an independent conjoined sample (N=1342) from six centers that assessed every PD criteria item by structured instrument (SCID, PDE, SIDP, or CCI). The cutoff, which maximizes information gain, is used to determine diagnostic threshold.

Results: At the 0.43 PD prevalence, a diagnostic threshold of ≥2 of the 15 PD criteria across samples is optimal. Maximum information gain is .42 bits and AUR is 0.94±.007. Other performance indices at this cutoff are .90 sensitivity, .84 specificity, .81 PPP, .91 NPP, and .86 hit rate.

Conclusion: Taken collectively, the 15 PD criteria selected by the data reduction techniques suggest an efficient screening test for identifying personality disorder with comparable or better psychometric properties than other tests routinely used for diagnosing medical disorders. If specific PD categorization is needed, a second-step comprehensive assessment can follow.

REFERENCES:

1. Tyrer P, Casey P, Ferguson B: Personality disorders in perspective. Br J Psychiatry 1991; 159:463–471.
2. Nurnberg HG, Martin GA, Pollack S: An empirical method to refine personality disorder classification using stepwise logistic regression modeling to develop diagnostic criteria and thresholds. Compr Psychiatry 1994; 35(6):409-419.

SCIENTIFIC AND CLINICAL REPORT SESSION 27—FORENSIC PSYCHIATRY

No. 80
PSYCHIATRIC DISABILITY EXAM FOR EMPLOYMENT DISCRIMINATION AND THE AMERICANS WITH DISABILITIES ACT

Lauren J. Wylonis, M.D., *Dept. of Psychiatry, Univ. of Pennsylvania, 3600 Market Street OPC 8th Fl, Philadelphia PA 19104;* Robert L. Sadoff, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participants should be able to do a comprehensive psychiatric disability examination for a claim of employment discrimination, answer questions specific to a disability examination under title I of the ADA in a report, and recognize the limits of their evaluation.

SUMMARY:

Psychiatric disabilities have consistently been the second largest group of illnesses claimed by persons filing with the Equal Employment Opportunity Commission (EEOC). Claims of those individuals with mental illness constitute a full 13% of those claiming employment discrimination due to an illness filing with the EEOC. This presentation reviews the Americans with Disabilities Act (ADA) and the EEOC guidance with the goal of identifying the essential elements, as well as the limits, of a psychiatric disability examination for a claim of employment discrimination and request for accommodation under the ADA. The recent release of the EEOC guidance on psychiatric disabilities, which was meant to clarify the application of the ADA, has fueled criticism from employers and the media. Understanding this EEOC guidance is important as it specifically emphasizes the usefulness of common sense solutions in accommodating those with psychiatric disabilities. Understanding the meaning of the ADA and its definitions is crucial to the psychiatric disability evaluation in an ADA-related case and essential for writing a useful report.

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1. Rennert S: EEOC Legal Division. Personal correspondence, July 25, 1997.
2. Zuckerman D, Debenham K, Moore K: The ADA and People With Mental Illness: A Resource Manual For Employers. American Bar Association and National Mental Health Association, Washington, D.C., 1994.

No. 81
THE EFFECT OF DEPRESSION ON COMPETENCY: A SURVEY

Kevin C. Hails, M.D., *Dept. of Psychiatry, A. Einstein Med. Center N.D., 5501 Old York Road, Philadelphia PA 19141*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to appreciate the difficulties in assessing decision-making capacity when a patient has symptoms associated with depression and should recognize the variability in assessments of decision-making among psychiatrists. The participant will learn potential solutions for this problem.

SUMMARY:

Objective: Psychiatrists regularly assess the competence or decision-making capacity of patients refusing life-saving treatment. It is acknowledged that depression impacts on the decision-making process but is difficult to recognize. This survey is an attempt to determine the degree to which psychiatrists are consistent in determining the influence of depression on the competency evaluation.

Method: Psychiatrists completed a questionnaire determining competence in six hypothetical situations in which a patient was refusing a life-saving procedure. The first scenario portrayed a patient with no depressive symptoms. The second mentioned some overt sadness, the third a history of depression, the next a patient who would welcome death, the fifth patient was suicidal, and the last had symptoms of major depression.

Results: Of 54 psychiatrists, none found the first patient incompetent. However, every other situation showed inconsistent results. For example, with a history of depression, 66% found the patient

competent, 21% incompetent, 13% did not know. Only 24% found the patient with major depression competent, 62% did not.

Conclusion: Psychiatrists are not consistent in assessing how depression influences competency. Although this study is limited in that these were not actual patients, the results suggest a need for continued education as well as guidelines.

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2. Sullivan MD, Younger SJ: Depression, competence, and the right to refuse lifesaving medical treatment. Am J Psych 1994; 151:971-978.

No. 82
MALPRACTICE LAW AND MANAGED CARE: NEW DEVELOPMENTS

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

EDUCATIONAL OBJECTIVE:

To understand the various legal issues related to physician liability when working with managed care to deal with managed care treatment denials in a medically and legally appropriate manner, and to participate in a more effective defense should a denial lead to a malpractice suit

SUMMARY:

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

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SCIENTIFIC AND CLINICAL REPORT SESSION 28—PSYCHIATRIC EPIDEMIOLOGY

No. 83
PREVALENCE OF DEMENTIA IN CENTENARIANS

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EDUCATIONAL OBJECTIVE:

The very high prevalence of dementia found in a complete sample of centenarians strongly suggests that we will all become demented if we live to our maximum life span potential.

SUMMARY:

Objective: Age is the prime risk factor for dementia, independent of etiology. Above age 65 the prevalence of senile dementia rises exponentially from approximately 1% to 15% at age 85. Despite numerous epidemiological studies concerning dementia, very little is known about the prevalence of dementia in the "oldest old." Whether the prevalence in the community levels off to near 40% to 45% around age 95 is an unanswered question. This question is important because it addresses whether dementia is an inevitable consequence of aging or a disorder that occurs within a specific age range.

Method: All 17 persons aged 100 or more in three Dutch towns with 250,000 inhabitants were examined by means of cognitive tests, informant questionnaires, and clinical interviews and hetero-anamneses. Only informat questionnaires and hetero-anamneses were available in two cases.

Results: Formal testing was difficult in most subjects because of visual, auditory, and motor handicaps. By combining the results of cognitive tests, informant questionnaires, clinical examinations, and hetero-anamneses a diagnosis of moderate to severe dementia could be made in 12 subjects. Three subjects were mildly demented. Two subjects could not be examined. Informant questionnaires indicated minor forgetfulness and dysfunctions in both.

Conclusions: At best, the majority of centenarians appear to be demented. We fear that very few people can live for 100 years or more without serious cognitive decline.

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2. Katzman R, Kawas C: The epidemiology of dementia and Alzheimer disease. In: Terry RD, Katzman R, Bick KL, eds. Alzheimer Disease. New York: Raven Press, 1994; 105–122.

No. 84
IS SCHIZOPHRENIA ON THE DECLINE?

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EDUCATIONAL OBJECTIVE:

To demonstrate a knowledge of the use of cumulative databases to follow changes in the occurrence of serious mental illness over time and be aware of possible confounding factors that may contribute to the observed changes.

SUMMARY:

Research from several parts of the world, including Canada, Great Britain, Denmark, and New Zealand, has suggested that in the last quarter century the incidence and prevalence of schizophrenia has decreased. The Kingston Psychiatric Record Linkage System (KPRLS), one of the few linked psychiatric databases in North America, was established in 1984 and is currently supported by the Ontario Ministry of Health. It includes information on all adult psychiatric inpatients, outpatients, and emergency department referrals to psychiatry at the three area hospitals. This database has accumulated information on 25,000 individual patients with over 300,000 contacts. Using data from the KPRLS for patients with schizophrenia, service utilization changes from 1985 to 1997 and prevalence rate changes in the decade from 1986 to 1996 will be analyzed. Both types of data show a substantial decline. It is important

to document, wherever the data exist, the trends in the occurrence of this serious mental illness as well as to consider the confounding factors related to this type of research. Such studies are not only necessary to plan appropriately and evaluate services but also contribute to understanding the etiology of schizophrenia, especially as related to environmental changes over time.

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1. Takei N, Lewis G, Sham PC, Murray RM: Age-period cohort analysis of the incidence of schizophrenia in Scotland. Psychol Med 1996; 26:963–73.
2. Woogh CM: Patients with multiple admissions in a psychiatric record linkage system. Can J Psychiatry 1990; 35:401–406.

No. 85
A PROSPECTIVE ANALYSIS OF ALCOHOL USE DISORDERS

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EDUCATIONAL OBJECTIVE:

To understand the epidemiology and natural history of alcohol use disorders in a community-based population.

SUMMARY:

Objective: Using prospective data, our principal aim was to assess the rates of incidence, remission, and chronicity of alcohol abuse and dependence within a large community-based sample.

Methods: In 1981, an area probability sample of 3481 household residents in east Baltimore was selected, as one site of the Epidemiologic Catchment Area program. To assess the occurrence of psychiatric and substance use disorders, participants were administered the Diagnostic Interview Schedule (DIS) based on DSM-III criteria. In 1993–94, a 13-year follow-up of the Baltimore cohort was completed and a total of 1920 of the study participants were traced and reinterviewed.

Results: Preliminary results indicate that of the study participants without a current DIS/DSM-III diagnosis of an alcohol use disorder at the time of the baseline interview, about one in 16 had developed alcohol abuse or dependence at the follow-up interview. For about one-half of those who had a current alcohol use disorder in 1981, there was persistence of the disorder: 56 qualified as current cases in 1993–94, providing evidence for chronicity of the disorders. The probability of remaining an active case varied by whether treatment was received and the type of mental health resources utilized.

Conclusions: This longitudinal study adds to our understanding about the natural history of alcohol use disorders in a community-based population.

Funding sources: This study was supported by grants from the National Institute of Mental Health (MH47447) and the National Institute on Alcohol Abuse and Alcoholism (K20-AA00168).

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SCIENTIFIC AND CLINICAL REPORT SESSION 29—THE WIDE WORLD OF NEUROPSYCHIATRY

No. 86
DRUG-INDUCED DELIRIUM IN INTENSIVE CARE UNITS

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EDUCATIONAL OBJECTIVE:

To recognize the significance of anticholinergic medications in the cause of acute delirium in I.C.U. and the appropriate use of physostigmine in the treatment of drug-induced delirium.

SUMMARY:

Delirium possess a great danger to the severely ill medical and surgical intensive care unit patients. Rapid and accurate assessment of the cause and proper management is essential in reducing the morbidity and mortality of these delirious patients.

From 1993-1996 our psychiatric consultation service was called upon to evaluate 87 cases of acute delirious patients in medical and surgical intensive care units. Among them, we found 54 cases of patients who had been treated with medications that have anticholinergic activity prior to the onset of delirium. Most notably among them are cimetidine, ranitidine, famotidine, digoxin, corticosteroid, lidocaine, morphine, meperidine, etc. All these 54 patients were given repeated physostigmine injection in small doses (0.4-0.5 mg q1-1.5 hr).

The result of physostigmine was remarkable; 41 cases were clear of delirium within six hours. Ten cases needed additional injection of haloperidol before their behavior were under control the next day. Three cases were noneffective and expired eventually.

Medications with anticholinergic activity are frequently neglected as the causal agent for delirium in I.C.U. patients. By careful and appropriate use of physostigmine, delirium can be resolved in a short period of time, thus reducing the morbidity and mortality of delirious patients.

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2. Tune L: Anticholinergic effects of drugs commonly prescribed for the elderly: potential means for assessing risk of delirium. Am J Psychiatry 1992; 149:1393.

No. 87
ROLE OF SYMPATHOADRENAL DYSFUNCTION IN HYPERTHERMIA

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will be able to identify the major hyperthermia syndromes, their distinct etiologies, and the role that dysregulated sympathetic nervous system hyperactivity plays in each.

SUMMARY:

Objective: To compare salient features of the major clinical hyperthermia syndromes with the aim of identifying one or more possible common pathophysiologic processes.

Method: Published studies of lethal catatonia (LC), serotonin syndrome (SS), malignant hyperthermia (MH), acute cocaine toxicity (ACT), and neuroleptic malignant syndrome (NMS) were reviewed in detail with respect to clinical signs, symptoms, laboratory findings, and pathophysiology.

Results: LC is almost indistinguishable from NMS clinically, but predates antipsychotic medications. SS shares some features with NMS but is less severe and typically is not associated with rigidity. MH is a genetic disorder in which the structure of the ryanodine receptor is altered, leading to excessive calcium release from sarcoplasmic reticulum (SR) following exposure to certain volatile anesthetics. ACT can present as acute NMS but is caused by dopamine (DA) excess since cocaine is a DA reuptake inhibitor. Autonomic dysregulation and hyperactivity are prominent in all of these syndromes. The SNS is intimately involved in all aspects of normal thermoregulation, a process that is modulated to some extent by serotonergic inputs. Adrenoceptors regulate muscle contractility by acting at a site at or near the ryanodine receptor to effect changes in intracellular calcium levels.

Conclusion: There is considerable evidence that SNS hyperactivity and/or dysregulation is a common pathophysiologic process linking these disorders. Excess SNS activity could impair regulation of calcium flux to and from SR, causing increased thermogenesis and muscle tone, and accounting for the variable response to treatment that has been observed in NMS. Dysregulated SNS hyperactivity, resulting in defective intracellular calcium regulation, could explain the remarkable similarity between these hyperthermia syndromes with distinct etiologies.

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2. Haggendal J, Jonsson L, Carlsten J: The role of sympathetic activity in initiating malignant hyperthermia. Acta Anaesthesiol Scand, 1990; 34:677-682.

No. 88
EPILEPSY AND PSYCHOSIS: A NEURODEVELOPMENTAL HYPOTHESIS

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EDUCATIONAL OBJECTIVE:

To recognize that the association between seizure disorders and psychosis exceeds chance expectation and in the process identify the risk factors for psychosis in patients with seizure disorders. Furthermore, the participant will gain a greater understanding of possible developmental factors in the pathogenesis of the psychosis.

SUMMARY:

Background: It is recognized that the frequency of psychosis occurring with epilepsy exceeds chance expectation. Whether temporal lobe seizures (TLE) are more often implicated is, however, unclear. Similarly, the long delay between onset of seizures and subsequent psychosis has yet to be explained.

Methods: A group of 62 patients with a diagnosis of "psychosis due to a general medical condition" were followed up for an average of 44 months and predictors sought for psychotic relapse. Subjects included 18 patients with temporal lobe epilepsy (TLE), 10 patients with generalized epilepsy (GE), and 24 control subjects with various neurological disorders.

Results: Patients with seizure disorders were significantly more likely to have had a psychotic relapse than those with other neurological disorders. A logistic regression analysis identified two significant predictors of psychotic relapse, namely temporal lobe epilepsy and the age of onset of the first seizure.

Conclusions: The study confirmed the susceptibility of patients with TLE as opposed to other forms of epilepsy to become psychotic. However, the importance of age of onset of seizures as a determinant of psychotic relapse was also identified; in particular, seizure onset before putative cerebral pruning (i.e., adolescence) occurs is a poor prognostic sign and suggests that for a subgroup of epileptic patients, psychosis may be developmental in origin.

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SCIENTIFIC AND CLINICAL REPORT SESSION 30—LONG-TERM TREATMENT ISSUES IN DEPRESSION

No. 89
EFFECTS OF DISCONTINUING LONG-TERM ANTIDEPRESSANTS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe the risk of relapse in discontinuing maintenance antidepressant therapy.

SUMMARY:

Discontinuation of maintenance treatment in bipolar disorders in schizophrenia is associated with a high risk of early relapse. Such risks are less well defined after stopping antidepressant medication.

Methods: A computerized literature search identified 27 follow-up studies involving a total of 3,037 patients mainly with unipolar major depression, with continued vs. discontinued antidepressant treatment and suitable for comparisons of relapse rates or for survival analysis.

Results: Antidepressant treatment was discontinued after 5.78 ± 11.0 (0–48) months, with 16.6 ± 12.8(5–66) months of follow-up in 27 trials. Crude relapse rates (%/month) were 3.37-fold lower with treatment continued (1.85 ± 1.51 vs. 6.24 ± 5.34;$p<0.0001$). Survival analysis of data pooled from 19 studies yielded a 3.37 fold later computed time to a 50% relapse ($p<0.0001$), of 48.0 ± 4.7 months with antidepressant treatment maintained (N=1,663) vs. 14.2+0.5 months after stopping it (N=952). Neither a longer period of stabilization on treatment nor gradual discontinuation (dose-tapering or discontinuing longer-acting antidepressants) was associated with lower relapse risk.

Conclusions: These findings differ appreciably from analyses for bipolar disorders and schizophrenia, in that time to relapse was longer, not clearly related to either the rapidity of drug discontinuation or to the preceding length of stabilization. These differences are provocative and may suggest the diagnostic heterogeneity of major depressive disorders as compared with bipolar disorder and schizophrenia.

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No. 90
ANTIDEPRESSANT EFFECTS ON PERSONALITY IN DYSTHYMIA

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EDUCATIONAL OBJECTIVES:

To describe the baseline personality abnormalities common in dysthymia, as assessed by Cloninger's Tridimensional Personality Questionnaire (TPQ), including Harm Avoidance (HA), Reward Dependence (RD), and Novelty Seeking (NS), and to describe the effects of antidepressant medication (sertraline or imipramine) or placebo treatment on these factors.

SUMMARY:

Evidence has accumulated to indicate that dysthymia, or chronic depression, commonly responds to antidepressant medications. Symptoms of dysthymia and psychosocial functioning have been shown to respond to treatment in the majority of dysthymic individuals. Dysthymics have also been shown to have poor psychosocial functioning (including impaired work functioning and social functioning) and abnormalities in personality measures. However, there have been no systematic studies of the impact of antidepressant treatment on personality variables in dysthymia. Cloninger has developed the Tridimensional Personality Questionnaire, a 100-item, self-report questionnaire that had been normed on a community sample of 1019 individuals. The TPQ measures temperamental dimensions of Harm Avoidance (HA), Reward Dependence (RD), and Novelty Seeking (NS), and a more recently added dimension of Persistence (PS).

In this paper we report the results of a multicenter study of 410 early-onset primary dysthymic patients, treated in a randomized prospective fashion with sertraline, imipramine, or placebo. We will discuss the baseline TPQ findings in dysthymia (particularly elevated HA scores, which are approximately 2 SDs above a community norm), the relationship of these abnormalities to impaired social functioning, and the impact of treatment in alleviating these abnormalities.

REFERENCES:

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2. Cloninger CP: A systematic method for clinical description and classification of personality variants. Arch Gen Psychiatry 1987; 44:573–588.

No. 91
FEASIBILITY OF ONE-YEAR TREATMENT OF DEPRESSION BY PHARMACOTHERAPY OR COMBINED THERAPY

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EDUCATIONAL OBJECTIVE:

To recognize that compliance pharmacotherapy during one year, as treatment of depression, is feasible in half of the patients; that it significantly enhances the efficacy of the treatment; and that addition of psychotherapy plays a role in improving compliance with pharmacotherapy.

SUMMARY:

Objective: Establishing the feasibility of pharmacotherapy as a treatment of depression and showing how the efficacy is influenced by feasibility.

Method: One-year randomized clinical trial comparing the efficacy of combined therapy (n=72) with pharmacotherapy alone (n=57) in 129 outpatients with a DSM-III-R-defined major depression, with a 17-item Hamilton Depression Rating Scale (HDRS) baseline score ≤14 points. All are treated according to an antidepressant protocol (fluoxetine amitriptyline moclobemide), intended to continue for one year. In the combined therapy, 17 sessions of short psychodynamic supportive therapy are added. Efficacy is assessed using the 17-item HDRS (remission defined as 0-7). Feasibility is defined as complying with the antidepressant protocol.

Results: After two, four, six and 12 months pharmacotherapy is feasible in 92%, 81%, 68%, and 51%, respectively. Pharmacotherapy compliance is greater in the combined therapy. After six months and one year, remission rates are 37% versus 28% in feasible versus not feasible treatment and 59% versus 46%.

Conclusions: The efficacy of antidepressant treatment significantly improves when pharmacotherapy is feasible. The feasibility of pharmacotherapy is enhanced by addition of psychotherapy.

Acknowledgement: This study is supported by an unrestricted educational grant from Eli Lilly Nederland and carried out by the PZA Depression Research Group.

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SCIENTIFIC AND CLINICAL REPORT SESSION 31—DIAGNOSTIC ISSUES IN GENERAL HOSPITAL PSYCHIATRY

No. 92
THE TEN-POINT CLOCK TEST IN THE GENERAL HOSPITAL

Peter J. Manos, M.D., *Department of Psychiatry, Virginia Mason, PO Box 900, 1100 9th Avenue, X7-Psy, Seattle WA 98111-0900*

EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation the participant should be able to administer and score the ten-point clock test and interpret the result to identify cognitive impairment.

SUMMARY:

Objective: To illustrate the utility of the ten-point clock test as a screen for cognitive impairment in the general hospital by examining a range of diagnoses and estimating sensitivity for each.

Methods: The author examined 195 consecutive medical and surgical inpatients referred for psychiatric consultation and obtained histories from patient, family, nurses, physicians, and hospital records. Seventy-six percent of these patients were administered the ten-point clock test at the initial evaluation.

Results: The percentages of patients scoring less than eight points on the ten-point clock test (sensitivities) for the following cognitive disorders were: delirium (92%), dementia (90%), opioid intoxication (70%), and cognitive disorder n. o. s. (64%). Only 5% of patients with a primary diagnosis of adjustment reaction scored lower than eight points. Thirty-nine percent to 70% of patients with these four cognitive disorders scored lower than five points, but none of the patients with a major depressive disorder, alcohol dependence, or adjustment disorder did so. The sensitivities of the ten-point clock test and Mini-Mental State Examinations appeared similar in a subset of patients.

Conclusion: The ten-point clock test is a useful screen for cognitive impairment in general hospital patients.

REFERENCES:

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2. Manos PJ: The utility of the ten-point clock test as a screen for cognitive impairment in the general hospital. General Hospital Psychiatry (in press).

No. 93
INCIDENCE OF DISSOCIATIVE IDENTITY DISORDER IN PSYCHIATRIC INPATIENTS

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EDUCATIONAL OBJECTIVE:

To evaluate the incidence of dissociative identity disorder in women admitted to a psychiatric inpatient service of a general hospital.

SUMMARY:

Objective: To replicate reports of a high incidence of dissociative identity disorder (DID) in psychiatric inpatients.

Method: We randomly selected women, 16-50 years old, who had recently entered a psychiatric division of a general hospital. Two interviewers made diagnoses using the SCID-D, a structured clinical interview schedule for dissociative disorders.

Results: One percent (1/100) of interviewed subjects had DID.

Conclusion: Contrary to previous studies, and using more accurate methodology, we found a low incidence of DID.

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2. Latz TT, Kramer SI, Hughes DL: Multiple personality disorder among female inpatients in a state hospital. Am J Psychiatry 1995; 152:1343-1348.

No. 94
FIBROMYALGIA: FACT OR FICTION?

Joseph Berger, M.D., *4430 Bathurst Street Suite 501, Downsview, ONT M3H 3S3, Canada;* Perry J. Rush, M.D.

EDUCATIONAL OBJECTIVE:

To understand the concept of fibromyalgia, the scientific difficulties in the diagnosis of symptoms in those labeled with fibromyalgia, and why it is inappropriate to use this label in the medicolegal setting.

SUMMARY:

Disability payments in North America total billions of dollars. In recent years the label of fibromyalgia has been used increasingly to support disability claims where there are subjective complaints and symptoms but no objective findings on clinical examination or laboratory testing.

This joint presentation by a psychiatrist and a physiatrist/rheumatologist, who both have much experience in disability assessment, will discuss the validity and reliability of the fibromyalgia label.

The physiatrist/rheumatologist will discuss the origin, history, clinical findings, diagnosis, and classification criteria for fibromyalgia. There is no scientific evidence for a physical basis for the symptoms of patients given the label fibromyalgia, and there is evidence that such patients do not give accurate descriptions of their physical capabilities.

The psychiatrist will discuss the psychiatric findings and will review psychological explanations and the relevance of DSM-IV categories for the symptoms these patients present. There are serious doubts about the presence of psychiatric disease in the majority of these patients.

Implications for final diagnosis, disability payment, and treatment will be discussed. We conclude that fibromyalgia is not a valid or reliable medical construct.

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2. Berger J: The explosive growth of psychiatric disability. American Journal of Forensic Psychiatry. 1997; 18:51-79.

SCIENTIFIC AND CLINICAL REPORT SESSION 32—MEASUREMENTS OF CLINICAL CARE

No. 95
CLINICAL PREDICTORS OF RECURRENT DEPRESSION

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EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation the participant should be able to identify neurotic personality traits, slower initial response, and shorter treatment duration of the acute episode as important clinical predictors of recurrence in depression.

SUMMARY:

Since the introduction of antidepressant drugs, there have been many attempts to determine the characteristics of depressed patients who do or do not respond to treatment. However, clinical predictors of treatment response have been inconsistent. It is suggested that patients who respond better are those with good premorbid personality, intermediate level of severity, and without psychotic features. Another aspect of prediction corresponds to the identification of depressive patients at higher risk of recurrence. The objective of our study was to evaluate if personality traits along with other clinical and therapeutic features could predict recurrence of depression once the acute episode has remitted.

As a part of a large clinical trial we followed 42 patients during one year after remission and without treatment. At the end of that period 24 patients had a recurrent episode and 18 did not. Recurrent patients differed from nonrecurrent in having more neurotic personality traits, a slower response rate to acute treatment, and a shorter

duration of treatment of the episode. A multivariate analysis found that together, these features predicted recurrence in 90.4% of all patients. These findings may be useful when making treatment determinations for preventing recurrence in depression.

REFERENCES:

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2. Alnaes R, Torgersen S: Personality and personality disorders predict development of relapses of major depression. Acta Psychiat Scand 1997; 95:336-342.

No. 96
CORRELATES OF DROPPING OUT OF SUBSTANCE ABUSE TREATMENT

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EDUCATIONAL OBJECTIVES:

To recognize the role of psychiatric comorbidity in retention of substance abuse outpatients; to illustrate services outside the sphere of the traditional mental health delivery, which may enhance the retention of outpatients; and to understand the use of logistic regression and survival analysis in the presentation of data in outcome studies.

SUMMARY:

Objective: To describe the association between various demographic and drug-use correlates in predicting completion of intensive outpatient treatment at a substance abuse treatment program.

Context: Reviews of the literature on substance abuse treatment have found that dual-diagnosis patients, individuals with both a substance abuse and psychiatric disorder, have higher rates of attrition than patients with a diagnosis of substance abuse disorder alone.

Methods: Between January 1996 and May 1997, we sampled 328 patient records of an institutional database and recorded length-of-stay and completion of intensive outpatient treatment as dependent variables. Descriptive statistics were analyzed and independent variables including sex, age, race, marital status, and primary diagnosis were entered into a logistic regression model to discern the magnitude of associations and their relative significance.

Results: 16.2% of dual-diagnosis patients, 11% of all outpatients, completed intensive outpatient treatment, compared with 32% of all other substance abuse patients. In our analysis, women younger than 30 years of age and patients with a dual diagnosis were associated with treatment dropout.

Discussion: These findings illustrate that substance use disorder treatment programs may require integration of the spectrum of non-traditional mental health services, such as housing, childcare, and transportation programs for dual-disorders patients and women of child-bearing age, in order to successfully engage and retain patients in treatment.

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1. Baekeland F: Dropping out of treatment: a critical review. Psychological Bulletin, 1975; 82:738-783.
2. Stark M: Dropping out of substance abuse treatment: a clinically oriented review. Clinical Psychology Review, 1992; 12:93-116.

No. 97
MEASURING THE QUALITY OF CARE FOR SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize why quality measurement and improvement is important in schizophrenia, understand how treatment recommendations can be used to measure quality, and be able to collaborate in the development of quality measurement systems.

SUMMARY:

Objective: To develop a standardized approach to measuring the quality of outpatient care for schizophrenia and employ it to evaluate routine care.

Method: We randomly sampled 224 patients in treatment for schizophrenia at two public clinics. Appropriate medication management was defined according to criteria derived from national treatment recommendations. Adequate psychosocial care was defined as the provision of case management and family management to patients for whom it is indicated. Care was evaluated using data from patient interviews and medical record abstractions.

Results: Although patients at the two clinics were clinically similar, the treatment they received was quite different. At both clinics, 15% of patients received poor quality medication management that was attributable to patient factors such as poor compliance or drug or alcohol use. Clinics differed in the proportion of patients receiving poor quality medication management not attributable to patient factors (16% vs. 28%). The clinic with better quality medication management provided case management to fewer of its severely ill patients (48% vs. 81%).

Conclusions: Many schizophrenics are receiving poor quality care, and a significant portion of this poor care is likely due to factors that can be modified. Systems to measure and improve the quality of care received by these individuals should be implemented.

Funded by the Veterans Health Administration, the Robert Wood Johnson Foundation, and NARSAD.

REFERENCES:

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SCIENTIFIC AND CLINICAL REPORT SESSION 33—AIDS AND DIAGNOSTIC ISSUES

No. 98
THE RELATIONSHIP BETWEEN DIAGNOSIS AND HIV RISK

Kevin J. Lourie, Ph.D., *Child and Family Psych., Rhode Island Hospital, 593 Eddy Street, Providence RI 02903;* Larry K. Brown, M.D., Michael Danovsky, Ph.D., Avi Shapira, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to understand the prevalence of HIV risk behavior among adolescents

diagnosed with psychiatric disorders; to recognize the increased HIV risk of those adolescents with concurrent disorders.

SUMMARY:

Objective: This study uses a computerized diagnostic interview for children (C-DISC) to determine differences in HIV-related risk according to diagnostic groups.

Method: Self-report data describe HIV knowledge, attitudes, condom use, risk behaviors, peer influences, history of sexual and drug abuse, aggressivity, impulsivity, and family functioning among 61 adolescents with depressive, impulse control, or both disorders.

Results: Although results show that no diagnostic category is immune to HIV risk, analyses of C-DISC and self-report data show significant differences between groups. Teens with concurrent depressive and impulse control disorder diagnoses reported significantly more inconsistent condom use, greater impulsivity, and higher rates of sexual abuse than their peers with only a single diagnosis.

Conclusion: Despite differences between groups in causes of risk behavior, rates of HIV risk behavior and general attitudes were largely similar between individual diagnostic groups. However, teens with concurrent depressive and impulse control disorder diagnoses appear to be at greater risk for HIV than their peers with any single diagnosis.

Research funded by NIMH grant R29 MH50416

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2. Brown LK, Reynolds L, Lourie KJ: A pilot HIV prevention program for psychiatrically hospitalized adolescents. Psychiatric Services 1997; 48:531–533.

No. 99
ACCURACY OF MEMORY REPORTING BY PATIENTS WITH HIV DISEASE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize how depressive symptoms and psychomotor speed efficiency affects the reporting of memory complaints in patients with HIV-1 disease.

SUMMARY:

Objective: To determine whether HIV-1 patients who are inaccurate (INACC) in their subjective evaluation of their memory status differ on objective neuropsychological (NP) testing and mood from HIV-1 patients who are accurate (ACC) in their memory evaluation.

Method: As part of a hospital-based research study, 40 HIV-1 patients were administered a memory complaint questionnaire, NP tests of attention (Digit Span), memory (CVLT), and psychomotor speed (Digit Symbol), and a self-report measure of mood (BDI). We calculated standardized difference scores between memory complaints and CVLT to identify three groups: INACC (patients who under- or over-reported memory complaints), ACC-LoCVLT (patients with high memory complaints and impaired CVLT memory performance), and ACC-HiCVLT (patients with low memory complaints and normal CVLT memory performance). All groups were matched on age [mean = 43 (9) yrs], education [mean = 16 (3) yrs,], CD4 count [mean = 237 (191)] and CDC stage.

Results: The INACC group, while having only mildly elevated depressive symptoms, fell intermediate on memory and attention measures relative to ACC groups, but had significantly slower psychomotor speed relative to the ACC-HiCVLT group. The ACC-LoCVLT group was significantly lower in memory performance, attention, and psychomotor speed, and had elevated depressive symptoms.

Conclusions: This study confirms earlier reports by other investigators that increased depressive symptoms can be associated with increased memory complaints, but adds that psychomotor speed is also important to consider when examining the relationship between patient's memory complaints and their objective memory performance.

This study was supported, in part, by the Canadian Foundation for AIDS Research.

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No. 100
FOR WHAT DSM-IV DISORDERS DO OUTPATIENTS WANT TREATMENT?

Mark Zimmerman, M.D., *Department of Psychiatry, Rhode Island Hospital, 235 Plain Street Ste 501, Providence RI 02905;* Jill I. Mattia, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize which psychiatric disorders outpatients want treatment for.

SUMMARY:

Objective: Epidemiological studies indicate that most patients in the community do not get treatment for psychiatric disorders. Unknown is whether individuals who present for outpatient psychiatric treatment desire treatment for all the disorders that they have, or whether they only desire treatment for the principal reason they seek treatment. The goal of the present study was to determine psychiatric outpatients' desire for treatment for Axis I disorders that are present at the time of initial intake evaluation.

Methods: Five hundred psychiatric outpatients were interviewed with the Structured Clinical Interview for DSM-IV (SCID). For patients with more than one disorder, diagnoses were assigned as principal or additional according to the DSM-IV convention of whether it was the principal reason for presenting for treatment. For all current disorders, patients were asked if they wished to receive treatment for that disorder.

Results: Nearly all patients wanted treatment for major depression, and more than 85% of patients with panic disorder, PTSD, or generalized anxiety disorder wanted treatment. Between half and two-thirds of patients with social phobia, OCD, intermittent explosive disorder, body dysmorphic disorder, or substance use disorders wanted treatment for these disorders. Only 30% of individuals with specific phobia wanted treatment for it.

Conclusions: There was great variability between Axis I disorders and patients' desire for treatment. This may explain, in part, the findings from epidemiologic studies regarding the undertreatment of psychiatric disorders in the community.

REFERENCES:

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2. DuFort G, Newman S, Bland R: Psychiatric comorbidity and treatment seeking. J of Nerv & Mental Dis. 1993; 181:467-474.

SCIENTIFIC AND CLINICAL REPORT SESSION 34—DIAGNOSTIC ISSUES IN PTSD

No. 101
COMORBIDITY OF COMPLEX PTSD AND OCD

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EDUCATIONAL OBJECTIVES:

SUMMARY:

Epidemiologic study has shown that in a general population sample, persons meeting criteria for post-traumatic stress disorder (PTSD) have twice the risk for another lifetime psychiatric diagnosis than do individuals who never experienced PTSD. This includes risk for obsessive-compulsive disorder (OCD). Brain neuroimaging studies in patients with complex PTSD demonstrate a pattern of glucose utilization nearly identical to that seen in patients with OCD. Both PTSD and OCD appear to be associated with serotonergic dysregulation, and drugs that block reuptake of serotonin have been shown to be effective in both disorders. Both PTSD and OCD have responded to cognitive-behavioral therapy. Patients with complex PTSD routinely have episodes of depersonalization and have obsessions and/or compulsions during both flashback and numbing phases of PTSD.

Participants: To test a hypothesis that OCD is a comorbid condition of patients with complex PTSD, 40 female patients with complex PTSD as assessed by clinical interview were given the Yale-Brown Obsessive Compulsive Scale to quantify the severity of their OCD as assessed clinically. All were adults with histories of childhood sexual abuse ongoing for two to eight years.

Results: All 40 patients with confirmed diagnostic criteria for complex PTSD also met criteria for OCD, demonstrating 100% concordance of PTSD and OCD. Obsessions involved food, bathroom habits, and safety issues, with relief of anxiety after performance of rituals. Compulsions focused around issues such as touching or checking, washing, and counting. Complicated rituals of unknown significance were compulsively acted out by patients with dissociative amnesia of PTSD. As treatment progressed, the meaning of each ritual became known along with its relationship to an abusive episode that had produced dissociation/amnesia.

Conclusions: Concordance of complex PTSD and OCD symptoms, considered in context with concordant neuroimaging patterns and response to neuropharmacologic and cognitive-behavioral therapy, suggest common body-brain-mind adaptations to an enduring pathologic environment. Comorbidity of PTSD and OCD may have implications for conceptualization and treatment of complex PTSD as a biphasic disorder.

REFERENCES:

1. Post RM, Weiss SRB, Smith M, et al: Kindling versus quenching: implications for the evolution and treatment of posttraumatic stress disorder, Psychobiology of Posttraumatic Stress Disorder Annual. 1997; 821:285-295.
2. Hollander E, Wong CM: Obsessive-compulsive spectrum disorders. J. Clin Psychiatry 1995; 56(suppl 4):3-6.

No. 102
PTSD FOLLOWING AN EARTHQUAKE IN SOUTHERN INDIA: A STUDY OF 1,582 INDIVIDUALS

Shamsah B. Sonawalla, M.D., *Dept. of Psychiatry, Massachusetts General Hosp., 15 Parkman Street WAC 812, Boston MA 02114;* Rajesh M. Parikh, M.D., Rakesh Jain, B.A., Neha Gada, B.A., Mrinmoyi Kulkarni, B.A., Shona Vas, B.A., Marissa D'Mello, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to appreciate the high prevalence of post-traumatic stress disorder following a natural disaster such as an earthquake. The psychiatric needs of a population that has experienced an earthquake are frequently ignored, and this presentation will seek to highlight these largely unattended needs of the victims of a natural disaster.

SUMMARY:

Objective: We wanted to assess the psychological consequences of a traumatic event such as the major earthquake of 1993 in southern India.

Method: We evaluated 1582 adults for post-traumatic stress disorder (PTSD) following the Latur earthquake in southern India. The study design incorporated a comparison between the affected population (N = 1156) and an unaffected group (N = 426). The study group was further stratified into three subgroups; Group A at the epicenter of the earthquake (N = 444), Group B about 20 kms from the epicenter (N = 357), and Group C about 40 kms from the epicenter (N = 355). The control group was about 400 kms from the epicenter. PTSD was diagnosed using the Structured Clinical Interview for DSM-III-R (PTSD module). The Impact of Events Scale (I.E.S.) was used to quantify the severity of symptoms. About 10% to 15% of the population of the villages was randomly sampled in the selected areas.

Results: 60% of the study group suffered from PTSD compared with 0.2% of the control group ($p < 0.001$). There was a gradient in increase in PTSD prevalence towards the epicenter where the prevalence was 77%. Mean total I.E.S. scores in the study group were 24.04 ± 4.8 compared with 1.98 ± 0.46 in the control group ($p < 0.001$). There was a gradient in increase in I.E.S. scores towards the epicenter where the mean total score was 28.68 ± 5.6. Analysis of variance on I.E.S. scores revealed a significant group effect for the number of family members lost due to earthquake.

Conclusion: There was a high incidence of PTSD in the affected population. The prevalence of PTSD was directly proportional to the proximity to the epicenter of the earthquake. The severity of symptoms was affected by death in the family.

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1. Goenjian A: A mental health relief programme in Armenia after the 1988 earthquake implementation and clinical observations. Br. J. of Psy. 1993; 163:230-239.
2. De Girolamo G, Orley J: Psychological Consequences of Disasters: Prevention and Management. World Health Organization, Division of Mental Health, Geneva, Switzerland, 1992.

No. 103
PSYCHIATRIC SYMPTOMS FOLLOWING AN EARTHQUAKE

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EDUCATIONAL OBJECTIVES:

To recognize the high prevalence of psychiatric symptoms following a major natural disaster such as an earthquake. The psychological

needs of an affected population are frequently neglected during most disaster management plans. The presentation will focus on these large unmet needs and emphasize the importance of psychiatric interventions in such situations, more so given the high frequency of suicidal ideation in this population.

SUMMARY:

Objective: We wanted to assess the psychiatric symptoms following a major earthquake in southern India.

Method: We evaluated 1582 adults for psychiatric symptoms following the Latur earthquake in southern India in September 1993. The study design incorporated a comparison between the affected population (N = 1156) and an unaffected group (N = 426). The study group was further stratified into three subgroups: Group A at the epicenter of the earthquake (N = 444), Group B about 20 kms from the epicenter (N = 337), and Group C about 40 km from the epicenter (N = 355). The control group was about 400 kms from the epicenter. We used the Self-Report Symptom Scale (SRSS) and the General Health Questionnaire (GHQ) to rate the symptoms.

Results: Mean total scores on the SRSS and GHQ were significantly higher in the study group than in the control group ($p < .001$). Within the study group there was a gradient in increase in mean total scores on the SRSS as well as the GHQ towards the epicenter; 61% of the individuals had a total score above the cut off of 8 on the SRSS compared with 29% in the control group. Also, 60% of individuals in Group A had suicidal ideation compared with 4% in the control group ($p < .001$). Analyses of variance and posthoc tests indicated that the factor scores of neurotic feelings, somatization, cognitive performance, depression, and fear-anxiety on the SRSS were all significantly higher in the study group than the control group. Similarly on the GHQ, factor scores of somatic symptoms, anxiety-insomnia, social dysfunction, and severe depression were significantly higher in the study group.

Conclusions: Psychiatric symptoms were highly prevalent in the study population compared with the control group and constituted a large unmet need. The high frequency of suicidal ideation was an issue of special concern.

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1. Freedy J, Saladin M, Kilpatrick D, et al: Understanding acute psychological distress following a natural disaster. J Trauma Stress 1994; 7:257-273.
2. Goenjian A: A mental health relief programme in Armenia after the 1988 earthquake: implementation and clinical observations. Br J Psychiatry 1993; 163:230-239.

SCIENTIFIC AND CLINICAL REPORT SESSION 35—EATING DISORDERS

No. 104
FEEDBACK OF ACTIVITY IN THE TREATMENT OF OBESITY

Daniel J. Safer, M.D., *7702 Dunmanway, Dundalk MD 21222-5436;* Richard P. Allen, Ph.D., Thomas A. Wadden, Ph.D.

EDUCATIONAL OBJECTIVE:

To appreciate that feedback from a computerized, precise, and continuously recording activity monitor can intensify the motivation of obese adults to increase their total daily motoric activity and in the process maintain the weight lost after completion of the initial phase of a comprehensive diet program.

SUMMARY:

Objectives: Regular exercise is accepted as the most successful method for obese individuals to maintain weight loss. This NIH-funded study sought to determine the optimal level of exercise intensity needed to support weight loss maintenance using precise, small, light-weight activity monitors, and to ascertain the effect of providing immediate feedback of total daily activity on adherence to exercise goals and on weight loss maintenance.

Methods: 79 obese adult subjects were randomly assigned to two identical weight loss treatment groups. One group wore ambulatory monitors that provided continuous recording with immediate feedback (Biotrainer Pro, IM Systems, Inc.); the other group wore the same monitor without feedback.

Results: Weight loss maintenance was enhanced only by daily activity at 2 or more mph. At this level of intensity, effects were optimal for average daily durations of at least 35 minutes. The feedback monitor group had significantly more moderate activity (≤ 2 mph) and significantly better weight loss maintenance.

Conclusions: Daily activity levels to improve weight loss maintenance should be about 35 minutes or more of activity at an intensity of 2 or more mph. Activity monitors providing feedback of daily activity levels heighten motivation to exercise, thereby improving weight loss maintenance.

REFERENCES:

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2. Safer DJ: Diet, behavior modification and exercise: a review of obesity treatments from a long-term perspective. Southern Med J; 84:1470–1474.

No. 105
SELF-HELP FOR BINGE EATING DISORDER

Jacqueline Carter, *D.Phil., Department of Psychiatry, The Toronto Hospital, 200 Elizabeth Street, Toronto, ONT M5G2C4, Canada;* Christopher G. Fairburn, D.M.

EDUCATIONAL OBJECTIVE:

To implement the basic principles of cognitive-behavioral-guided self-help for binge eating problems; to gain an understanding of the effectiveness of self-help treatments for those who binge eat.

SUMMARY:

Objective: The aim of this study was to evaluate the relative effectiveness of two self-help treatments for binge eating disorder, "pure self-help and "guided self-help".

Method: Seventy-two women with binge eating disorder recruited directly from the community were randomly assigned to one of three conditions for 12 weeks: pure self-help (PSH), guided self-help (GSH), or waiting list (WL). Both interventions involved following the cognitive behavioral self-help manual *Overcoming Binge Eating* (Fairburn, 1995). In PSH, the subjects were simply asked to follow the self-help manual on their own. In GSH, they also received up to eight 25-minute sessions with a "therapist" who did not have any formal clinical qualifications. This intervention was designed to be suitable for use by nonspecialists in primary care. The main role of the "therapist" was to encourage subjects to follow the self-help program. Subjects allocated to the WL were subsequently randomized to pure self-help or guided self-help following a 12-week waiting period.

Results: Nine subjects (12%) dropped out. The data were analyzed using intention-to-treat analysis. At post-treatment, the percentage of subjects who had ceased to binge eat was 50% in GSH, 43% in PSH, and 8% in the WL condition. On other measures of outcome, a

similar pattern emerged with subjects in both GSH and PSH showing significant improvement and there being little change in the WL condition. There were no changes in body weight. The improvements were well maintained at three- and six-month follow-up. Results at one-year follow-up will also be presented.

Conclusion: The results of this study suggest that a significant subgroup of women with binge eating disorder could be helped by a cognitive-behavioral self-help intervention, and that self-help may be of value in the secondary prevention of eating disorders.

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1. Fairburn CG, Carter JC: Self-help and guided self-help for binge eating problems. Chapter in Handbook of Treatment for Eating Disorders, edited by D.M. Garner and P.E. Garfinkel. 1997; New York: Guilford Press.
2. Carter JC, Fairburn CG. Treating binge eating problems in primary care. Addictive Behavior, 1996; 20(6):765–772.

No. 106
ATTACHMENT DYNAMICS OF EATING DISORDERS

Marc A. Lindberg, Ph.D., *Department of Psychology, Marshall university, 1600 Hal Greer Blvd., Huntington WV 25755;* Stuart W. Thomas, Ph.D., Colleen Opell, M.A.

EDUCATIONAL OBJECTIVE:

To better understand and diagnose specific relationship, family, and related personality characteristics associated with eating disorders.

SUMMARY:

Objective: The attachment relationships and personality characteristics of 23 female eating-disordered therapy patients were compared with 297 controls selected from a larger study who matched on age, socioeconomic status, and sex.

Method: Subjects completed the Attachment and Personality Dynamics Questionnaire, a test with an average alpha of .79 over the 29 different scales measuring secure, avoidant, ambivalent, and codependent attachments to mother, father, and partner and other scales measuring sexual functioning, anxiety, shame, denial, abusiveness, and family-of-origin dynamics.

Results: A stepwise discriminant function analysis found that the family suppression of feelings, shame, sexual intimacy, denial, and abuser scales best distinguished the samples F (5, 283) = 19.67, p<.001. Dominant attachment styles were then computed, revealing a preponderance of avoidant attachments for the eating-disordered subjects. Finally, standard deviations across the scales were higher for the eating-disordered group with a Kruskal-Wallis Test Chi Square approximation = 13.87, p<.01.

Conclusion: The results showed clear differences between the two groups in terms of relationship functioning and related personality measures. The standard deviation data, however, suggest that the researcher and clinician must consider individual differences in any diagnostic evaluation.

Funding source: Marshall University.

REFERENCES:

1. Armstrong JG, Roth DM: Attachment and separation difficulties in eating disorders: a preliminary investigation. Int. J of Eating Disorders 1990; 8:141–145.
2. Fairburn CG, Beglin SJ: Studies of the epidemiology of bulimia nervosa. Am J Psychiatry; 147:401–408.

SCIENTIFIC AND CLINICAL REPORT SESSION 36—MEDICAL STUDENTS AND PSYCHIATRIC EDUCATION

No. 107
EDUCATING MEDICAL STUDENTS ABOUT PHYSICIAN-PATIENT SEX

John H. Coverdale, M.D., *Dept of Psychiatry, Univ of Auckland Med School, Private Bag, Auckland 00224, New Zealand*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the limits of a particular strategy for educating medical students about physician-patient social and sexual contact.

SUMMARY:

Objective: This study assessed the impact of an educational intervention on medical students' attitudes toward social and sexual contact with patients by physicians from three medical specialties (general practice, obstetrics-gynecology, and psychiatry).

Method: Medical students from two consecutive clinical year classes at one medical school participated in one three-hour program that included instruction on the standards of the profession, discussion of case scenarios, and a video reporting first-hand accounts by patients on the harm that had accrued as a consequence of a sexual relationship with their professional. Students were assigned to intervention or control groups and responded to an anonymous questionnaire (response rate 66.8%; n = 141).

Results: As many as 14.5% of control group students thought it was (sometimes or usually) appropriate for general practitioners to date their own patients, and at least 3% thought it appropriate for members of any of these three medical specialties to engage in sexual contact with their own patients. However, there were no significant differences in attitudes toward hugging, dating, or sexual contact with current patients between those who had attended the seminar and the control groups. The program significantly influenced attitudes toward obstetrician-gynecologists and psychiatrists hugging and having sexual contact with former patients (χ^2 = 14.39, d.f. = 2, p<0.001, χ^2 = 13.22, d.f. = 2, p<0.005 respectively).

Conclusions: A need for program expansion is indicated by the failure of this educational intervention to significantly influence attitudes.

REFERENCES:

1. Coverdale J, Bayer T, Chiang E, et al: Medical students' attitudes towards specialist physicians' social and sexual contact with their patients. Academic Psychiatry, 1996; 20:35-42.
2. Coverdale J, Turbott S: Teaching medical students about the appropriateness of social and sexual contact between doctors and their patients: evaluation of a program. Medical Education (in press).

No. 108
INCREASING THE POOL OF AMG PSYCHIATRY APPLICANTS

Walter Weintraub, M.D., *Univ. of MD at Baltimore, Green and Redwood Streets, Baltimore MD 21201;* S. Michael Plaut, Ph.D., Eric Weintraub, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify in the freshman year of medical school the cohort from which future psychiatrists will be recruited.

SUMMARY:

Objective: The authors demonstrate that as early as the freshman year in medical school it is possible to identify the cohort of students from which future psychiatrists will be recruited.

Method: During a three-year period, medical students at the University of Maryland completed a specialty preference form early in their freshman year. A total of 403 students participated.

Results: The higher the ranking of psychiatry in the freshman year, the more likely was the student to choose psychiatry as a career after graduation. This was true both for students pursuing the regular psychiatry curriculum and for those participating in an enriched psychiatric program. Freshman students ranking psychiatry fourth or lower had little chance of choosing psychiatry as a career no matter how much encouragement they received from the department of psychiatry. Participants in the enriched program were significantly more likely to choose careers in psychiatry than those pursuing the regular curriculum.

Conclusions: Specialty preferences in the freshman year are predictive of future career choices. An enriched medical school program in psychiatry can increase the number of graduates choosing careers in psychiatry.

REFERENCES:

1. Nielsen AC: Choosing psychiatry: the importance of psychiatric education in medical school. Am J Psychiatry 1980; 137:428-431.
2. Eagle PF, Marcos LR: Factors in medical students' choice of psychiatry. Am J Psychiatry 1980; 137:423-427.

No. 109
CHANGING MEDICAL STUDENT ATTITUDES ABOUT SPANKING

Amy C. Brodkey, M.D., *Dept. of Psychiatry, Friends Hospital, 4641 Roosevelt Blvd., Philadelphia PA 19124;* Edward Gracely, Ph.D., Beth Rabin, M.A., Irwin Hyman, Ph.D., Mindy Rothbart, M.D.

EDUCATIONAL OBJECTIVE:

To discuss the potential negative outcomes to children and society of the widespread use of corporal punishment, to review the common behavioral problems presenting to physicians and their attitudes towards corporal punishment; and to outline elements of an educational intervention that attempts to alter deeply held beliefs, attitudes, and behaviors in a sensitive manner.

SUMMARY:

Objective: Many experts in interpersonal violence believe in a relationship between "ordinary" forms of physical punishment, such as spanking, and the acceptance of more extreme aggression. Physicians are often asked how to handle common behavioral problems; many endorse spanking as a solution. This study addressed the attitudes of medical students towards corporal punishment and other forms of discipline, their demographic correlates, and their susceptibility to change following an educational intervention.

Method: An instrument to assess knowledge of, attitudes towards, and personal histories of various disciplinary methods was developed and administered to freshman medical students at the Medical College of Pennsylvania and the University of Pennsylvania before and after their behavioral science courses in 1995. A culturally sensitive educational intervention including child development, noncorporal disciplinary methods, and potential negative effects of spanking was given at MCP.

Results: Male gender, non-Asian minority status, and frequency of corporal punishment experienced personally correlated with approval of spanking. Disapproval of spanking and endorsement of noncorporal alternatives increased significantly (both $p<0.001$) following the intervention; no such change occurred in the control group. Minority students' attitudes changed equivalently to other groups.

Conclusions: It may be possible to influence the attitudes and recommendations of future physicians regarding such personal issues as corporal punishment.

REFERENCES:

1. McCormick KF: Attitudes of primary care physicians toward corporal punishment. JAMA. 1992; 267:3161-3165.
2. Straus MA: Beating the Devil Out of Them: Corporal Punishment in American Families. New York, Lexington Books, 1995.

SCIENTIFIC AND CLINICAL REPORT SESSION 37—COMORBID DEPRESSION, PERSONALITY DISORDER, AND SUBSTANCE MISUSE

No. 110
ALCOHOL CONSUMPTION IN MOOD AND ANXIETY DISORDERS

John J. Worthington III, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 815, Boston MA 02114;* Mark H. Pollack, M.D., Maurizio Fava, M.D., Michael W. Otto, Ph.D., Bonnie Zucker, B.S., Jerrold F. Rosenbaum, M.D., Robert Gould, Ph.D.

EDUCATIONAL OBJECTIVE:

To understand the impact of moderate levels of alcohol, nicotine, and caffeine use on response to treatment in mood and anxiety disorders.

SUMMARY:

Background: There has been little attention to the impact of consumption of alcohol, nicotine, and caffeine in moderate amounts on the presentation and response to treatment of mood and anxiety disorder patients.

Objective: We assessed patterns of consumption and response to treatment in patients with either major depressive disorder (MDD), panic disorder (PD), or generalized anxiety disorder (GAD).

Method: Eligible subjects were adult outpatients participating in pharmacologic trials in the Clinical Psychopharmacology Unit of the Massachusetts General Hospital (MGH). Patients received diagnostic assessments using the Structured Clinical Interview for DSM-III-R-Patient Edition. Exclusion criteria included alcohol or other substance use meeting criteria for abuse or dependence within the previous 12 months. A total of 147 patients from the Depression Research Program and 39 patients from the Anxiety Disorders Research Program were enrolled in this study. Patients were assessed with the MGH Drug Consumption Questionnaire, the 21-item Hamilton Rating Scale for Anxiety, the 17-item Hamilton Rating Scale for Depression, and the Clinical Global Impression.

Results: Alcohol use was associated with poorer response to treatment in GAD ($p = .01$) and MDD ($p = .04$) patients. Cigarette smoking was linked to greater severity of illness ($p = .01$) at baseline in GAD patients. Caffeine use was associated with decreased response to treatment ($p = .04$) in PD patients.

Conclusions: Use of even moderate amounts of alcohol, cigarettes, and caffeine are associated with greater severity of illness and/or poor response to treatment in patients with MDD, PD, or GAD. We will present data on the relationship of age of onset of mood and anxiety disorders and substance use to examine whether early onset of affective difficulties confers increased risk of cigarette and/or alcohol use, an issue with important health implications.

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1. Worthington JJ, Fava M, Agustin CM, et al: Consumption of alcohol, nicotine and caffeine among depressed outpatients: relationship with response to treatment. Psychosomatics 1996; 37:518–522.
2. Yergani VK, Pohl R, Balon, et al: Smoking in patients with panic disorder. (letter) Biol Psychiatry 1988; 24:365–366.

No. 111

PERSONALITY AND SUBSTANCE MISUSE IN FAMILIES

Collaborative Presentation with the National Institute on Drug Abuse

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

EDUCATIONAL OBJECTIVE:

To recognize the importance of personality dimensions in predicting substance misuse in adolescents seeking treatment for substance misuse and conduct disorder, and in their parents and controls.

SUMMARY:

Objective: To study whether a relationship exists between personality typology and substance misuse in adolescents, their mothers, their fathers, and controls.

Method: One hundred male adolescents (mean age 15.8 years) entering a residential treatment center for youth with substance misuse, their mothers (N=88; mean age 39.4 years), their fathers (N=36; mean age 44.9 years), and community controls (N=100 adolescents, mean age 16.5 years; N=96 mothers, mean age 43.8 years; N=87 fathers, mean age 45.9 years) were recruited. All completed a personality questionnaire and were interviewed on a number of measures, including structured interviews for psychopathology and substance misuse.

Results: Novelty seeking (NS), one of the personality dimensions, was significantly related to substance misuse in adolescent probands, adolescent controls, and in proband fathers and mothers, but not in control fathers and mothers. NS in probands and controls was not significantly correlated with NS in their mothers or fathers. Regression analyses that included conduct disorder (CD) or antisocial personality disorder (APD) symptoms indicated that NS and CD or APD symptoms made significant independent contributions to substance misuse in probands and in treatment fathers, but not in treatment mothers.

Conclusion: NS is an important contributant to substance misuse in adolescents. NS and antisocial behavior contribute independently to substance misuse in severely disturbed adolescents and their fathers.

This research was supported in part by NIDA Center Grant DA-10540, NIDA Grant DA-06941, and NIDA NRSA DA-05570.

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2. Howard MO, Kivlahan D, Walker RD: Cloninger's tridimensional theory of personality and psychopathology: applications to substance use disorders. Journal of Studies on Alcohol 1997; 58:48–66.

No. 112

A PROSPECTIVE ANALYSIS OF DEPRESSION AND HEAVY DRINKING IN WOMEN

Anita R. Dixit, M.H.S., *Department of Acute Care, CDC/NCICP/DACCRDP, 4770 Buford Hwy N.E. MSF41 Atlanta GA 30341;* Rosa Maria Crum, M.D.,

EDUCATIONAL OBJECTIVE:

To understand the epidemiology of depression and subsequent heavy drinking among women.

SUMMARY:

Objective: To determine whether depression is associated with an increase in the risk of heavy alcohol consumption in women.

Method: The study was based on the one-year follow-up of the Baltimore cohort of the Epidemiologic Catchment Area project, a survey of psychiatric disorders in the general population. After excluding women with a history of alcohol disorders and/or who reported recent heavy alcohol use at baseline, the sample consisted of 1383 women at risk for heavy alcohol use. History of depression and frequency of lifetime-experienced depressive symptoms were assessed at baseline, and incident cases of heavy drinking were identified one year later.

Results: In a logistic regression model, the initial estimate of relative risk for heavy drinking in women associated with a history of depression, relative to no history of depression, was 2.60 (95% CI 1.19–5.68, p=0.02). This estimate did not change markedly after adjustment for significant confounders including age, a history of antisocial personality disorder, and a paternal history of heavy drinking (RR=2.22, 95% CI 1.00–4.92, p=0.05). An increment in the number of lifetime-experienced depressive symptoms was also found to be associated with an elevation in the risk of heavy alcohol use (adjusted estimate: RR=1.09, 95% CI 1.01–1.18, p=0.02).

Conclusion: These results add to other evidence that depression must be considered in assessment of vulnerability for heavy alcohol use in women.

Funding Source: National Institute of Mental Health grant MH47447, National Institute on Alcohol Abuse and Alcoholism award K20-AA000168.

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1. Secretary of Health and Human Services: Eighth Special Report to the U.S. Congress on Alcohol and Health-Chapter 2: Psychiatric comorbidity with alcohol use disorders. 1993; Rockville, MD, U.S. Department of Health and Human Services, 37–59.
2. Kendler KS, Health AC, Neale MC, et al: Alcoholism and major depression in women: a twin study of the causes of comorbidity. Arch Gen Psych 1993; 50:690–698.

SCIENTIFIC AND CLINICAL REPORT SESSION 38—EMERGING TRENDS IN THE MANAGEMENT OF PSYCHIATRIC ILLNESS

No. 113

CURRENT PRESCRIBING PRACTICES FOR BIPOLAR PATIENTS

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

EDUCATIONAL OBJECTIVE:

To gain a better understanding of the naturalistic treatment of bipolar illness by evaluating treatment regimens given to stable bipolar patients in a clinically oriented setting.

SUMMARY:

Objective: Bipolar illness is a chronic condition characterized by recurrent mood swings. For years, the major mainstay of pharmacotherapy for acute and recurrent bipolar disorders is lithium carbonate. Recently, new pharmacotherapeutic treatments have been evaluated and found to be useful for the treatment of recurrent manic and depressive mood swings. It is generally recommended that individuals who are successfully treated for bipolar illness with lithium carbonate or other agents remain on medication for six months to two years following resolution of symptoms. It is the purpose of this paper to assess the treatment regimens of bipolar patients euthymic for at least six consecutive months at three time points: Aug. 1989, Aug. 1994, Aug. 1997 to assess changing treatment patterns in the prophylactic treatment of bipolar illness.

Method: As noted at the three time points, Aug. 1989, Aug. 1994, and Aug. 1997 we evaluated the records of all patients who attended the Foundation for Depression-Manic Depression (an outpatient affective disorder clinic associated with Columbia University) who had been rated euthymic for six consecutive months and determined the prophylactic medication(s) that had kept the patient stable. With respect to the time periods, Aug. 1989, Aug. 1994, and Aug. 1997 there were 246, 197, and 175 such patients, respectively.

Results: Overall the percentage of patients on lithium either alone or as part of combination therapy during this time period decreased from 86% to 74% to 58%, respectively. The percentage of patients on depakote either alone or as part of combination therapy increased from 4% to 24% to 51%, respectively. The percentage of patients on carbamazepine during these three time periods was 10%, 25%, & 26%, respectively, either alone or as part of combination therapy. Overall the percentage of patients on monotherapy alone over this period (Aug. 1989, Aug. 1994, and Aug. 1997) decreased from 56% to 37% to 30%, respectively. Patients who presented over the last years (1995–1997) and who were included in the 1997 analysis tended to receive depakote either alone or in combination at a rate of 72% vs 43% on lithium and 31% on carbamazepine.

Conclusions: Over the last eight years treatment of bipolar disorder has been associated with greater depakote usage and lower lithium usage. Implications of these findings within the long-term context of treatment for bipolar disorder will be discussed.

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2. Sachs GM, et al: Lithium monotherapy: miracle, myth, and misunderstanding. Psychiatric Annals, 1994; 24:299–306.

No. 114
MEDICARE REVIEW ENHANCEMENT OF PSYCHIATRIC CONSULTATION

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EDUCATIONAL OBJECTIVE:

To understand the importance of accurately identifying psychiatric comorbidity in Medicare DRG's in a consultation-liaison program, and to recognize the positive fiscal and clinical impact of collaborating with primary care physicians through structured educational processes.

SUMMARY:

Purpose: To determine the financial impact of appropriately documenting a mental health comorbidity as a secondary diagnosis in the Medicare inpatient population.

Process: Following baseline data retrieval 1/1/94-4/30/94, the medical staff received a structured educational intervention from the Psychiatric Consultation/Liaison Division on the clinical significance of accurately identifying, treating, and/or referring patients for appropriate management of mental health comorbidities; that should ultimately result in shorter LOS, improved discharge planning and aftercare, decrease in unnecessary nursing home placements, and decrease in hospital readmissions and ER visits. Also, the psychiatric consultation/liaison multidisciplinary staff worked on improving their consult documentation. These efforts resulted in facilitating the medical records coder's ability to effectively identify comorbidity complications for the appropriate DRG's.

Results: Between 1/1/96-4/30/96 there were 52 Medicare admissions representing 1.5% of all Medicare admissions where a mental health secondary diagnosis enhanced the Medicare DRG revenue, generating $130,952. Out of this total, there were 36 cases that generated $84,705 through psychiatric consults with appropriate secondary diagnoses. During the same period in 1994, there were only nine cases identified that enhanced the revenue of the Medicare DRG by $21,878. Of that amount $4,919 was attributed to a psych consult.

Conclusion: The consultation-liaison psychiatry service, through direct patient care and educational outreach efforts to physicians and allied staff, can directly enhance hospital revenue in very tangible ways.

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2. Koran LM: Funding consultation-liaison psychiatry via Medicare screening. General Hospital Psychiatry 1992; 14:7–14.

No. 115
USE OF THE NEW ANTIEPILEPTIC DRUG TOPIRAMATE AS A MOOD STABILIZER

David B. Marcotte, M.D., *Marcotte and Associates, 210 Fairway Drive, Fayetteville NC 28305-5512*

EDUCATIONAL OBJECTIVE:

To explain the results of administration of topiramate to treatment-refractory, rapid-cycling patients.

SUMMARY:

Rationale: Because some antiepileptic drugs (AEDs) are effective in bipolar affective disorders, the new AED topiramate (TPM) may be effective in psychiatric illnesses. TPM was evaluated in mood disorders refractory to previous therapies including newer AEDs.

Methods: Charts of 23 consecutive outpatients (eight males, 15 females) were reviewed. TPM 25 mg bid was added to existing therapy and titrated in 50-mg increments every three to seven days. Improvement was rated with a global assessment of sleep, appetite, mood, and concentration.

Results: Of 21 patients with rapid-cycling bipolar disorders characterized by manic, hypomanic, or mixed episodes, 12 were bipolar I, six bipolar II, and three cyclothymic; one patient had general anxiety disorder and one had organic psychosis. Mean duration of TPM treatment was 8.4 weeks; mean TPM dosage, 200 mg/day. 13 of 23 (57%) patients exhibited marked or moderate improvement, usually within days or weeks. Minimal/no improvement was observed in four; six were rated as worse. Most of those rated as worse experienced symptoms known to be TPM side effects, including agitation in one patient with generalized anxiety disorder and confusion and hallucinations when TPM was increased from 200 to 600 mg/day

in one bipolar patient with previous and subsequent episodes of psychotic symptoms when not taking TPM. Other adverse events were somnolence, fatigue, and impaired concentration and memory.

Conclusion: TPM may be useful in patients with mood disorders unresponsive to traditional therapy.

SCIENTIFIC AND CLINICAL REPORT SESSION 39—PSYCHOSOCIAL FACTORS IN VIOLENCE AND RISK FOR SELF-HARM

No. 116
RELIGIOUS DELUSIONS AND SELF-HARM: SUICIDE

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EDUCATIONAL OBJECTIVE:

To recognize the danger of concrete interpretations of biblical passages by actively psychotic patients; the need to understand the danger of patients who harbor religious delusions can be exposed to during significant religious holidays like Easter; and the need to understand the protective function of psychosis for patients who have committed crimes and can experience guilt.

SUMMARY:

This clinical report will describe three forensic cases that focus on the interface between valid delusional thought and the meaning of spiritual or religious problems as defined in the V code of DSM-IV. The first case will describe a patient with schizophrenia who read Christ's instruction to "pluck out thy right eye if it offends thee." He did. The second case describes a patient with schizophrenia who drowned his son. Found not guilty by reason of insanity, he remained depressed for several months, but the following Easter, he returned to "church" for the first time by attending Holy Thursday services. This was interpreted as a sign of improvement. He hung himself on Good Friday.

The third case describes a male patient with bipolar disorder who killed a woman while in a manic state. For several weeks during the treat-to-competency period he remained overcontrolled and delusional until medication brought him back to reality. Then he acknowledged his crime and as a regular "churchgoer" expressed remorse. His apparent clinical improvement resulted in a transfer to a less secure unit. He hung himself the Friday before he went to trial.

Identifying religious delusional themes may be an important factor in preventing psychotic patients who suffer from disordered thinking, like concrete thinking and literal interpretation, from suicide. Whether these cases fit the DSM-IV V Code will also be discussed.

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1. Oates WE: The Religious Care of the Psychiatric Patient. The Westminster Press, Philadelphia, 1978.
2. APA: DSM-IV; Washington, D.C. 1994.

No. 117
VIOLENCE IN THE LIVES OF ADULT BORDERLINE PATIENTS

Mary C. Zanarini, Ed.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont MA 02178;* Frances R. Frankenburg, M.D., D. Bradford Reich, M.D., Margaret F. Marino, Ph.D., Michelle C. Haynes, A.B.

EDUCATIONAL OBJECTIVE:

To recognize that borderline patients of both genders are at substantial risk for being physically and/or sexually assaulted as adults, and that a substance use disorder with a juvenile onset is as important a risk factor for these assaults as childhood experiences of emotional neglect and sexual abuse.

SUMMARY:

Objective: The purpose of this study was to assess the experiences of adult violence reported by a sample of criteria-defined borderline patients and Axis II controls.

Method: The experiences of adult physical and/or sexual assault reported by 290 borderline patients and 72 Axis II controls were assessed blind to diagnostic status using a semistructured research interview.

Results: Borderline patients were significantly more likely than Axis II controls to report having been an adult victim of violence, having had a physically abusive partner, having been raped, having been raped multiple times, having been raped by a known perpetrator, and having both been physically assaulted by a partner and raped. Female borderline patients were significantly more likely than male borderline patients to have been physically and/or sexually assaulted as adults (50% vs. 26%). However, both of these rates were significantly higher than those reported by controls of the same gender. Four risk factors were found to significantly predict whether borderline patients had an adult history of being a victim of violence: female gender, a substance use disorder that began before the age of 18, childhood sexual abuse, and emotional withdrawal by a caretaker.

Conclusions: The results of this study suggest that both male and female borderline patients are at substantial risk for being physically assaulted by a partner and/or raped as adults. They also suggest that a substance use disorder with a juvenile onset is as important a risk factor for adult experiences of violence as a chaotic childhood environment marred by both emotional neglect and sexual abuse.

Supported in part by NIMH grant MH47588.

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1. Jacobson A: Physical and sexual assault histories among psychiatric outpatients. Am J Psychiatry 1989; 146:755-758.
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No. 118
SPOUSAL HOMICIDE AND EXTENDED SUICIDE IN QUEBEC

Dominique Bourget, M.D., *Royal Ottawa Hospital, 1145 Carling, Ottawa, ONT K1Z 7K4, Canada;* Pierre W. Gagne, M.D., Javad Moamai, M.D.

EDUCATIONAL OBJECTIVE:

To gain further knowledge in family domestic violence and related phenomena, particularly spousal homicide and major differences between homicide and extended homicide-suicide events.

SUMMARY:

Objective: Domestic violence is cause for major concern and yet little is known in relation to the amplitude and dynamics of spousal homicide and extended suicide. This descriptive study reports the clinical and demographic features of the victims of such dramas in the province of Quebec.

Method: Within the jurisdiction of the Quebec provincial coroner's office, the investigational files on all consecutive cases of deaths secondary to domestic or intrafamilial violence occurring between 1991-1996 were reviewed. Using a validated checklist, a variety of

variables were systematically collected and reviewed for descriptive analysis.

Results: 276 cases of violent deaths were studied. Out of this sample, 110 (39.8%) concerned victims of conjugal homicide. Thirty-two (29.1%) of these were victims whose homicidal spouses subsequently killed themselves. Significant clinical differences between victims of suicidal offenders and nonsuicidal offenders were identified in relation to the gender, killing method, and motives. Suicidal offenders were predominantly males who used a firearm, whereas one-quarter of nonsuicidal offenders were females. The weapon was most often a knife.

Conclusion: Based on these findings and comparisons with selected studies addressing the issue of violent spouses, the authors will discuss psychiatric dynamics underlying the outcome of spousal violence.

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1. Wilson M, Daly M: Spousal homicide risk and estrangement. Violence and Victims 1993; 8:3-16.
2. Goodman LA, et al: Male violence against women: current research and future directions. American Psychologist, 1993; 48:1054-1057.

SCIENTIFIC AND CLINICAL REPORT SESSION 40—SEEING CLEARLY IN PSYCHIATRIC RESEARCH

No. 119
BRIGHT LIGHT THERAPY FOR BULIMIA NERVOSA

Devra L. Braun, M.D., *Department of Psychiatry, NY Hospital/ Cornell, 21 Bloomingdale Road, White Plains NY 10605-1504;* Suzanne R. Sunday, Ph.D., Victor M. Fornari, M.D., Katherine A. Halmi, M.D.

EDUCATIONAL OBJECTIVE:

To understand the evidence for a relationship between seasonality, light exposure, and bulimic symptoms; to understand the evidence for a potential role for bright light therapy in reducing binge eating in bulimic women.

SUMMARY:

Objective: To determine the effect of winter bright light therapy on binge and purge frequencies and depressive symptoms in subjects with bulimia nervosa.

Method: Forty female bulimic outpatients were treated with either 10,000 lux of bright white light or 50 lux of dim red light (the placebo control) during winter months. In this double-blind study, the placebo group (n=22) and the bright light group (n=18) were matched in age, degree of seasonality (measured by SPAQ), and concurrent depression (measured by SCID interviews). Three weeks of baseline data collection were followed by three weeks of half-hour daily morning light treatment and two weeks of follow-up.

Results: The overall effect of bright light treatment approached significance (F(1,34=2.778, p=.105). Mean binge frequencies decreased significantly more from baseline to the end of treatment for the bright light group (F(1,34)=4.69, p=.038). Level of depression (measured by daily BDIs) did not significantly differ between the groups during any phase; and neither depression nor seasonality affected response to light treatment. Purging frequency did not differ at any point between the groups.

Conclusion: In this double-blind study, bulimic women who received three weeks of winter bright light treatment reported reduced binge frequencies during the active treatment period in comparison to subjects receiving dim red light.

(Funding Sources: NIMH Grant RO3-MH52765-02 and DeWitt Wallace NY Community Trust)

REFERENCES:

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2. Fornari VM, Braun DL, Sunday SR, et al: Seasonal patterns in eating disorder subgroups. Comprehensive Psychiatry 1994;35(6):450–455.

No. 120
THE VALIDITY OF AUTOBIOGRAPHICAL MEMORY

Daniel Offer, M.D., *Dept of Psych Behav Sci, Northwestern Univ Med School, 303 E Superior St, Chicago IL 60611-3015;* Marjorie Kaiz, B.S., Kenneth I. Howard, Ph.D., Emily S. Bennett, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the strengths and limitations of the use of people's autobiographical accounts.

SUMMARY:

Objective: To provide new evidence from a longitudinal study of autobiographical memory and to discuss the implications for the development and implementation of appropriate treatment plans and goals.

Method: Seventy-three 14-year-old males were studied in 1962. Sixty-seven of these were reinterviewed at age 48. Twenty-nine questions about events and relationships that occurred during adolescence were asked in both interviews.

Results: Significant differences were found between adult memories of adolescence and what was actually reported during adolescence. For example, at age 14, 81% reported that they had been subjected to physical punishment as a form of discipline. At age 48, only 33% reported that they had been subjected to physical punishment when they were adolescents. Even more striking, 65% of those who reported being physically punished in adolescence did not remember this as adults.

Conclusion: Childhood memories are important to the understanding of a patient's current adaptation. However, the accuracy of these memories is questionable. Establishing the truth of an autobiographical memory would require evidence from other sources.

Support for this research was provided, in part, by a grant from Thomas F. Pick.

REFERENCES:

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2. Thompson CP, Skowronski JJ, Larsen SF, Betz AL: Autobiographical Memory: Remembering What and Remembering When. 1996; Mahwah, New Jersey: Lawrence Erlbaum Associates.

No. 121
HOW BLIND IS DOUBLE-BLIND?

Michael Sobel, M.D., *Department of Psychiatry, NYU School of Medicine, 251 East 32nd Street Apt. 8D, New York NY 10016;* Eric D. Peselow, M.D., Ronald R. Fieve, M.D.

EDUCATIONAL OBJECTIVE:

To understand factors that are necessary to keep the integrity of the double-blind, placebo-controlled study and to understand factors involved in biasing the results.

SUMMARY:

Objective: In order to prove that a drug or any new treatment is efficacious, it must be shown that the treatment in question is equal to standard and that both are better than placebo. This must be done under double-blind conditions to ensure the integrity of the study and to avoid bias. It is the objective of this paper to evaluate how well under protocol conditions the double-blind conditions are maintained.

Method: This study involved 122 patients who participated in a double-blind trial evaluating the efficacy of paroxetine vs. imipramine vs. placebo in the treatment of acute depression. At the end of the study (3–6 weeks) both the patient and the clinician were asked to guess which treatment the patient was on. The patient was asked to guess whether the treatment condition was drug or placebo and the clinician was asked to guess which drug (imipramine or paroxetine) or placebo. Overall 105 of the 122 patients were involved in the trial.

Results: Overall, for 76/105 (72%) cases, clinicians guessed correctly on the exact treatment condition (imipramine, paroxetine, or placebo). For 79/105 (75%) cases, the patients guessed right on whether they were on drug or placebo. Interestingly 52 patients were considered responders to one of the three conditions and 53 nonresponders. Clinicians and patients tended to guess that 81% of the responders were on drug and 73% of the nonresponders were on placebo. A high number of side effects tended to elicit more of a guess for drug (in the clinician's case a greater number of side effects elicited a guess of imipramine) and a low number of side effects correlated with a guess of placebo for both patient and clinician.

Conclusion: Overall, clinicians, and patients were able to guess their correct treatment 75% of the time. This corresponds to the studies in the existing literature. The results seem to suggest that the double-blind may not have been well-maintained indicating a potential bias for the study results.

Funding: Though Smith-Kline-Beecham funded the efficacy study (paroxetine vs. imipramine vs. placebo) there was no funding for the evaluation of integrity of the double-blind.

REFERENCES:

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2. Model W, Houde R: Factors influencing clinical evaluation of drugs. JAMA, 1958;167:2190–2199.

SYMPOSIUM 1—EVALUATING GROUP INTERVENTIONS FOR CANCER PATIENTS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) describe psychosocial group interventions for cancer patients, and (2) identify appropriate evidence for evaluating the benefits of group interventions for cancer patients.

No. 1A
STRUCTURED PSYCHIATRIC INTERVENTION FOR MELANOMA PATIENTS

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SUMMARY:

Early research in psycho-oncology consisted of *descriptive* studies that identified the psychiatric and psychosocial variables associated with cancer diagnosis and treatment. Subsequent research has focused on developing psychosocial *interventions* which might improve psychological and physiological outcome for cancer patients. Studies of *short-term* outcome (2–10 months) and *long-term* outcome (1–10 years) following a psychosocial intervention reveal that patients receiving such an intervention demonstrate lower levels of emotional distress, improved problem resolution and coping methods, improved compliance, increased immune system response, and lower rates of recurrence and mortality as compared with controls. A structured psychoeducational intervention model incorporates health education, stress management, problem solving and coping skills training, and psychological group support. The goal of *health education* is to increase knowledge and replace patients' feelings of helplessness with a sense of mastery and control. The goal of *stress management* is to teach skills that will help patients reduce stress, cope effectively, and promote compliant behavior. The goal of *problem solving and coping skills* training is to teach patients effective coping strategies that will enhance adjustment and allow patients to reclaim their personal control. *Psychological group support* reinforces each of these goals by encouraging patients to share information with each other and to support one another emotionally.

No. 1B
THE BREAST EXPRESSIVE-SUPPORTIVE THERAPY (BEST) STUDY: RANDOMIZED CONTROLLED TRIAL OF GROUP SUPPORT IN METASTATIC BREAST CANCER

Pamela J. Goodwin, M.D., *Department of Medicine, Mount Sinai Hospital, 1284-600 University Avenue, Toronto, ONT M5G 1X5, Canada;* Molyn Leszcz, M.D., Jan Koopmans, M.S.W., Harvey M. Chochinov, M.D., Margaret Navarro, M.D., Richard Doll, M.S.W., Julia A. Masterson, M.D., Narilyn Hundleby, Ph.D.

SUMMARY:

The BEST (Breast Expressive-Supportive Therapy) Study is a multicenter randomized trial designed to replicate an unexpected observation by Spiegel et al (Lancet 1989) that a specific form of group support prolongs survival in women with metastatic breast cancer. A total of 256 women receiving standard medical therapy for metastatic breast cancer are randomized 2:1 to participate in a weekly, therapist-led support group supplemented by educational materials, or to receive educational materials alone. The group intervention follows a manual developed by Spiegel et al (1990); compliance is monitored through central review of randomly selected videotapes (one per month). Women remain in the group for at least one year. They complete a battery of psychosocial questionnaires at study entry and every four months thereafter. The primary study outcome is survival; adjustment is made for important biological and treatment related variables. Secondary outcomes include psychosocial variables, quality of life, and health care costs. Recruitment will be completed in late 1997, with statistical analysis of survival effects in late 1998 or early 1999.

Detailed information will be presented on recruitment (the group nature of the intervention had a net effect on sample size of 50%), baseline psychological and medical variables, as well as overall survival.

No. 1C
GROUP THERAPY AND SURVIVAL IN BREAST CANCER

Michael E. Stefanek, Ph.D., *Department of Psychiatry, University of Maryland, 701 West Pratt Street #330, Baltimore MD 21093;* Andrea Barsevick, D.N.Sc., David Cella,, Ph.D.

SUMMARY:

This paper describes a prospective clinical trial funded by the American Cancer Society comparing two types of group interventions on survival and other outcome measures among women diagnosed with metastatic breast cancer. One hundred and twelve (n=112) women were randomly assigned to attend either a coping skills/support group intervention weekly for 16 weeks or a two-session educational intervention. Sites included Johns Hopkins Oncology Center and community hospitals in the Baltimore area, Fox Chase Cancer Center, and Rush Presbyterian-St. Lukes Medical Center. Interventions included standardized manuals for both groups, and trained group facilitators. In addition to following women for survival following intervention, we also assessed quality of life, social support, psychological distress, coping strategies, personality measures, and other psychosocial variables to detect overall benefit of the groups and to assess differences on these variables between groups. In addition to these psychosocial variables, we recorded treatment and disease variables and comorbidity throughout the intervention extending to one year post-intervention. In addition, women who refused participation were followed, with their permission, for survival purposes only (n=90). We have just completed the final one-year follow-up mailing and will continue survival follow-up only. We will present data on quality of life and other psychological variables.

No. 1D
MULTICENTER TRIAL: GROUP THERAPY FOR BREAST CANCER

David Spiegel, M.D., *Department of Psychiatry, Stanford Medical School, 401 Quarry Road, Room 2325, Stanford CA 94305-5544;* Gary R. Morrow, A., Catherine Classen, Ph.D., R. Raubertas

SUMMARY:

A multicenter trial of group therapy for women with primary breast cancer was conducted at 11 sites through the NCI's Community Clinical Oncology Program. Patients with Stage I and II breast cancer were recruited through these sites for participation in 12 weekly supportive/expressive group therapy sessions conducted by psychologists, nurses, and oncology social workers. These therapists were trained using a treatment manual, videotapes, and participation in a two-day workshop. The treatment involves intensifying bonds of support among the group members, identifying affect-laden themes, and encouraging expression of illness-related emotion along

with problem restructuring and guidance in managing relationships with family, friends, and health care personnel. In the pilot phase of the project, 111 women were recruited for a non-randomized protocol with baseline, and three-, and six-month assessments. The primary dependent variable was the total mood disturbance score on the Profile of Mood States. There was a significant decrease in total mood disturbance over time (repeated measures ANOVA $F(1, 174) = 3.97$, $p < .02$. Mean POMS scores declined from 24.8 (SD 31.7) at baseline to 15.9 (SD 33.6) at six months. The effect was relatively consistent across sites, although there were some differences, largely driven by a few outlying subjects with high mood disturbance. There was a decline in scores on the Hospital Anxiety and Depression Scale and the Impact of Event Scale as well. Data from the randomized phase of the trial involving comparison of 240 women offered this group therapy in comparison with 240 given routine care on measures of mood disturbance and self-efficacy will also be presented. These studies provide evidence that structured expression of emotion leads to a reduction in disease-related emotional distress.

No. 1E
AUSTRALIAN RANDOMIZED CONTROLLED TRIAL OF COGNITIVE-EXISTENTIAL GROUP THERAPY FOR WOMEN WITH EARLY-STAGE BREAST CANCER

David W. Kissane, M.D., *University of Melbourne, 104 Studley Park Road, New Victoria 3126, Australia;* David Clarke, Ph.D., Sydney Bloch, M.D., Patricia Miach, Ph.D., Jillian F. Ikin, B.A., Graeme Smith, M.D., Dean McKenzie, B.A.

SUMMARY:

A randomized controlled trial of cognitive-existential group therapy has been conducted with 303 women with early stage breast cancer. Sociodemographics include a mean age of 46 (SD 8) years, 76% married, 73% Australian born, and 49% employed. Mastectomy occurred for 46%, radiotherapy for 57%, chemotherapy for 95%, and hormone therapy for 47%. Using a structured psychiatric interview to generate DSM-IV psychiatric diagnoses, 9.3% had major depressive disorder, 28.7% adjustment disorder, 2.3% dysthymic disorder, 1.7% generalized anxiety disorder, 4.7% post-traumatic stress disorder, and 8.2% panic and phobic states. Family dysfunction was in evidence for 24.5% (FAD); sexual functioning was impaired in over 80%. On the EORTC BR23, 29% felt substantially less attractive, 15% less feminine, 13% couldn't look at their body naked, and 18% were dissatisfied with their body. Quality of life is being monitored longitudinally across four time points. The final therapy group concluded in September 1997. Preliminary time 2 (post-therapy) results will be available by May 1998.

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6. Kissane DW, Bloch S, Miach P, Smith GC, et al: Cognitive-existential group therapy for patients with primary breast cancer-techniques and themes. Psycho-Oncology, 6:25–33, 1992.

SYMPOSIUM 2—IS THERE AN OBSESSIVE-COMPULSIVE SUBTYPE OF SCHIZOPHRENIA?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The goal of the symposium is to increase awareness of the association between OC symptoms and schizophrenia and to improve the recognition and treatment of patients with such symptoms in the clinical practice.

No. 2A
PREVALENCE AND PROGNOSIS OF OBSESSIVE-COMPULSIVE SYMPTOMS IN SCHIZOPHRENIA

Paul C. Bermanzohn, M.D., *Department of Psychiatry, Hillside Hospital, 87-80 Merrick Boulevard, Jamaica NY 11432;* Linda Porto, M.S.N., Samuel G. Siris, M.D.

SUMMARY:

Background: Recently, OC symptoms in schizophrenia have become a focus of research attention. OC symptoms have been found in several studies to predict a poor outcome, and to be, at least in some cases, responsive to anti-obsessional therapies. Prevalence rates of OC symptoms in schizophrenia have reportedly varied from 7.8% to 59.2%.

Method: A total of 100 patients with chronic schizophrenia were assessed using the SCID for DSM-IV. Exclusion rules interfering with the diagnosis of associated syndromes, including OCD, in the presence of scz were bypassed. Treating clinicians were consulted in all cases.

Results: Results from the first 37 patients studied indicate that 15 patients (40.5%) had clinically significant OC symptoms. Eleven (29.7%) met full criteria for OCD, but two patients (5.4%) failed to meet OCD criteria because they were obsessed exclusively with a psychotic content. Several of these patients responded well to openly administered anti-obsessional pharmacological treatments. We will present results from the entire cohort of 100 patients.

Conclusions: The wide variability of prevalence estimates has to do with differences in definitions of the disorders, in study design, and interpretation. Studies are often difficult to interpret because OC symptoms may become intertwined with psychotic symptoms in complex ways. OC symptoms, even without schizophrenia, may become psychotic when patients lose insight into their excessive or irrational character; conversely, schizophrenia patients may become obsessed with psychotic themes. Such confounds may affect estimates of prevalence. These and other differences in study design and interpretation will be discussed and their relevance for proposing an OC subtype of schizophrenia and, more generally, for a clinical subtyping system of schizophrenia will be addressed.

No. 2B
RELATIONSHIP BETWEEN OBSESSIONS AND DELUSIONS: INSIGHT IN OCD

Jane L. Eisen, M.D., *Butler Hospital, Brown University, 345 Blackstone Boulevard, Providence RI 02906*

SUMMARY:

An awareness of the senselessness or unreasonableness of obsessions (often referred to as "insight") and the accompanying struggle against obsessions (referred to as "resistance") have been generally accepted as fundamental to the diagnosis of obsessive-compulsive disorder (OCD). However, there has been increasing interest in several facets of the relationship between OCD and psychotic symptoms—the co-occurrence of OCD symptoms and schizophrenia, the relationship between obsessions and delusions, and the role of insight in OCD.

Several studies, which have systematically assessed the range of insight in OCD, support the notion that OCD patients do not always maintain good insight but rather have varying degrees of insight. To reflect these findings, DSM-IV established a new OCD specifier: "with poor insight." DSM-IV also acknowledges that the beliefs that underlie OCD obsessions can be delusional and notes that in such cases, an additional diagnosis of delusional disorder or psychotic disorder NOS may be appropriate. Whether insight is a predictor of prognosis and treatment response in OCD is an intriguing question with significant clinical importance. Data will be presented on the frequency of OCD with poor insight or no insight (delusional OCD) and the relationship between insight and pharmacologic response.

No. 2C
COGNITIVE FUNCTION IN PATIENTS WITH OBSESSIVE-COMPULSIVE SYMPTOMS AND SCHIZOPHRENIA

Ileana Berman, M.D., *Department of Psychiatry, Taunton State Hosp/Harvard Med, 60 Hodges Avenue, Taunton MA 02780;* Demetra Pappas, B.S., Alan I. Green, M.D.

SUMMARY:

Using neurocognitive testing, the present study assessed whether obsessions and compulsions could represent a distinct cluster of symptoms in schizophrenia. We formulated our hypothesis based on data from non-schizophrenic patients, expecting to find that schizophrenic patients with obsessive-compulsive (OC) symptoms would experience more difficulties in the same cognitive areas as non-schizophrenic patients with obsessive-compulsive disorder (OCD). Patients had separate psychiatric and cognitive evaluations. The OC and non-OC schizophrenic subjects did not differ significantly on the positive and negative symptom scores. However, compared with non-OC schizophrenic patients, those with OC symptoms performed worse on cognitive areas thought to be impaired in OCD (i.e., visual-spatial skills, delayed nonverbal memory, and cognitive shifting abilities). In addition, the severity of OC scores correlated with poor performance in these areas of cognition. Our results support our hypothesis, specifically that OC symptoms may constitute a distinct cluster separate from psychosis in schizophrenia and raise the possibility of a distinct subtype of schizophrenia altogether. The theoretical and clinical implications of these findings are discussed.

No. 2D
TREATMENT OF OBSESSIVE-COMPULSIVE SYMPTOMS IN SCHIZOPHRENIA

Joseph Zohar, M.D., *Department of Psychiatry, Chaim Sheba Medical Center, Tel Hashomer 52621, Israel;* Yehuda Sasson, M.D.

SUMMARY:

Recent knowledge about the diagnosis and treatment of obsessive-compulsive (OC) symptoms coupled with the development of new atypical neuroleptics may suggest new avenues for treatment of OC symptoms in schizophrenia. As many as 15% of chronic schizophrenic patients also suffer from obsessive-compulsive disorder (OCD). As the presence of OCD in schizophrenia was found to predict a poor prognosis, a special emphasis on the treatment of these patients is called for. We will present an open study (ABA design) in which the anti-obsessive medication clomipramine (CMI) was added to ongoing antipsychotic medications in a subgroup of schizophrenic patients with OCD. Eighteen patients completed this open study. Twelve showed a marked decrease in OC symptoms; in nine, it was also associated with improvement in their psychosis (as expressed by decrease in their BPRS). In all patients for whom reinstitution of CMI treatment was possible, improvement in OC symptoms was observed once again. Preliminary data regarding the role of atypical neuroleptics such as clozapine and olanzepine in the treatment of this subset of patients also will be presented.

No. 2E
OBSESSIVE-COMPULSIVE SYMPTOMS IN RELATIVES OF SCHIZOPHRENIA PATIENTS

Alan I. Green, M.D., *Department of Psychiatry, Harvard Medical School, 74 Fenwood Road, Boston MA 02115-6106;* Stephen V. Faraone, Ph.D., Hang Lee, Ph.D., C. Robert Cloninger, M.D., Charles A. Kaufmann, M.D., Ming T. Tsuang, M.D.

SUMMARY:

Obsessive-compulsive (OC) symptoms have been reported in a substantial subgroup of patients with schizophrenia. Those with such OC symptoms appear to have a poorer outcome than those without OC symptoms, and are improved by the addition of "anti-obsessional" pharmacotherapy to their neuroleptic regimen. One recent study has further suggested that patients with OC symptoms are characterized by neuropsychological deficits that are a hybrid between those with schizophrenia (and no OC symptoms) and patients with clearly diagnosed obsessive-compulsive disorder. The meaning of OC symptoms in patients with schizophrenia is unclear. We have launched an investigation to assess whether subjects with OC symptoms and schizophrenia are more likely to have relatives with OC symptomatology than are schizophrenic patients without such OC symptoms. Our assessment of OC symptomatology has involved schizophrenic families from the NIMH Genetics Initiative, a multicenter study of families with more than one schizophrenic proband. Probands and relatives were assessed within the study utilizing the Diagnostic Instrument for Genetic Studies (DIGS). We have analyzed the database from this Genetics Initiative to assess the families of 54 probands who have OC symptoms and 144 probands who do not have such symptoms. Concordance of OC symptoms of sib-pairs within the sample was assessed. The results of the analyses of these data will be presented, and the implications for the understanding of the overall meaning of the OC symptoms in patients with schizophrenia will be discussed.

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schizophrenic patients with clomipramine. J Clin Psychopharmacol 15:206–210, 1995.

SYMPOSIUM 3—VIOLENCE AND ABUSE: FULL CIRCLE
APA Auxiliary

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To educate and help psychiatrists and other health workers recognize violence and it's impact on society.

No. 3A
VIOLENCE IN THE WORKPLACE

Harold I. Eist, M.D., *5705 Rossmore Drive, Bethesda MD 20814-2227*

SUMMARY:

Psychiatry, the quintessential biopsychosocial medical specialty, is resolute in our opposition to violence and we have the wide breadth essential to make major contributions to the understanding of and finding approaches to modify violence. Workplace violence is a serious public health problem. Violence begins in our families and communities. Violence suffered in childhood—psychological, physical, and/or sexual—has long-term consequences. Violence is often predictable and preventable. Four basic risk categories for violence are defined. Work place assaults result in homocides, lost work days, and negative impacts on coworkers who witness assaults.

The public perception that those with mental disorders are violent is an important aspect of stigma against the mentally ill. The stigma condoned by our current laws, and discrimination in health insurance and the legal system, are also forms of workplace violence.

No. 3B
MISSION-DRIVEN FAMILIES: PRIMARY PREVENTION OF FAMILY VIOLENCE

Carl C. Bell, M.D., *Community Mental Hlth Council, 8704 South Constance, Chicago IL 60617-2746*

SUMMARY:

This presentation will emphasize the importance of institutionalizing the family's mission as a method of violence prevention. The importance of removing impediments that prevent a family from institutionalizing it's mission will also be highlighted.

Sooner or later all persons involved in intimate relationships have to deal with conflicts or aggresion. Being mission driven counteracts the potentially destructive outcome of conflict or aggression. Commitment to being a mission driven family means that the family mission supersedes the need to be dominant and the need to respond to injury with violence. It is nearly impossible to achieve family goals and objectives without a clear mission. Accordingly, a great deal of family violence prevention depends on the front end of work at defining personal missions with each individual family member, establishing common family goals that will lead to synergy. Risk and protective factors for violence in families will be outlined. Finally impediments to becoming a mission driven family will be discussed.

No. 3C
VIOLENCE AND ABUSE: FULL CIRCLE

David C. Wright, M.D., *Department of Psychiatry, Homewood Center, 150 Delhi Street, Guelph, ONT N1E 6K9, Canada*

SUMMARY:

The treatment issues of adults who were abused as children will be discussed. The experiences of Canada's only inpatient unit treating survivors of trauma will be shared and outcome results presented. How the adult abused person often oscillates among the roles of victim, rescuer, and abuser suggests that treating the adult survivor may lead to prevention of future child abuse.

No. 3D
STARTING THE CYCLE OF VIOLENCE: THE EFFECTS OF TRAUMA IN CHILDHOOD

Sandra L. Bloom, M.D., *1110 North West End Blvd., Quakertown PA 18951-4122*

SUMMARY:

According to the Third National Incidence Study of Child Maltreatment, serious injuries to children from all forms of maltreatment quadrupled between 1986 and 1993. We are beginning to accumulate a large body of data showing that victims of child abuse are at significant risk for psychiatric, medical, and legal complications of the abuse later in life. There is also a predictable stability of aggressive behavior patterns throughout the life course as documented in longitudinal research. We now know that the outcome of any traumatic experience is a result of complex interaction between the trauma itself, the body and brain of the child, the way the child makes meaning of the event, and the immediate and prolonged response of the child's support network. Understanding the complex nature of traumatic experience helps us to understand why some children seem to fare well after an apparently damaging event while other children develop serious symptoms after an experience that may be viewed by many as relatively mild or a "normal" life stress. This part of the symposium will focus on presenting a biopsychosocial model of how overwhelming exposure to stress impacts on every aspect of the child's life, including brain development and the capacity to form healthy attachments throughout life. The maltreatment and neglect of children initiates a cycle of violence that can remain unabated through cross-generational patterns of attachment and child rearing.

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SYMPOSIUM 4—TRAINING AT THE INTERFACE OF PSYCHIATRY AND PRIMARY CARE
Joint Session With the Association for Academic Psychiatry

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will understand the practical and conceptual issues regarding training of psychiatrists to work in primary care settings, training psychiatrists as primary care providers, and training primary care physicians in psychiatric assessment and treatment.

No. 4A
TRAINING PSYCHIATRISTS TO PROVIDE PRIMARY CARE

Edward K. Silberman, M.D., *Department of Psychiatry, Thomas Jefferson University, 1025 Walnut Street, Rm 327G, Philadelphia PA 19107*

SUMMARY:

Medical illness in psychiatric patients often goes undetected, especially in populations with serious or chronic psychiatric disorders. Furthermore, having a primary care physician does not necessarily improve the detection and treatment of medical illness in such populations. These findings suggest that an adequately trained psychiatrist may be in the best position to deliver primary medical care to seriously and chronically mentally ill patients.

This presentation reviews issues in training psychiatrists to provide primary care. Among the questions discussed will be:

(1) Is it practical or beneficial to expand the scope of psychiatric practice to include primary care?

(2) For which patients would this be appropriate?

(3) Can psychiatrists be adequately trained for such a role within four years of residency?

(4) What models of training are now in place, and how are they working?

(5) What are the current career opportunities for psychiatrists as primary care providers?

(6) How are psychiatrists now providing primary care?

In discussing these questions, we will review current survey data, the experience of programs developing training programs in primary care for psychiatrists, and the experience of the VA Prime program.

No. 4B
TEACHING PSYCHIATRY RESIDENTS IN PRIMARY CARE SETTINGS

Stephen J. Weiler, M.D., *Department of Psychiatry, B6/210 Clinical Science Center, 600 Highland Avenue, Madison WI 53792-0001*

SUMMARY:

This presentation will summarize the results of an AAP task force project on psychiatry and primary care. The project comprised two parts: a literature review, and a telephone survey. We reviewed articles dealing with medical education in ambulatory primary care settings. We also identified and interviewed a "focus group" consisting of psychiatric educators who are developing clinical teaching programs for psychiatric residents in such settings.

We will summarize salient training issues as they are reflected in the current literature. These include general issues of training in ambulatory care settings as well as issues specific to psychiatry, including educational planning, financial support, interdepartmental collaboration, and research potential.

We will also summarize results of the focus group discussions, in which we asked the following questions:

(1) What are the current models of psychiatric practice and teaching in ambulatory primary care settings?

(2) What are the current experiences of psychiatrists working and training residents in such settings, in terms of role definition, role conflict, and acceptance by primary care physicians?

(3) What educational and clinical outcomes should we be measuring to gauge success of the new and evolving models of training and practice?

No. 4C
TEACHING PSYCHIATRY TO FAMILY PHYSICIANS

Elizabeth H. Rand, M.D., *Department of Psychiatry, University of Alabama, P.O. Box 870326, Tuscaloosa AL 35487*

SUMMARY:

This presentation will address principles of curriculum development and models for training family physicians in the area of human behavior and psychiatry.

Curriculum development should occur with equal input from psychiatry and family medicine. A review of the literature indicates that psychiatrists and family physicians would not independently create the same curriculum and thus they should both be at the table to hear each other's views, with committee members carefully selected to include both "friendly" and "not so friendly" members, and chief residents from both disciplines. At a minimum family practice special essentials for human behavior and psychiatry should be met.

The curriculum should cover all three years of the residency. Badger and Rand showed that in a program that had only a PGY-1 two-month Block Rotation, a PGY-3 Difficult Patient Case Conference series, residents' recognition and management of mental disorders deteriorated systematically over the three residency years. (An example of a three-year curriculum will be described.)

It is valuable to utilize a variety of training sites and personnel because each offers different opportunities for learning. In building a comprehensive curriculum, the strengths and weaknesses of each potential educational setting should be assessed as to precisely which educational goal(s) it can meet, so that a composite of experiences is developed covering all goals. (See reference above.) (Examples will be given.)

There must be an evaluation component demonstrating whether resident attitudes, skills, and/or knowledge have improved or exceeded a certain threshold. A two-year evaluation process will be described, which allows for assessment at the end of PGY-2 and assignment of additional training as needed in the PGY-3 year. The purpose of evaluation is to assess both the resident and the curriculum and its faculty, so that either party can undertake remedial work as needed.

No. 4D
TRAINING PSYCHIATRISTS IN FAMILY-CENTERED CARE

James L. Griffith, M.D., *Department of Psychiatry, George Wash Univ Med Center, 2150 Pennsylvania Avenue, NW, Washington DC 20037*

SUMMARY:

Systemic family therapy provides a training model for psychiatrists in primary care settings that holds advantages over approaches that treat patients only as individuals. Family therapists have elaborated methods for framing clinical problems, interviewing family members, and intervening therapeutically that fit well into the primary care mission to provide care in the contexts of family, culture, and community. For psychiatrists, such training emphasizes skills needed for family-centered care of patients referred for psychiatric and medical disorders, the integration of psychopharmacology with family therapy, and collaborative relationships with both patients' families and nonpsychiatric clinicians. This presentation provides recommendations for how psychiatry residents can be trained to practice in primary care settings utilizing a family therapy model. These recommendations are drawn from the curricula of psychiatry residencies that have successfully organized residency training around a family model and from two recent studies of the relevance of psychiatric residency training to the realities that psychiatrists face in entering clinical practices.

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3. Rand EH, Thompson TL II: Using successful models of care to guide the teaching of psychiatry in primary care. Psychosomatics March-April Vol. 38, No. 2, 1997.
4. Slovik LS, Griffith JL, Forsythe L, Polles A: Redefining the role of family therapy in psychiatric residency training. Academic Psychiatry 21:35–41, 1997.

SYMPOSIUM 5—CRITICAL ISSUES IN PSYCHIATRIC NOSOLOGY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of this symposium, the participant should have a greater awareness of: (1) some of the fundamental problems of psychiatric nosology, (2) some of the less apparent problems of diagnosis, (3) the steps required to address nosological problems, and (4) the way other disciplines have dealt with similar problems.

No. 5A
AN ALTERNATIVE APPROACH TO CLASSIFYING PERSONALITY DISORDER

John Livesley, M.D., *Department of Psychiatry, University of British Columbia, 2255 Westbrook Mall, Vancouver, BC V6T 2A1, Canada*

SUMMARY:

Although substantial improvements have occurred in successive editions of the DSM, the classification of personality disorder remains one of the most problematic areas of psychiatric nosology. Debate continues on such fundamental issues as the definition of personality disorder, including the way it should be differentiated from other mental disorders, and the basic diagnostic constructs for describing reliable and valid forms of psychopathology. This paper will consider both issues and present a framework for classifying personality disorder that is consistent with current empirical knowledge. As part of this framework it will be argued that personality disorder should be classified on Axis I and Axis II, reserved for coding clinically significant personality characteristics.

A systematic approach to the definition of personality disorder will be proposed based on: (1) an analysis of clinical concepts, (2) the functions of normal personality, and (3) evolutionary concepts. Empirical data will be presented to show that the resulting definition may be used to develop a reliable assessment instrument. Finally, a hierarchical system for coding clinically important personality characteristics will be proposed.

No. 5B
THE INTERNAL STRUCTURE OF THE DSM-IV

John Livesley, M.D., *Department of Psychiatry, University of British Columbia, 2255 Westbrook Mall, Vancouver, BC V6T 2A1, Canada;* Roger K. Blashfield, Ph.D.

SUMMARY:

Psychiatric classifications contain an explicit and implicit structure. The DSM-IV Axis I organizes diagnoses into 18 classes such as mood disorders and anxiety disorders. Within each class disorders are organized into a hierarchy that has a different number of levels across classes. This structure imposes an organization of mental disorders that has profound implications for clinical practice and research. For most clinicians and researchers these groupings seem fundamental and self-evident. Clinical activities are often organized around these groupings. Funding resources are often channeled along similar lines and knowledge is organized on the basis of these classes. Yet the basis for these groupings is rarely discussed and the principles used to establish and define them are poorly explicated. Similarly, although most psychiatric classifications are hierarchically organized, the nature of this hierarchical arrangement is unclear. This paper examines these issues and attempts to explicate the principles underlying the organization of the DSM-IV. Suggestions will be made regarding the principles that could be used to differentiate among classes and to establish a hierarchical structure. It will be argued that the explication of these principles should help to reduce diagnostic overlap and enhance the operating characteristics of the system.

No. 5C
BIOLOGICAL CLASSIFICATION AND PSYCHIATRIC NOSOLOGY

Roger K. Blashfield, Ph.D., *Department of Psychology, Auburn University, 226 Thach Hall, Auburn, AL 36830*

SUMMARY:

Commentators about psychiatric classification often refer to biological classification as an area for emulation, almost as if biological classification has solved its major theoretical issues. Interestingly, there have been four quite different theoretical approaches to biological classification that have been popular in the latter half of the 20th century: (1) a classical approach based upon a set theory view of categorical systems; (2) numerical taxonomy, which relies on multivariate statistical methods to create classifications; (3) cladistics, which centers on the evolutionary significance of the hierarchical systems; and (4) ethnobiological classification, which is derived from regularities noted in the classifications of living organisms by non-Western peoples.

Each of these models will be briefly reviewed with comments about their relevance for psychiatric classification. The ethnobiological approach has the greatest structure similarity to modern classifications of psychopathology. The analysis of these approaches to biological classification suggests that there are two facets to psychiatric classification that have been relatively neglected and that need to be studied in the future: (1) the understanding of how clinicians utilize classificatory concepts when thinking about patients, and

(2) the implications of a hierarchical organization of classificatory concepts.

No. 5D
OPENNESS IN THE DSM-IV PROCESS

John Z. Sadler, M.D., *Department of Psychiatry, Univ. of TX Health/ Science Ctr., 5323 Harry Hines Blvd, Dallas TX 75235-9070*

SUMMARY:

A value guiding the DSM-IV process was "openness." Having an explicitly open DSM-IV process was intended to improve the DSM through incorporating diverse clinical, research, and conceptual opinion into deliberations over the classification. This paper provides a brief historical overview of the "open" aspects of the DSM-IV process, evaluates this component of the process, and makes recommendations for future DSM efforts. The value of openness in DSM-IV is cast as an effort (among other reasons) to democratize the nosological process. The main embodiments of these democratizing efforts include: (1) the open invitation to DSM outsiders to communicate with task force/committee members, (2) the preparation and distribution of the DSM-IV *Options* and *Draft Criteria* books, and (3) the comprehensive literature reviews and *Sourcebooks*. These efforts, while praiseworthy, were only partially successful. While outsider input was endorsed, no formal procedure was released about how such input was to be assessed and utilized. Examples illustrate how this omission may have paradoxically enhanced outsider assessments of the DSM process as politicized and elitist. The risks and benefits of a open DSM process are discussed, and recommendations are made for avoiding such difficulties in future open DSM processes.

No. 5E
GENDER DIFFERENCES IN THE DSM-IV: CONCLUSIONS AND CONTROVERSIES

Thomas A. Widiger, Ph.D., *Department of Psychology, University of Kentucky, 115 Kastle Hall, Lexington KY 40506-0044*

SUMMARY:

One of the more controversial issues for mental disorder diagnoses has been their differential sex prevalence. The conclusions provided in the DSM-IV were derived from systematic reviews of the research literature. However, this research is complicated by common sources of error—two in particular will be emphasized—biases in sampling and biases within the diagnostic criteria themselves. These biases are illustrated for a wide variety of diagnoses across DSM-IV, and suggestions for research to address them are provided.

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SYMPOSIUM 6—A REVIEW OF EMPATHY IN PSYCHIATRY AND PSYCHOTHERAPY

Fetschrift in honor of Arnold Goldberg, M.D.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to better understand the concept of empathy, appreciate the skills that need to be developed and fostered for empathy to be therapeutically effective, use empathy more adequately in clinical work, and recognize its limitations.

No. 6A
A REVIEW OF EMPATHY IN PSYCHIATRY AND PSYCHOTHERAPY

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

SUMMARY:

This paper will review the various definitions of "empathy" as they have come to be used in the Western philosophical, psychiatric, and psychoanalytic tradition. There are several different meanings to the term, and there is no generally accepted definition or any agreement on the importance of empathy in psychotherapy and psychoanalysis. It seems to be common knowledge that the experience of empathy coming from another person is soothing and therapeutic, but that empathy can also be used for evil purposes such as is done by swindlers and con-artists.

An effort will be made to present a psychodynamic understanding of empathy and outline the various ways practicing psychiatrists and psychoanalysts can use it in their everyday clinical work. This presentation will also consider, as did Kohut, the importance of empathy in the advancement of knowledge by getting rid of interdisciplinary rivalries. Even more urgently, the importance of empathy in the development of world peace and understanding between cultures, especially those today who are warring in a senseless mutual destruction, for example in Ireland and the Middle East, will be discussed. The focus of the paper, however, will be clinical, with observations on the actual employment of empathy in the treatment process.

No. 6B
PHILOSOPHICAL UNDERPINNINGS OF EMPATHY

Hermann Lang, M.D., *Psychotherapy, University, Klinikstrasse 3, 97070 Wuerzburg, FRG*

SUMMARY:

In empirical therapy research the notion of "empathy" plays a central role as a basic factor of the therapist's attitude. It has been introduced and emphasized in psychotherapy, especially by Carl R. Rogers' client-centered therapy. Rogers' definition of empathy is the therapist's capacity to accurately receive the client's emotions and to understand them in their personal significance. By using the concept of "precise sympathetic understanding," Rogers explicitly refers to existential and dialogical philosophy. There is no doubt that phenomenology, hermeneutics, and existential philosophy have provided the essential framework for the concept of empathy. For Husserl, for example, the notion of "empathy" was important to achieve an understanding of the Other. In the sense of Scheler, Heidegger, and Buber's philosophy of encounter, the concept of

empathy could be misleading if it presupposes the idea of a monadic subject, which tries to throw a bridge to another equally monadic subject. These authors argue that the Other is already present by virtue of the fundamental structure of human existence as one's being with others. From that point of view empathy is not considered as an instinctive or merely intuitive capacity, but as a phenomenon that includes man's insertion into a universal community of language (Gadamer) as a necessary prerequisite. A similar position is held by structuralist writers like the ethnologist C. Lévi-Strauss, or the psychoanalyst J. Lacan.

No. 6C
UNDERSTANDING AND EMPATHY IN THE DIAGNOSTIC PROCESS

Professor Dr. Alfred Kraus, *Department of Psychiatry, University of Heidelberg, Vosstrasse 4, Heidelberg 69115, Germany*

SUMMARY:

Relating to Jaspers's concept of understanding among others the following questions arise: what is the difference between the mere understanding of connections of meanings and motives and understanding of the real person? What are the conditions of the possibility of the understanding of another person: is it partial identification putting oneself in the position of the other, feeling or imagining the feelings of others, or are these only means of precision and verification of understanding but not already understanding itself as an original form of being with the other (Mit-sein)? Here a kind of understanding is described, which, regarding the other as an equal partner in a mutual relationship, is not objectifying the other in isolated phenomena. It instead intends the unity of the other person and its prepredicative relationship to the world. Relating to psychopathological phenomena especially, the question is explored: what in a phenomenological (Husserl) and daseins-analytical orientation the principle of not understanding (Jaspers) of psychotic phenomena in schizophrenics and manic-depressives in each case really means? Finally, relating to the importance of understanding in the diagnostic process, we investigate the question what has changed with the introduction of diagnostic glossaries. Possibilities of a further development of these glossaries are discussed.

No. 6D
EMPATHIC UNDERSTANDING IN PSYCHOTHERAPY

Vladan Starcevic, M.D., *Institute of Mental Health, Palmoticeva 37, 11000 Belgrade, Yugoslavia*

SUMMARY:

It is usually assumed that the aim of empathy is to understand another human being. Empathic understanding is perception of the patient's innermost feelings and meanings that the patient attaches to them. It crucially depends on the balance and clear distinction between intellectual grasping of the patient, i.e., the therapist's own construction of the patient, and emotional knowing of him/her, i.e., the therapist's understanding of the patient "from within" the patient. This presentation will critically examine several models of understanding patients empathically. They differ mainly in terms of conceptualizing boundaries between therapists and patients, and in terms of relative importance accorded to the role of the therapists as participants in their patients' emotional lives, as opposed to their role as objective observers of patients. Empathic understanding has little therapeutic value *per se*, and it is more important *how* the therapist uses his/her understanding of the patient, e.g., for specific therapeutic interventions. Ultimately, psychotherapy cannot be effective without understanding the patient, but the therapist must be careful as to how his/her understanding is conveyed to the patients, because they may respond to it idiosyncratically. Since understanding is only an approximate reflection of the patients' authentic inner world, the therapist's task is also to continuously verify its value.

No. 6E
THE LIMITS OF EMPATHY AND THE VALUE OF MISUNDERSTANDING

Arnold I. Goldberg, M.D., *Institute for Psychoanalysis, 122 S. Michigan Ave. Ste 1305B, Chicago IL 60601-7401*

SUMMARY:

This paper divides empathy into its afferent and efferent branches and illustrates how it is constrained by three principles: the theory employed, the countertransference of the analyst, and the necessary moments of misunderstanding inherent in any analysis. Case vignettes demonstrate these points and serve to suggest that these three principles may well result in different forms that an analysis may take. It is made paramount that the patient's unfolding transference should dictate the necessary moments of misunderstanding in an analysis, and that this goes beyond the first two principles of theory and countertransference.

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SYMPOSIUM 7—INTERPERSONAL PSYCHOTHERAPY IN THE MEDICALLY ILL

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) recognize the rationale for using interpersonal psychotherapy (IPT) in medically ill patients with depression and adjustment disorders, (2) understand the modifications that may be required in the use of IPT in the medically ill.

No. 7A
INTERPERSONAL PSYCHOTHERAPY AND THE MEDICALLY ILL: A RATIONALE

Laurie Gillies, Ph.D., *Department of Psychiatry, Clarke Institute, 250 College Street, Toronto, ONT M5T 1R8, Canada*

SUMMARY:

IPT is being investigated for the treatment of major depression and adjustment disorder in a range of medical conditions. The four classic foci for IPT include role transitions, grief, role disputes, and interpersonal deficits. All are of potential relevance in the medically ill. Major medical illness typically involves significant transitions in interpersonal roles. Serious medical illness may reactivate grief related to earlier losses or may be associated with the loss of others with the same illness who one comes to know over the course of one's illness. Medical illness may activate conflicts or disputes or provide an "acceptable" reason for seeking help about long-standing disputes. Finally, illness may bring to light long-standing interpersonal deficits in the context of dealing with the medical team or accessing the instrumental and emotional support the patient requires. IPT may be particularly helpful when patients are reluctant to accept pharmacotherapy and where psychotherapy may be strongly indicated. Given that IPT is a manualized therapy, it allows for modifications specific to the needs of patients with particular diseases. For example, it has been modified to allow for its use via the telephone for patients undergoing intensive chemotherapy. Combining IPT and pharmacotherapy will be reviewed.

No. 7B
INTERPERSONAL PSYCHOTHERAPY FOR DEPRESSED HIV-POSITIVE PATIENTS

John C. Markowitz, M.D., *Department of Psychiatry, Cornell University Medical Col, 445 East 68th Street, Ste 3N, New York NY 10021;* Gerald L. Klerman, M.D., Kathleen F. Clougherty, M.S.W., Lisa A. Spielman, Ph.D., Lawrence B. Jacobsberg, M.D., Samuel W. Perry, M.D., Baruch Fishman, Ph.D.

SUMMARY:

Introduction: This randomized clinical trial compared 16-week interventions with interpersonal psychotherapy (IPT), cognitive-behavioral therapy (CBT), supportive therapy (SP), and SP *w*ith *i*mipramine (SWI) for HIV-positive patients with depressive symptoms.

Methods: Subjects (n = 101, 85 male, 16 female) with known HIV-seropositivity for ≥6 months were randomized to 16 weeks of treatment. Inclusion criteria were 24-item Hamilton Depression score ≥15, clinical judgment of depression, and medical health sufficient to attend outpatient sessions. Therapists were trained in manualized therapies specific for HIV-positive patients. Treatment adherence was monitored.

Results: Subjects randomized to IPT (n = 24) and SWI (n = 26) had significantly greater improvement on depressive measures than those receiving SP (n = 24) or CBT (n = 27). Similar results appeared in the completer subsample.

Conclusions: Depressive symptoms appear treatable in HIV-positive patients. IPT may have particular advantages as a psychotherapy for patients who have experienced the significant life events of HIV infection.

No. 7C
INTERPERSONAL PSYCHOTHERAPY IN BREAST CANCER PATIENTS

Susan E. Abbey, M.D., *Department of Psychiatry, Toronto Hospital, 200 Elizabeth Street, 8EN-212, Toronto, Ontario M5G 2C4, Canada*

SUMMARY:

Depressive disorders occur in 16% to 27% of women with breast cancer, with higher rates at the time of initial diagnosis, recurrence, and the detection of metastatic disease. These disorders do not resolve spontaneously and are persistent if not treated. Anecdotally, there has been a reluctance on the part of many women with breast cancer to use pharmacotherapy for the treatment of their depression for a wide variety of reasons. Cognitive based therapies have been found to be helpful in small studies in the treatment of depressed women with breast cancer. IPT appeared to be a potentially useful treatment for these women based on clinical experience. The rationale for IPT in women with breast cancer includes its efficacy in other populations; its relevance to the major psychological tasks faced by women with the disease; and its focus on interpersonal factors, which is congruent with the central importance of relational issues in women's lives. A protocol has been developed for treating women with breast cancer with IPT. Data will be reviewed on the initial cohort of 10 women treated with IPT. All met DSM-IV criteria for major depression. The main foci for therapy were: role transition (6/10), interpersonal disputes (2/10), interpersonal deficits (2/10). All of the women showed a remission in their depression and rated the treatment as acceptable to them. The experience of other centers using this modality will be reviewed.

No. 7D
INTERPERSONAL PSYCHOTHERAPY AND CHRONIC PHYSICAL DISABILITIES

Edward McAnanama, BMR (OT), *Interpersonal Ther. Cl., Clarke Institute of Psychiatry, 250 College Street, Toronto ON M5T 1R8, Canada*

SUMMARY:

People with chronic physical disabilities have increased rates of depressive disorders ranging from 9% to 25% in prevalence studies. Chronic physical disability associated with medical illness poses numerous challenges and often disrupts the interpersonal network. Individuals undergo significant transitions in their interpersonal roles and relationships. Interpersonal disputes may be precipitated or worsened by chronic disability. As part of the general trend to explore the use of IPT in medical patients, we have started to offer IPT for patients with chronic medical disabilities and depressive disorders. To date, patients have been treated with multiple sclerosis and rheumatoid arthritis. This paper will use two case studies to exemplify what we have learned in the use of IPT in this population.

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SYMPOSIUM 8—DEVELOPING MENTAL HEALTH CARE IN A POST-TOTALITARIAN SOCIETY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The purpose of the symposium is to provide the participants with an overview of developments in mental health care reform in the newly emerging democracies in Central & Eastern Europe and the former USSR, the problems and complexities of reform in a post-

totalitarian society, and solutions sought and progress made since the start of the reform process.

No. 8A
MENTAL HEALTH CARE DEVELOPMENT IN BELARUS: FORTH OR BACK?

Dr. Vladimir Poznyak, *Medical Inst., Social Clin. Psych., Prosp, Dzerzhinskogo 83, Minsk 220116, Belarus*

SUMMARY:

In the Soviet period in Belarus there existed an out-dated but comparatively comprehensive system of psychiatric care. An overview of social, economic, epidemiological, and political factors currently influencing mental health care development in Belarus will be presented.

There is evidence in Belarus of a growing discrepancy between the mental health care needs and the existing health care system. New solutions are needed. In the Soviet Union the solutions used to come from Moscow. At present many psychiatrists in Belarus are still looking to the East while others connect their hopes with Western contemporary psychiatry. The real problem is actually not in the ways mental health services are developing, which are widely accepted, but in the technologies of their implementation in specific circumstances with adequate support on political, administrative, and professional levels. Scientific and educational backup from the academic sector is of great importance for successful implementation and subsequent evaluation of the progress. The results of several projects carried out in Belarus will be presented to show that international cooperation in specific areas of mental health care seems to be the best format for such developments.

No. 8B
REFORMING MENTAL HEALTH CARE IN THE UKRAINE: A REPORT FROM PRACTICE

Dr. Viktor Shumlyansky, *Geneva Initiative, P.O. Box 1282, Hilversum, Netherlands*

SUMMARY:

I represent a typical post-Soviet psychiatric hospital, with all of its typical post-Soviet problems. In the past, our situation could be characterized as follows:

(1) total absence of information, including purely professional, from behind the Iron Curtain;

(2) monopoly of the so-called Moscow School of Psychiatry;

(3) absence of legal regulations and guarantees in our professional field of work.

One of the results of all the above-mentioned factors is known: the political abuse of psychiatry.

The most important aspects of our work are currently as follows: increasing the professional level and informedness of our doctors and nurses; founding a professional service of social workers in psychiatry; change of orientation of psychiatry from an intra-mural model to an extra-mural community psychiatry.

No. 8C
MENTAL HEALTH AND MEDICAL INSURANCE: A LITHUANIAN EXPERIENCE

Dr. Dainius Puras, *Geneva Initiative, P.O. Box 1282, Hilversum, Netherlands;* Dr. Raimundas Milasiunas

SUMMARY:

In 1997 a new law on health insurance came into force in the Republic of Lithuania. Psychiatrists and other mental health professionals had been waiting with great expectations for this reform. Since the end of the 1980's, when democratic changes started in the country with restored independence, much has been achieved in changing attitudes and priorities in the field of mental health. New demonstration sites emerged and their activities demonstrated that Lithuania is ready to replace a highly centralized system of segregated institutions by modern concepts of community-based services that integrate a biopsychosocial approach into the interdisciplinary care of children, adolescents, and adults with mental, behavior, and developmental disorders. A new generation of professionals has been trained in the field of mental health, and general consensus has been reached within the professional community on priorities in providing mental health care. The mental health act, adopted by the Lithuanian Parliament in 1995, declared that mental health centers in each municipality will provide outpatient health services.

However, the first and most important package of official documents, issued by the Ministry of Health immediately after the adoption of the law on health insurance, with an official list of services that will be covered by the National Health Insurance Fund, revealed the sad fact that mental health services (especially outpatient and day care services) once more have no chance to be adequately funded. The primary health services (general practicioners) will be paid "per capita" of population, while for all other medical specialists, including psychiatrists, only one visit in three months will be paid. Other nonmedical mental health professionals will not be paid by medical insurance.

The Lithuanian psychiatric community represented by the Lithuanian Psychiatric Association, immediately reacted with a protest resolution, which was supported by the mass media and NGO of users and relatives. A long process of negotiations on the needs and costs of mental health services began.

No. 8D
FAMILIES IN TRANSITION: RELATIONS BETWEEN FAMILIES AND MENTAL HEALTH WORKERS IN A POST-TOTALITARIAN SOCIETY

Dr. Carmen Andreesch, *Geneva Initiative, P.O. Box 1282, Hilversum, Netherlands;* Dr. Gabriela Grigoresch

SUMMARY:

The totalitarian system also shaped the relationship between health workers, on one side, and patients and their families, on the other. This polarized and authoritarian relationship has changed significantly in the new political and economic system. The families of mentally ill patients are challenged with both economic burden and contestation of absolute medical authority. This paper analyzes attitudes and expectations of families in transition.

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2. Mehilane, L (ed.): Mental Health Care in the Baltic Countries. Tartu University/Geneva Initiative, Tartu, 1996.
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SYMPOSIUM 9—RISK AND VULNERABILITY TO DRUG ABUSE Collaborative Session With the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should have a good understanding of some of the major new findings about the etiology of drug abuse, clear concepts enabling better early recognition of children and adolescents at higher risk for later drug use, and an understanding about potential targets for psychiatrically based interventions.

No. 9A
BEHAVIORAL GENETIC APPROACH TO DRUG ABUSE LIABILITY

Ralph E. Tarter, Ph.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburg PA 15213*

SUMMARY:

The liability to substance use disorder (SUD) is determined by genetic and environmental factors. One factor, manifest early in life, is temperament. In particular, deviations in temperament during childhood are associated with increased risk for drug use in adolescence. How familial and peer environmental factors interact with temperament makeup remains to be clarified.

This presentation will review the role of childhood temperament from a developmental perspective in the context of reciprocal interaction with the social environment. Findings will illustrate the capacity of difficult temperament scores to predict with a high degree of accuracy drug use between ages 10 and 12 and age 16. In addition, the extent and manner in which environments operate via selection and contagion processes will be addressed insofar as they impact on the direction and momentum of the developmental trajectory. Moderating variables, specifically psychopathology and aggression pertinent to temperament and drug use liability will also be addressed.

No. 9B
FAMILIAL TRANSMISSION OF DRUG ABUSE AND COMORBID DISORDERS

Kathleen R. Merikangas, Ph.D., *Department of Psychiatry, Yale University, Geru 40 Temple St, Lower Level, New Haven CT 06510*

SUMMARY:

This presentation will report the results of a large-scale family study that investigates the familial links between substance abuse and comorbid psychiatric disorders in adults and children. Adult and child relatives of probands with drug abuse, alcoholism, and/or anxiety disorders selected from treatment and community settings are compared with those of controls with no history of substance abuse or major psychiatric disorders. The major findings reveal *a strong degree of familial aggregation of substance abuse, with some indication of familial specificity of drug dependence and alcoholism.* Likewise, there was a *strong association between parental substance dependence and alcohol and drug abuse among their adolescent offspring.* Whereas none of the offspring of parents without substance abuse or psychopathology exhibit substance abuse problems, 20% of the offspring of the substance abusing parents already meet criteria for alcohol or drug abuse themselves. Possible explanations for familial aggregation including primary psychiatric disturbances, disrupted family structure, parental and family adjustment, and assortative mating are also investigated. Implications of these findings for prevention of substance abuse through family-based approaches and treatment of primary psychiatric disorders will be discussed.

No. 9C
EXTENT OF DRUG USE AND DEPENDENCE IN THE POPULATION

Denise Kandel, Ph.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 20, New York NY 10032*

SUMMARY:

Objectives: To specify common and drug-specific patterns of association between frequency and quantity of drug use and liability for dependence on marijuana, cigarettes, and cocaine, and determine aspects of consumption that account for gender and age differences in drug-specific rates of dependence.

Method: Data are from three aggregated surveys (1991 to 1993) of the National Household Survey on Drug Abuse, national cross-sectional probability samples of the U.S. population aged 12 and over. Proxy measures of DSM-IV dependence criteria were developed from self-reported dependence symptoms and drug-related problems. Descriptive and logit analyses were implemented.

Results: Group differences in liability observed between adolescents and adults and between males and females can be explained by consumption differences, greater sensitivity to drug effects at low consumption levels, or differential responsiveness at similar levels. Certain processes are common across drugs, others are substance-specific.

Conclusions: The results provide new understanding of risk factors for drug dependence and the extent of problematic use and treatment need represented by particular patterns of drug use in the population. The results also suggest hypotheses to be tested in the laboratory.

This research is supported by Grant DA09110 and Senior Scientist Award DA00081 from NIDA.

No. 9D
FIRST GRADE CLASSROOMS: COURSE OF AGGRESSION AND PREVENTION

Sheppard G. Kellam, M.D., *SHPH, Johns Hopkins University, 5200 Eastern Ave/MFL Bldg #500, Baltimore MD 21224;* Xiange Ling, M.S., Rolande Merisca, Ph.D., C. Hendricks Brown, Ph.D., Nicholas I. Ialongo, Ph.D.

SUMMARY:

Aggressive, disruptive classroom behavior has been repeatedly found as early as first grade to be an important risk factor for later drug abuse, delinquency, and related problem outcomes. A developmental epidemiological, classroom-based, randomized preventive trial was implemented in Baltimore over first and second grades directed at early aggressive, disruptive behavior. Nineteen public elementary schools and 1,196 first-grade children participated. Schools, children, and teachers were randomly assigned to intervention or control classrooms at the start of first grade. Improvement was found in aggressive behavior and tobacco use as far as middle school. In high aggressive first-grade control classrooms the more aggressive boys were at markedly increased risk (60:1 Odds) of being among the most aggressive males in middle school compared with those at the median. In contrast, high aggressive boys in lower aggressive first-grade classrooms were at only modestly increased risk (2.5:1 Odds). The preventive intervention appeared to improve high aggressive classrooms. These results point to the importance of social context interacting with predisposing behavior on the development of later aggressive behavior, the first grade as a locus for

preventive interventions, and the importance of early antecedents as targets for prevention trials.

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SYMPOSIUM 10—GAY MEN, LESBIANS AND BISEXUALS: CONTROVERSIAL ISSUES

Joint Session With the Association of Gay and Lesbian Psychiatrists

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize that there are many complex issues involved in treating gay men, lesbians, and bisexual people and for gay, lesbian, and bisexual psychiatrists to function professionally; and, have a working knowledge of how to address such concerns either clinically or through education and professional development.

No. 10A
CHILDHOOD DEVELOPMENT OF GAY MEN: WHAT IS KNOWN

Graeme Hanson, M.D., *Dept. Child & Adol Psych., Langley Porter UCSF, 401 Parnassus Avenue, San Francisco CA 94143-0984*

SUMMARY:

There has been much theoretical speculation about the development of a homosexual orientation in males, ranging from a biological/genetic deterministic view to psychoanalytic formulations that typically invoke significantly disturbed parent-child relationships and family dysfunction. Although research on the development of sexual orientation is crucially important, the study of children's sexual lives, their fantasies and motivations, and the evolution of sexual object choice is complicated by a variety of social and developmental factors. Most of the data on the childhood development of boys who will become gay are derived from adults and their memories of childhood, an approach that has significant limitations.

There is research evidence that a sub-population of "effeminate" boys are more likely to grow up to be gay men. However, many gay men do not give such histories. Gender identity disorder in childhood presents complex and unresolved diagnostic, treatment, and social policy issues.

No. 10B
ASSAULTING OURSELVES: DOMESTIC VIOLENCE IN LESBIAN RELATIONSHIPS

Amy E. Banks, M.D., *Victims of Violence, Cambridge Hospital, 114 Waltham St., Lexington MA 02173*

SUMMARY:

Domestic violence within the lesbian community has been in the closet until only recently. Studies are consistently showing a rate of violence in lesbian relationships that is similar to the rate of violence in heterosexual relationships. As the extent of violence is revealed within lesbian relationships, the feminist based, domestic violence movement is in need of expanding its understanding of the causes of violence in our culture. The latest theories will be reviewed in this presentation with a particular focus on the role homophobia may play in allowing the violence to stay "in the closet."

Target Audience: any member of the mental health or health care communities

No. 10C
MID-LIFE DEVELOPMENT IN GAY MEN: AIDS AND AGE REVISITED

Robert M. Kertzner, M.D., *NYS Psychiatric Inst., 722 Wesst 168th St. Unit 10, New York NY 10032*

SUMMARY:

Little is known about normative psychological change in gay men during middle age and what factors might contribute to psychological well-being during this transition. Descriptions of midlife development based on the general population suggest that developmental tasks related to intimacy and generativity are important determinants of mental health and that important changes in self-appraisal occur. In the lives of gay men, the HIV epidemic and novel configurations of family and friendship also shape midlife experience. An exploratory study was conducted to assess the applicability of these descriptions to gay men: 30 middle-aged gay men between 40 and 55 years of age were interviewed and completed self-report assessments of psychological health and gay identity. Themes consistent with Erik Erikson's description of generativity were found in 40% of respondents and quantitative data analyses suggested a relationship between generativity and psychological well-being. A subset of respondents with prominent concerns about aging had persistent difficulties with self-acceptance during young adulthood and histories of recurrent mood disorders and substance use. These findings are preliminary and exploratory, given the study's small sample size and other methodological limitations. Further research is needed to study the relationship between midlife development and mental health in gay men.

No. 10D
CULTURE CLASH: LATINOS AND THE FAILURES OF GAY IDENTITY

Francisco J. Gonzales, M.D., *3653 24th Street #3, San Francisco CA 94110*

SUMMARY:

Drawing on material from both academic and clinical sources, this paper examines the difficulties "gay identity" presents in the

lives of Latino men who have same-sex relations. An introductory section will frame the issues by providing a brief critical overview of theories of gay identity development. A grounding premise of this paper is that culture defines and constitutes (homo)sexuality, and hence, that "gay identity formation" is not a universal, transcultural phenomenon. Rather, forms of homosexuality are indigenous and local. The paper will focus primarily on Spanish-speaking men who have immigrated to the United States. Many of these men are caught in a "culture clash" between "American" gay sexuality and the sexual forms of their countries of origin. A model developed by B. V. Marin and the author, using data from a representative sample of unmarried Latino men in the U.S., will demonstrate how this cultural dissonance might be related to difficulties in practicing safer sex. Examples from focus group work done in three large U.S. cities with Latino gay and bisexual men and from clinic practice and psychotherapy will help bring immediacy and a personal dimension to the concepts presented. The conclusion of the paper will indicate possible implications for further discussion.

No. 10E
LESBIAN RULES: WHAT'S SEX GOT TO DO WITH IT?

Maggie Magee, M.S.W., *12011 San Vicente Blvd. Ste250, Los Angeles CA 90049;* Diana C. Miller, M.D.

SUMMARY:

This paper discusses sexuality in lesbian relationships. It defines the characteristics of essentialist sexual theories and demonstrates how such theories limit perception, distort experience, and restrict possibilities. Using slides of photographs from advertising and art, the authors discuss the importance of using "lesbian rules" (a term deriving from a mason's tool that allows measuring flexibility) to understand the dimensions of sexual expression in female same-sex relationships. Lesbian rules help both theory and clinical practice accommodate to the individual variety of sexual possibilities, and to the effects of changing contexts. The paper discusses eight "common sense" axioms about sex that are frequently ignored in discussions of heterosexuality and homosexuality. If these concepts are taken into consideration, they have, as lesbian theorist Eve Sedgwick notes, the "potential to disrupt many forms of the available thinking about sexuality."

No. 10F
INSTITUTIONAL HOMOPHOBIA: THE MAKING OF A GAY PSYCHIATRIST

Robert P. Cabaj, M.D., *Mental Health Services, San Mateo Cty Mental Hlth Ctr, 225 W 37th Avenue, San Mateo CA 94403*

SUMMARY:

Institutionalized homophobia is so common and pervasive, its presence and its effects on the training of psychiatrists is rarely noted or examined. The combination of societally sanctioned heterosexism and homophobia makes teaching about homosexuality, gay men, lesbians, and bisexuals uncommon and difficult to institute in medical schools and post-graduate medical training; when included, many schools and programs still teach outdated material. Many textbooks that mention homosexuality also contain myriad mistakes and outdated material.

Professional journals have consistently failed to accept articles on gay, lesbian, or bisexual themes—especially those written from the non-pathological viewpoint—with a variety of rejections, many based on homophobia. Research on gay, lesbian, or bisexual issues is extremely difficult to fund and proposals are routinely rejected.

Gay, lesbian, and bisexual medical students and residents wonder if is safe to come out in their schools or programs, especially during the interview process; many programs are notorious for their institutionalized homophobia. The effect on professional identity as well as comfort in developing a gay, lesbian, or bisexual identity is profound. Internalized homophobia may combine with the institutional homophobia and heterosexism—with concomitant discrimination and stigma—to cause many problems for gay, lesbian, and bisexual psychiatrists and other professionals.

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SYMPOSIUM 11—INTERNATIONAL HEALTH CARE AND TELEPSYCHIATRY
APA Committee on Telemedical Services

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

This symposium will enable participants to (1) compare and contrast access to mental health care under differing national systems, (2) compare different national approaches to mental health workforce issues, and (3) recognize the potential of telemedicine as a tool for enhancing access among hard-to-reach populations and meliorating workforce needs.

No. 11A
MENTAL HEALTH IN CANADA: CHANGES AND CHALLENGES

Pierre A. Beausejour, M.D., *Dept. of Psychiatry, University of Ottawa, 1145 Carling Ave CB5, Ottawa, ONT KZP 2H3, Canada*

SUMMARY:

Canadian mental health care is undergoing changes. The Canada Health Act universality principles are challenged by reform and restraint agendas. A more active, participating role of the provincial governments in the management of the health system has its impact. Doing more with less and doing things differently are constant challenges for today's health providers.

Current trends are influencing Canadian mental health policy: the devolution and regionalization of mental health services; the changing role of hospital psychiatry and the decreasing numbers of psychiatric beds; the shift toward community-based care; the beneficial impact of women on the practice of psychiatry and their increasing leadership involvement; the evolving role of primary care physicians

in the prevention, assessment, and treatment of mental illnesses; the emphasis on evidenced-based, best practices; and a client-centered approach to care with its emphasis on continuous quality improvement and outcome measures. These trends trigger changes and challenges on the diverse roles of the Canadian psychiatrist in the health system. Clinical practice, education, research, and advocacy issues are brought forward. Psychiatrist human resource and workforce issues remain with an undersupply of psychiatrists in many geographical areas and the hospital sector.

The presenter will highlight these changes and challenges in Canadian psychiatry.

No. 11B
PSYCHIATRIC CARE IN NEW ZEALAND

Janice M. Wilson, M.D., *Department of Mental Hlth, Ministry of Health, 133 Molesworth Street, Wellington, New Zealand*

SUMMARY:

New Zealand is a small country, challenged with achieving economies of scale and program complexity in mental health service delivery and with a widely dispersed population of 3.6 million. However, there is high commitment to the reconfiguring and developing of mental health services with targeting for those with severe mental disorders.

Health care is publicly funded through national taxation, with very little private provision or funding. A total of 7.4% of GDP is spent on health with an OECD average of 7.8%. In 1996/97 approximately $147 per capita was spent on mental health.

In 1993 reform of the health sector introduced divisions between the funder, purchaser, and provider of services. In 1994 the government produced a national strategy reconfiguring mental health services over the next ten years, the major thrust being toward community-based, comprehensive, integrated mental health services with priorities for Maori, children, and young people. Policy was set for specialty services to target those with severe mental disorders, attempting to "benchmark" the achievement of "adequacy" in mental health services in terms of the population to be served in any one month. This strategy is ongoing until the year 2002 with commitment from government to increase funding over the next four years.

No. 11C
PSYCHIATRIC HEALTH CARE IN AUSTRALIA

Harvey A. Whiteford, M.D., *Australian Government Health, GPO Box 9848, Canberra AC 2601, Australia*

SUMMARY:

Australia has a mixed public and private health system. A universal compulsory national health insurance scheme, Medicare, provides partial reimbursement (i.e., 85% of a schedule fee for outpatients and 75% for inpatients) for treatment by all private medical practitioners (including psychiatry), on a fee-for-service basis. It also contributes to (along with the states) to funding the public health system. Private insurers cover private hospital costs, for medical consultations the gap between the schedule fee and the Medicare rebate for inpatients (this is prohibited for outpatients), and a range of nonmedical ancillary health services. They must cover psychiatry in their basic tables.

Australia has 10.5 psychiatrists per 100,000 population with a maldistribution causing access problems. Under a National Mental Health Strategy, which is generally supported by the Royal Australian and New Zealand College of Psychiatrists, and which started in 1993, the federal and state governments have been gradually introducing mental health reform of both the private and public sectors. This reform includes major structural changes to service delivery, financial disincentives to long-term outpatient therapy for some groups, moves to output-based funding and measuring consumer outcomes, national service standards, and programs (such as telepsychiatry) to assist psychiatrists to better service rural areas.

No. 11D
APPROACHING THE MILLENNIUM: PSYCHIATRIC CARE IN THE UNITED STATES

Herbert S. Sacks, M.D. *Yale University, 260 Riverside Avenue, Westport CT 06880-4804*

SUMMARY:

Universal mental health coverage, an ideal aspired to but not yet achieved, is an objective for the millennium. In the United States a patchwork of systems for private and public care provides for many but still leaves psychiatric care beyond the reach of too many families and individuals. Obstacles include cost, distance, physician maldistribution, limitations placed on definitions of mental health need, restrictions on reimbursement for given services, and changing definitions of the psychiatrist's role. Despite enormous research strides, such as in psychopharmacology, genetics, imaging, and epidemiology, and given its sophisticated clinical strength, the psychiatric care system has inherited psychosocial problems consequent to poverty, violence, and drug use. A projected decline in numbers of new psychiatrists may be a further obstacle to care.

Solutions are emerging as we approach the 21st century. Physician activism is already supporting enhanced child health coverage for low income families. Overzealous restrictions on provision of health care are coming under public scrutiny and protest. Patients are becoming more empowered in their own health care through the Internet. Telemedicine will meliorate workforce problems by enabling us to reach hard-to-reach and underserved individuals. The prognosis for psychiatry at the millennium is hopeful.

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SYMPOSIUM 12—WOMEN'S REPRODUCTIVE HEALTH AND PSYCHOLOGICAL ISSUES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of this symposium, the participants will gain knowledge in areas of maternal-infant psychological health, effect of abuse on pregnancy and postpartum, infanticide, and the controversial topic of HRT in menopause.

No. 12A
EFFECT OF ANXIETY DISORDER ON MATERNAL INFANT INTERACTION

Shaila Misri, M.D., *Department of Psychiatry, St. Paul's Hospital, 1081 Burrard Street, Vancouver, BC V5Z 1Y6, Canada;* Pratibha Reebye, M.D.

SUMMARY:

Research on the emotional, cognitive, and behavioral impact on infants of postpartum women suffering from anxiety disorders is relatively nonexistent. In this prospective sample of postpartum women with anxiety disorder the authors will study: (1) maternal infant interaction in 30 days before and after pharmacological intervention, and (2) identify risk and protective factors for the mothers and infants.

Patients will be recruited from the Reproductive Psychiatry Program from two teaching hospitals attached to the University of British Columbia, Canada, by an adult psychiatrist. Maternal-infant interaction will be evaluated by a trained infant psychiatrist. Medically healthy infants living with their mothers (caregivers) will be included in the study. Diagnosis of anxiety disorder in the mothers will be based on the semi-structured interview, DSM-IV criteria, and diagnostic instruments, i.e., Ham A, Ham D, Y Box, and Kellner.

Dyadic interaction will be videotaped and coded prior to and after the pharmacological treatment. Sensitive and valid instruments will be used to assess the dyadic intervention and maternal receptivity.

No. 12B
MATERNAL DEPRESSION: IMPACT ON INFANT HEALTH

Zachary N. Stowe, M.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive, Ste 4003, Atlanta GA 30322;* Alexis M. Llewellyn, B.A., Anindya De, Ph.D., Charles B. Nemeroff, M.D.

SUMMARY:

There are numerous studies demonstrating the adverse impact of maternal depression on mother-infant attachment, infant behavior, and infant cognitive development. The severity and duration of maternal depression has varied between studies. The focus of the current study is to assess the impact of postpartum onset major depression and its treatment on infant health. Infant health was determined from pediatric records and calculating the illness density ratio (IDR) in each category of illness (e.g., respiratory, gastrointestinal, etc.) per week of life for the first postpartum year. The initial postpartum year was divided into the following stages: when the mother was euthymic prior to depression onset (1), depressed prior to treatment (2), following the onset of treatment to recovery (3), and recovery to 12 months postpartum (4). A total of 205 women were treated for postpartum onset depression with initial Ham-D = 21.3 ± 2.2. Data collection is complete for 32 of these mother-infant pairs (17 breast feeding, 15 bottle feeding). There was a significant increase in the IDR of gastrointestinal illnesses for both breast feeding and formula feeding infants, 7- fold (700%) and 16- fold (1600%) respectively, during the stage when mother was depressed prior to treatment compared with all other stages. Seventeen infants were formally diagnosed with reflux and the impact of infant treatment is discussed. These increases resolved when mother depression was effectively treated. These data suggest an intimate relationship between maternal depression and infant health. The significance of these findings will be discussed in the context of communicating with pediatric colleagues and the risk-benefit assessment of medications in breast feeding.

No. 12C
ABUSE AND PREGNANCY: RELATED MOOD DISORDERS, RATE, FORM AND RECOVERY

Susanne I. Steinberg, M.D., *Department of Psychiatry, St. Mary's Hospital, 3830 Lacombe Avenue, Montreal, PQ H3T 1M5, Canada;* Francois Bellavance, Ph.D., Angelina Wan

SUMMARY:

Objectives: (1) To describe the rate and nature of abuse in women having an adjustment disorder (AD) or major depression (MD) by DSM-IV criteria associated during pregnancy or postpartum. (2) To identify the impact of abuse upon course of recovery of mood as measured by scores on the Hamilton Rating Scale for Depression and Edinburgh Postnatal Depression Scale (EPDS).

Methods: A total of 148 women were recruited, 46 AD, 103 MD. Recurrent themes of abuse were identified from data recorded during therapy sessions. A sub-sample (96) entered a six-month treatment trial and completed questionnaires. Quantitative statistical methods involved chi square and repeated measures of analysis.

Results: Childhood abuse occurred in 24% AD, 25% MD, current abuse in 9(8%) and both in 11(21%), respectively. Personality disorders were present in 12% of non-abused and 24% of abused women ($p = 0.07$). Low self-esteem was most common among women with major depression (AD: 46%, MD: 60%; $p = 0.11$) and abuse (non-abused: 38%, abused: 72%, $p < 0.01$) Abuse occurs in many forms and by a variety of perpetrators. Recovery was more gradual and less complete for those currently abused.

Conclusions: Abuse places women at risk for mood disorders associated with pregnancy and yet both are under-diagnosed. Routine screening is required using direct inquiry and self-report scales: Women's Abuse Screening Tool and EPDS.

No. 12D
INFANTICIDE IN THE UNITED STATES: WITCH HUNT OR SCIENTIFIC PROBE?

Margaret G. Spinelli, M.D., *Department of Psychiatry, Columbia University, 722 West 168th St. Box 14, New York NY 10032*

SUMMARY:

Objectives: "Neonaticide" is the murder of an infant on the day of birth. In most countries, infanticide is judged to be the consequence of an altered mental status at delivery. In the United States, it remains a crime against society.

Method: Nine women charged with murder for alleged neonaticide were interviewed in preparation for expert witness psychiatric testimony. Each subject completed the Dissociative Experiences Scale (DES).

Results: All women shared elevated DES scores, similar precipitants and symptoms including denial of pregnancy, "la belle indifference," and amnesia for the alleged offense.

Conclusion: Identifying common features may validate a neonaticide dissociative syndrome, and thereby provide psychiatric evaluation and treatment for women otherwise lost to the penal system.

No. 12E
DECISION MAKING AT MENOPAUSE

Robert L. Reid, M.D., *Department of OB/Gyn, Queen's University, Victory 4 Kingston Gen. Hosp., Kingston On K7L 2V7*

SUMMARY:

The climacteric years leading up to the menopause are marked by menstrual irregularity and hot flashes of increasing severity as ovarian activity waxes and wanes. These external manifestations of the impending cessation of ovarian estrogen production bring a heightened awareness of the need for important decisions in the coming years, which may have profound impact on well being, health promotion, and disease prevention. This presentation will highlight key decisions that face the aging "baby boomer" generation—issues related to lifestyle modification (through diet, exercise, smoking cessation) and hormone replacement therapy (pros and cons). Symp-

tom control, prevention of osteoporosis, cardiovascular disease, and cancer risk will be discussed.

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5. Hammond CB: Menopause and hormone replacement therapy: an overview. Obstetrics and Gynecology 87(2)Supple, 2S–15S; February 1996.

SYMPOSIUM 13—THE MEDICAL PSYCHOANALYST: MULTIPLE ROLES Joint Session With the American Academy of Psychoanalysis

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium the participant should be able to recognize the current crucial influence of psychoanalytic theory and practice in the organization and delivery of psychiatric services.

No. 13A THE CLINICAL ROLE OF THE MEDICAL PSYCHOANALYST

Myron L. Glucksman, M.D., *27 Hospital Avenue, Ste. 401, Danbury CT 06810-5954*

SUMMARY:

Physicians trained in psychiatry and psychoanalysis possess knowledge and expertise that distinguish them from their non-physician psychoanalytic colleagues. As physicians, they are conversant with the pathophysiology of physical illness. As psychiatrists, they are familiar with psychopathology, neurobiology, and mind-body connections. As psychoanalysts, they have a sophisticated understanding of psychodynamics and their application to the psychotherapeutic process. Therefore, as medical psychoanalysts they are in a unique position to diagnose and treat patients in a variety of settings utilizing psychoanalytic concepts. Patients with anxiety disorders, obsessive-compulsive disorders, depression, and personality disorders can be treated with psychodynamic psychotherapy and psychotropic medication. Somatoform disorders can be translated into the underlying conflicts and dysphoria they symbolize. Psychophysiological disorders, eating disorders, and a multiplicity of physical illness can be treated in conjunction with other medical specialists, paying particular attention to the interrelationship between psychodynamic, biological, genetic, and social factors. Clinical illustrations will be provided.

No. 13B CHANGES IN TREATING SEVERE MENTAL ILLNESS

Ann-Louise S. Silver, M.D., *AA of Psychoanalysis, 47 East 19th Street, 6th Floor, New York NY 10003*

SUMMARY:

Chestnut Lodge, having pioneered psychoanalytic treatment of schizophrenia, as developed by Frieda Fromm-Reichmann, Harold Searles, and others is now eclectic. Our treatment includes complex medication regimens. We collaborate in research with NIMH; our behavior modification program is nationally prominent. Hospital stays have shrunk; patients soon move to local residences. We now are part of CPC-Health, a 60-year-old nonprofit cluster of local mental health clinics, which purchased the lodge from the Bullard family in August 1996. Insight-oriented psychotherapy remains central, as illustrated by treatment of a patient suffering both from schizophrenia and obsessive-compulsive disorder.

Treatment goals emphasize improvements in social functioning, successful self-regulation, and often gainful employment. Psychotherapy still relies on personality features of both the patient and therapist, in active and uniquely evolving relationships, structured within the boundaries of delineated technique. Therapists strive to use their countertransference responses to enhance empathic awareness. We help our patients recognize and modulate their grandiose assessment of their destructiveness, freeing them from delusions of magical power. Meanwhile, therapists acknowledge the improvements in antipsychotic and other medications, along with the constraints on our professional authority. For both therapist and patient, the complex changes in treatment approaches are humbling and thus maturing.

No. 13C THE MEDICAL PSYCHOANALYST IN MANAGED CARE SETTINGS

James C. Bozzuto, M.D., *AA of Psychoanalysis, 47 East 19th Street, 6th Floor, New York NY 10003*

SUMMARY:

Many psychoanalysts and dynamically oriented physicians choose not to work within managed care settings because of the restrictions placed on psychotherapy in medical practice. The other alternative is to be an active participant in these plans with a goal of education and influence. The dynamic or analytic psychiatrist has a unique perspective on patient care in general and specialized expertise in understanding complex mental states and the treatments necessary to address these issues. This presentation will focus on working within managed care settings, as either a committee director or a member of various committees within a managed care company, and the kinds of influence and change one can attempt.

No. 13D THE ROLE OF THE PSYCHOANALYST AS AN ADMINISTRATOR

Joseph P. Merlino, M.D., *AA of Psychoanalysis, 47 East 19th Street, 6th Floor, New York NY 10003*

SUMMARY:

Increasingly, psychoanalytic practitioners are finding uses for their training and experience outside the consultation room. As Freud noted, psychoanalysis is more than a form of treatment; it is a way of thinking, assessing and understanding.

Whether in a psychiatric health care facility, multi-specialty practice, or general hospital, the psychodynamic therapist's approach to

conflict and its management positions him or her to be a highly effective administrator. Many psychoanalytic therapists do not consider work in the many areas outside of their private practices for which they are exceptionally qualified. One goal of this presentation is to familiarize practitioners with the multiple areas of applied psychoanalysis that can benefit from their expertise.

One such role is as administrator. This paper will briefly describe and discuss some of the administrative areas the author has worked in. These include roles as outpatient administrator, inpatient team leader and unit chief, department administrator, and hospital committee chair.

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3. Olarte SW: The medical psychoanalyst in time of change; the utility of PRN therapy. J American Academy of Psychoanal Volume 24, 3:445–457, 1996.
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SYMPOSIUM 14—PSYCHIATRIC FORMULATION: WHAT'S ESSENTIAL?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will be able to state what is essential in a psychiatric formulation.

No. 14A FORMULATION FROM THE PERSPECTIVE OF CHILD AND ADOLESCENT PSYCHIATRY

Jerry M. Wiener, M.D., *Dept Psych & Behav Sci, George Washington Univ, 2150 Pennsylvania Ave NW, Washington DC 20037-3201*

SUMMARY:

Because children and adolescents are still in the most actively evolving stage of development and because development itself is a dynamic process of interaction between the individual and the environment, a formulation based on a biopsychosocial model is both ideal and necessary in the evaluation of a child or adolescent. A formulation then is a reconstruction of past events leading up to and attempting to provide an understanding of a described and/or observed/current clinical concern. Past events include biological, intrapsychic/psychological, and psychosocial circumstances that range from obviously reasonable (age, ethnicity, genetic endowment, temperament, physical characteristics, family structure, number of siblings, tests) to more or less subjective assessments and judgments (early environmental influences, quality of interpersonal constancy and nurturing, seminals or traumatic events, family dynamics, peer relationships, the emergence of ego functions, etc.)

The goal then of the formulation is the reconstruction and integration of these past events, informed by a useful theoretical model, resulting then in a descriptive and dynamic clarification and rationale for both diagnosis, treatment, and prognosis.

No. 14B CONFIGURATIONAL ANALYSIS

Mardi J. Horowitz, M.D., *Professor of Psychiatry, Langley Porter Psych. Inst., 401 Parnassus Ave Box 37B, San Francisco CA 94122-2720*

SUMMARY:

This method proceeds in four steps of formulation that lead to the fifth step, which is a treatment plan. The first step identifies the focal problems and crisis. The second indicates variance in symptoms and patterns in states of mind. The third addresses defensive avoidances of key themes. The fourth infers self and other patterns and person schemas such as role relationship models.

No. 14C CASE FORMULATIONS FROM THE PERSPECTIVE OF COGNITIVE-BEHAVIORAL THERAPY

Jesse H. Wright, M.D., *Department of Psychiatry, University of Louisville, Norton Psy Clin. PO BOx 35070, Louisville KY 40232*

SUMMARY:

The case formulation in cognitive-behavioral therapy (CBT) directly links theories with clinical observations and specific interventions. Although outcome research on CBT has emphasized use of treatment manuals and standardized methods, considerable importance is also placed on developing an individualized formulation for each patient. Typically, cognitive-behavioral therapists consider both cross-sectional and longitudinal dimensions in case formulations. A learning theory approach is used in which the therapist attempts to uncover characteristic patterns of dysfunctional information processing and related behavioral pathology that may be modified through CBT procedures. In short-term, symptom-focused therapies, the case formulation may be primarily cross-sectional. A longitudinal perspective becomes more important in treatment of characterological pathology or chronic disorders. This presentation describes and illustrates the case formulation in cognitive-behavioral therapy.

No. 14D EVALUATION INDICATORS IN PSYCHOPHARMACOLOGY

Donald F. Klein, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 722 West 168th Street, Unit 22, New York NY 10032-2603*

SUMMARY:

It would be ideal to have an all-purpose formulation of a patient's symptomatology, impairments, attitudes, developmental history, etc., that one could rationally inspect and arrive at an objective decision as to the treatment program most appropriate for the patient. However, this is not the case. People who are interested in, or expert in, a given treatment often emphasize those patient aspects that make them particularly appropriate for the treatment the therapists have in mind—a Procrustean approach.

It should also be realized that given the amount of difficulty at arriving at definitive decisions that it's not unusual to embark on tentative and sequential treatment plans that may have to be altered if substantial progress has not occurred within a reasonable time. Defining this period remains controversial.

No. 14E
ACUTE CARE PSYCHIATRY: THE FOUR QUESTIONS

Lloyd I. Sederer, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont MA 02178-1048*

SUMMARY:

Four critical areas of assessment can be used as the structure for the clinical encounter with an acutely ill patient. When used effectively, the clinician's ability to understand and articulate these key areas will optimize alliance, intervention, and outcome; provide necessary documentation for the medical chart and malpractice prevention (risk management); and meet the increasing demands of payers and regulators.

The four questions are:

1. What is the patient's descriptive diagnosis and the attendant differential diagnosis?
2. What are the ego defenses principally used by the patient at the time of the examination and what is the character diagnosis of the patient?
3. What current stresses have affected what intrinsic vulnerabilities (biologic and psychological) to render the presenting symptom picture?
4. What problem(s) must be addressed to restore safety and/or equilibrium to enable the patient to leave acute care?

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SYMPOSIUM 15—DYSTHYMIA: THE FORGOTTEN DEPRESSION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: recognize, diagnose, and treat dysthymia effectively.

No. 15A
STANDARDIZED ASSESSMENT OF DYSTHYMIA

Harry E. Gwirtsman, M.D., *Department of Psychiatry, Vanderbilt University, 1310 24th Avenue South (116A), Nashville TN 37212;* Mary C. Blehar, Ph.D., James P. McCullough, Jr., Ph.D., James H. Kocsis, M.D., Robert F. Prien, Ph.D.

SUMMARY:

Dysthymia is a chronic mood disorder that affects 3% to 4% of the entire population, or approximately 10 million people in the United States. This report provides a summary of a conference organized by the National Institute of Mental Health to address the lack of diagnostic specificity in dysthymia and to define the areas of consensus and controversy concerning the disorder. The aims of the meeting were: (1) to develop a consensus concerning the definition of the key symptoms and course of illness of dysthymia, (2) to define a set of assessment instruments and procedures to guide future research on the disorder, and (3) to provide an acceptable definition of response to treatment and to develop recommendations for reassessment and follow-up in studies of dysthymia. Another goal was to provide investigators with a selection of recommended assessment tools. Twenty-three individuals representing 12 research sites participated in the conference. The conferees provided recommendations deemed essential for future research studies regarding the diagnosis, course, and comorbidity of dysthymia. Also agreed upon were suggestions for diagnostic screening instruments, rating scales, and criteria for treatment response. Areas of considerable controversy remained among the panelists, which will be discussed in greater depth.

No. 15B
THE PREVALENCE OF DYSTHYMIA IN PRIMARY CARE

Barbara Bell, M.D., *Caroline Medical Group, 2250 Fairview Street, Burlington ON L7R 4C7, Canada;* Gina Browne, Ph.D., Meir Steiner, M.D., Jacqueline Roberts, M.S.C., Amiram Gafni, Ph.D>, Carolyn Byrne, R.N., Edward Dunn, Ph.D.

SUMMARY:

Dysthymia can result in significant somatic, social, and occupational impairment for both the index patient and all members of a household. This and other comorbid disorders go unrecognized a significant portion of the time. This study sought to determine the 12-month comorbid prevalence of Axis I psychiatric disorders in a primary care health service organization in Southern Ontario. A prospective survey of 6,280 adults between the ages of 18 and 75 years was conducted. Consenting adults were screened using the University of Michigan Composite International Diagnostic Instrument (UM-CIDI) short form for nine mood disorders. Adults with any one of the nine mood disorders were asked to consent to a further interview with the family physician who used the Structured Clinical Interview for the Diagnosis of Non Patient Populations (SCID-NP) to confirm the presence of dysthymia. The prevalence of dysthymia was 5.1% in this primary care population, suggesting that dysthymia is two times more prevalent in primary care populations than in general populations (0.8% to 2.5%). It is associated with significant costs in terms of poor health status, concomitant mental disorder, ineffective patterns of coping, poor social adjustment, family dysfunction and childhood disorder, higher reliance on social assistance, and use of health and social services. Consistent with other studies, dysthymia is found more in the general medical than specialty mental health or psychiatric clinics. Comorbidity in adults with dysthymia and their children may be more likely to go unrecognized in solo practices without the advantages of the interdisciplinary and intergenerational management of mental, behavioral, and health disorders available through a health service organization.

[Supported by a grant from the Medical Research Council of Canada-Pharmaceutical Manufacturers Association of Canada and Pfizer Canada Inc.]

No. 15C
PHARMACOTHERAPY OF DYSTHYMIA

James H. Kocsis, M.D., *Department of Psychiatry, New York Hospital, 525 East 68th Street, Box 147, New York NY 10021-4873*

SUMMARY:

Dysthymia is a chronic form of depression, which usually appears insidiously in childhood or adolescence. Symptomatology typically waxes and wanes in severity. Most dysthymic patients experience periods of major depression in their lifetime, a phenomenon that

has been termed "double-depression." Dysthymia appears to have marked impact on personality development and social-interpersonal functioning. The course of illness may also be complicated by substance abuse. This presentation will review a number of clinical trials of various antidepressant medications, mainly SSRI's and TCA's, for the treatment of dysthymia. Dysthymia appears to be less responsive to placebo than major depression. Drug-specific pharmacologic response appears to be similar to that of major depression. Remarkable improvement in social and interpersonal functioning is often seen with response to pharmacotherapy, which suggests that these disabilities may represent chronic symptoms of affective illness. Comorbid disorders such as personality disorders, anxiety disorders, and a prior history of substance abuse do not affect response to pharmacotherapy in patients with dysthymia. Long-term treatment may be indicated and may be helpful for a substantial percentage of dysthymics.

No. 15D
IPT AND SERTRALINE IN DYSTHYMIA: SIX-MONTH FOLLOW-UP

Gina Browne, Ph.D., *Research Unit, McMaster University, 1200 Main Street West, Rm 3N46, Hamilton, ONT L8N 3Z5, Canada;* Meir Steiner, M.D., Jacqueline Roberts, M.S.C., Amiram Gafni, Ph.D., Carolyn Byrne, R.N., Barbara Bell, M.D., Edward Dunn, Ph.D.

SUMMARY:

Rostered patients in a Health Service Organization in southern Ontario, as well as persons recruited from the region, were screened by phone for nine psychiatric disorders using the UM-CIDI short form. Those who scored positive on any disorder were invited to see a health care provider. Those who consented to the visit were screened for dysthymia and/or major depressive disorder using a modified SCID-NP. Those who were positive for dysthymia and consented to participate were randomized to one of three treatment groups: sertraline alone, IPT alone, or sertraline in combination with IPT. Of the 5,872 persons screened, 2,535 were positive on at least one of the nine disorders. A total of 1,544 consented to the visit; 736 were positive for dysthymia and 29 of these patients refused to participate. Altogether, 707 dysthymic patients were randomized: 229 to sertraline alone; 231 to IPT alone; and 247 to sertraline in combination with IPT. Sertraline was prescribed at an initial dose of 25 mg/day and up to a maximum of 200 mg/day. IPT, up to 16 sessions within the first three months of the study, was provided by trained staff. Preliminary results at the six-month follow-up visits indicate that sertraline alone is easier to comply with than IPT alone, is as effective as sertraline plus IPT, and is more effective than IPT alone. At the one- and two-year follow-up we will assess the enduring nature of these comparative effects and evaluate the respective societal costs associated with these three treatments.

[Supported by a grant from the Medical Research Council of Canada - Pharmaceutical Manufacturers Association of Canada and Pfizer Canada Inc.]

No. 15E
COGNITIVE-BEHAVIOR THERAPY AND SERTRALINE IN DYSTHYMIA: EFFICACY AND PHYSIOLOGY

Arun V. Ravindran, M.B., *Department of Research, Royal Ottawa Hospital, 1145 Carling Avenue, Ottawa, ONT K1Z 7K4, Canada;* Hymie Anisman, Ph.D., Jenna Griffiths, M.S.C., Zul Merali, Ph.D., Yolanda Charbonneau, M.D.

SUMMARY:

Given the morbidity and functional impairment associated with primary dysthymia, surprisingly few studies have examined the relative efficacy of psychotherapeutic interventions and pharmacotherapy in this patient population. The present investigation assessed the effectiveness of the SSRI, sertraline, and placebo, as well as group cognitive behavioral therapy alone and in combination. The clinical measures included efficacy ratings based on HAM-D, HAM-A, MADRS, and CGI scores evaluated over the 12-week trial. In addition, various functional measures were assessed prior to and following treatment, including quality of life, stress perception, and coping styles. While sertraline was significantly more effective in treating the clinical symptoms of dysthymia, cognitive therapy reduced several components of the functional impairment. Given the evidence that dysthymia may be a biologically distinct disorder with altered immune and hypothalamic-pituitary-adrenal (HPA) axis functioning, we assessed several endocrine and cytokine parameters in this patient population. Among other things our results indicated increased numbers of certain lymphocyte subsets, reductions in mitogen-stimulated T-cell proliferation, and increased interleukin-1 in the supernatants of mitogen-stimulated cells relative to normal controls. These data, while supporting the notion of immune activation at some levels of the immune system, also suggest that other immune components in dysthymia may be suppressed. A major subgroup of the dysthymic patients (those exhibiting significant atypical symptoms) showed a distinct endocrine and immune profile including low plasma cortisol, heightened ACTH, as well as altered cytokine levels. These data as well as the effects of the two major treatment interventions on the physiological measures will be presented.

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SYMPOSIUM 16—ARE EATING AND SUBSTANCE ABUSE DISORDERS RELATED?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: recognize the complex interrelationships between eating and substance abuse disorders, including new results that they are inherited separately, share links to victimization, PTSD, and major depression, and probably involve similar psychobiological mechanisms affecting hedonic reward systems.

No. 16A
FAMILIAL ASSOCIATION OF BULIMIA NERVOSA AND SUBSTANCE DEPENDENCE

Lisa R. Lilenfeld, Ph.D., *Department of Psychiatry, Western Psychiatric, 3811 O'Hara Street, Pittsburgh PA 15213;* Walter H. Kaye, M.D., Catherine G. Greeno, Ph.D., Kathleen R. Merikangas, Ph.D., Katherine Plotnicov, Ph.D., Michael Strober, Ph.D., Cynthia M. Bulik, Ph.D.

SUMMARY:

Substance use disorders are common among women with bulimia nervosa (BN) and their relatives. However, the nature of the familial relationship between these two disorders is unclear. We employed blind, structured interviews to study 47 bulimic women, 44 non-eating disordered community control women, and their first-degree relatives (177 and 190, respectively). Bulimic probands were stratified by presence (n=20) or absence (n=27) of lifetime substance dependence. Relatives of substance dependent bulimic probands had significantly higher rates of substance dependence compared with relatives of the other two groups. This suggests that substance dependence aggregates independently from BN in families. We then investigated familial patterns of psychopathology to understand some etiological factors that may contribute to this substance dependent subtype of BN. Social phobia, conduct disorder, and clusters B and C personality disorders were significantly more prevalent among substance dependent bulimic probands than the other two proband groups. Social phobia, panic disorder, and cluster B personality disorders were significantly more prevalent among relatives of these probands than relatives of the other two groups. These findings raise the possibility that a familial vulnerability for anxiety, impulsivity, and affective instability may contribute to the development of substance dependence in a subgroup of bulimic women.

No. 16B
EATING DISORDERS AND SUBSTANCE ABUSE: FAMILY AND FOLLOW-UP DATA

Michael Strober, Ph.D., *Department of Psychiatry, UCLA, 760 Westwood Plaza, Los Angeles CA 90024*

SUMMARY:

Objective: To investigate possible shared etiological mechanisms between anorexia nervosa, bulimia nervosa, and substance use disorders.

Method: Discrete time survival analysis and logistic regression models were applied to family study and longitudinal follow-up data ascertained on two large cohorts of patients with eating disorders. In the follow-up study we determined time to onset of first signs of substance use disorder and examined the predictive significance of binge eating at intake. In the family study, we examined rates of substance use disorder in relatives of patients vs relatives of a matched group of normal controls, and considered the impact of patient comorbidity for substance abuse on transmission patterns.

Results: Binge eating very significantly increased the hazard of first onsets of substance use disorder, a finding that accorded with evidence of higher rates of substance abuse disorder among relatives of binge eating anorexics than in relatives of anorexic restrictors. In the family study, rates of substance use disorder were found to be lower among relatives of anorexics compared with relatives of controls, whereas increased rates of substance abuse among relatives of bulimia nervosa probands was accounted for by comorbid substance abuse in the proband.

Conclusions: Binge eating may be an important marker of heterogeneity in anorexia nervosa, signifying a propensity to a broader spectrum of dysregulated behaviors. Familially, eating disorders and substance abuse appear to arise from independent transmitted liabilities.

No. 16C
WEIGHT CONTROL AS A MOTIVATION FOR COCAINE ABUSE

Carolyn E. Cochrane, Ph.D., *Department of Psychiatry, Medical Univ of South Carolina, 171 Ashley Avenue, Charleston SC 29425;* Robert J Malcolm Jr, M.D., Timothy D. Brewerton, M.D.

SUMMARY:

Objective: A major pharmacological effect of cocaine use is appetite suppression. Despite this knowledge, little has been done to investigate the possibility of appetite-related motivational use and/or eating disorders in the cocaine abusing population.

Methods: To study this question, 40 men and 37 women between 18 and 48 years old who endorsed cocaine as their primary substance of abuse were administered the SCID for DSM-III-R, the Eating Disorder Inventory (EDI), and the Diagnostic Survey for Eating Disorders-Revised (DSED-R). Items addressing use of weight control drugs, such as cocaine and other stimulants, were added to the DSED as were questions inquiring about reasons for beginning or maintaining cocaine use. All subjects were nonpsychotic, able to read, not pregnant, and could be alcohol dependent.

Results: The results showed that 18 of the 37 women used cocaine as a weight control measure while five of the 40 men (13%) did the same. Thirteen of the 18 women (72%) endorsing weight related use of cocaine had a current ED diagnosis (BN = 7, AN = 4, EDNOS = 2), while only two men (5%) had a past history of an eating disorder. Eleven of the 13 women (85%) with a current ED endorsed using alcohol as an appetite suppressant. Women were significantly more likely than men to endorse beginning use of cocaine for decreasing appetite ($X^2 = 5.39$, $p \leq 0.02$) and losing weight ($X^2 = 11.94$, $p \leq 0.0005$); women were also significantly more likely than men to continue using cocaine for decreasing appetite ($X^2 = 5.65$, $p \leq 0.01$) and for losing weight ($X^2 = 10.53$, $p \leq 0.001$). Women scored significantly higher on the Drive for Thinness subscale of the EDI ($F = 5.8 \pm 6.14$, $M = 1.6 \pm 2.1$: $p \leq 0.0008$) than men. Women's higher score on the bulimia subscale of the EDI approached significance at $p\ 0 \leq 0.0923$ in comparison with men. Women with weight-related motivation for cocaine use endorsed an average of three other substances for appetite control.

Conclusions: These findings support the need to evaluate weight control in cocaine users and provide specific treatment aimed at addressing the interaction between the eating disorder and the substance abuse disorder.

No. 16D
VICTIMIZATION AND SUBSTANCE ABUSE: RISK FACTORS FOR BULIMIA NERVOSA

Bonnie S. Dansky, Ph.D., *Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425;* Timothy D. Brewerton, M.D., Dean G. Kilpatrick, Ph.D.

SUMMARY:

Objective: In recent years there has been increased interest regarding the role of alcohol abuse (AA) and drug abuse (DA) in bulimia nervosa (BN), which at times has been conceptualized as a disorder characterized by addictive behaviors. One problem with this conceptualization is that other comorbid disorders such as major depression (MD) and environmental influences such as victimization were not taken into account when the association between alcohol/drugs and BN was examined.

Method: A national, representative sample of 3,006 women completed structured telephone interviews. The extent to which AA/DA (alcohol or drug abuse; DSM-III-R criteria) was associated with BN, MD, post-traumatic stress disorder (PTSD), and victimization was examined.

Results: Chi-square analyses indicated that comorbid AA/DA was a *nonspecific* risk factor for BN, given that the prevalence rate of AA/DA was equally high in women with MD and/or PTSD. Hierarchical log linear analyses revealed that AA/DA and BN were significantly related to one another via their links with victimization, PTSD, and MD [Final Model: BN x PTSD x MD x AA/DA; BN x Victimization x AA/DA; PTSD x Victimization; MD x Victimization].

Conclusions: It is essential to consider other comorbid psychiatric disorders (MD, PTSD) and factors such as victimization when evaluating the relationship between AA/DA and BN.

No. 16E
BULIMIA AND ALCOHOL ABUSE: PROPOSED LINKAGE MECHANISM

Dean D. Krahn, M.D., *Neuroscience, University of North Dakota, 1919 North Elm Street, Fargo NC 58102;* Blake A. Gosnell, Ph.D.

SUMMARY:

The mechanism that links clinical and subclinical eating disorders and substance use symptoms has been our focus of study for several years. Our group originally hypothesized that food deprivation caused a change in central reinforcement pathways, which led to a loss of control of eating and substance use. We based this hypothesis on animal studies and the behavior of starved humans, which showed that organisms self-administered more drugs and intracerebral stimulation when partially food-deprived than when sated. Consistent with this hypothesis is that severity of dieting, frequency of substance use, alcohol-related problems, and alcohol use disorders are correlated. At-risk dieters progress to heavy drinking more often than casual or nondieters. Abstinence by alcohol-dependent subjects is associated with increased desire for sweets and likelihood of binge eating. Thus, deprivation of either reinforcer leads to increased use of the alternative reinforcer.

However, many women who restrict food intake do not develop substance use disorders. To account for this fact we posit that more impulsive women are more likely to lose control of substance use during food deprivation. Subjects who are neurotic extroverts (i.e., impulsive) are more likely to have both eating disorder and substance use symptoms than are neurotic introverts. Both opioidergic and dopaminergic systems are thought to play roles in the hedonic and reinforcing effects of sweet taste and many drugs of abuse. Antagonists of these systems decrease the reinforcing effects of these substances. The comorbidity of eating and substance use disorders may, therefore, be related to one or both of these systems. Future research should be directed at understanding the neurobiology of temperament and food deprivation.

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SYMPOSIUM 17—MULTIGENERATIONAL ASPECTS OF TRAUMA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the presentation the participants should: (1) become familiar with the latest concepts on intergenerational aspects of trauma, (2) understand the necessity of an eclectic multidisciplinary approach in the research and assessment of intergenerational trauma; (3) comprehend the clinical implications of intergenerational aspects of trauma.

No. 17A
MULTIGENERATIONAL LEGACIES OF TRAUMA

Yael Danieli, Ph.D., *Group Project, Holocaust, 345 East 80th Street, Suite 31J, New York NY 10021*

SUMMARY:

This presentation will portray a comprehensive picture of the "state of the art" of the field of multigenerational transmission of trauma. Main findings, from around the world, will be mapped within Danieli's Trauma and the Continuity of Self: A Multidimensional, Multidisciplinary Integrative Framework (TCMI Framework). Dimensions of the framework include the biological and intrapsychic; the interpersonal—familial, social, communal; the ethnic, cultural, ethical, religious, spiritual, natural; the educational/professional/occupational; the material/economic, legal, environmental, political, national, and international. These systems dynamically coexist along the time dimension to create a continuous conception of life from the past through present to the future. The presentation will address aspects of the time dimension and of justice, two underemphasized yet crucially important issues in the trauma literature.

No. 17B
INTERGENERATIONAL EFFECTS OF STRESS IN RHESUS MONKEYS

Stephen J. Suomi, Ph.D., *Comp. Ethology, NIH/NICD, 9000 Rockvile Pike, 31 B2B-15, Bethesda MD 20892*

SUMMARY:

This paper examines psychobiological processes involved in the transmission of behavioral and physiological sequelae of stress across generations. Most of the relevant data come from prospective longitudinal studies of nonhuman primates, especially rhesus monkeys. Findings to date suggest at least three means by which an individual's behavioral propensities and physiological functioning can be affected by specific social stresses experienced by one or both parents earlier in life: the first is via observational learning, the second encompasses specific parental behaviors, and the third involves prenatal mechanisms. Examples of each of these three modes of intergenerational transmission of stress effects will be presented. It is argued that these three modes are unlikely to be mutually exclusive; rather, their effects are probably cumulative, if not multiplicative, for most individuals.

No. 17C
ASSESSING INTERGENERATIONAL TRAUMATIC STRESS

Andrei Novac, M.D., *Department of Psychiatry, University of California, 400 Newport Center Dr, Ste 309, Newport Beach CA 92660-7604*

SUMMARY:

Children of traumatized parents display clinical symptoms that can be empirically demonstrated. This paper will present an overview of three major intergenerational parameters (transmission of information, transmission of traits, and intrafamilial traumatization—a dysregulating factor) considered to be operational in intergenerational trauma. The concept of acquired vulnerability will be considered.

Preliminary data obtained from the use of the Intergenerational Trauma Scale will be presented and correlations with psychopathology and specific key items, i.e., suicide risk, will be examined.

An intergenerational diathesis, thought to be present in a latent form in an exposed patient population, will be analyzed. How to apply the findings of research of the cumulative effects of trauma to intergenerational traumatic stress with respect to patients who are already seeking treatment will be suggested.

No. 17D
OFFSPRING OF HOLOCAUST SURVIVORS' VULNERABILITY TO PTSD

Rachel Yehuda, Ph.D., *Department of Psychiatry, Mt. Sinai School of Medicine, 130 West Kingsbridge Road, Bronx NY 10468;* Milton L. Wainberg, M.D., Karen Binder-Brynes, Ph.D., Sheila Erlich, Ph.D., Dan Aferiot, M.S.W., Stacey Namm, Tamar Duvdevani

SUMMARY:

There is still considerable controversy regarding the presence of adverse effects of the Holocaust on the second generation. Although most clinical anecdotal studies have described psychopathology and increased vulnerability, these descriptions have been heavily criticized as not reflecting the true second generation population, only the subset that are psychiatric patients. Our studies have tried to address the issue of whether there is more psychopathology in offspring by studying a representative, nonclinical sample and comparing such subjects to a clinic sample. We will present data that demonstrate an increased prevalence of both current and lifetime post-traumatic stress disorder and other psychiatric disorders in offspring of Holocaust survivors (both a clinical and nonclinical sample). We will also present data that show that offspring of Holocaust survivors tend to have lower cortisol levels than demographically appropriate comparison subjects, particularly, although not necessarily, if they have PTSD. Results from a third study will be presented that demonstrate that PTSD in children of Holocaust survivors is present only in offspring whose parents have chronic PTSD, but does not appear to be present in Holocaust offspring whose parents did not develop PTSD from their Holocaust-related experiences. We believe our findings suggest that offspring are more vulnerable to the development of PTSD and other psychiatric disorder, and may constitute an important high risk group for the study of PTSD.

No. 17E
CULTURE AND FAMILIAL TRANSMISSION OF TRAUMA

Cecile Rousseau, M.D., *Department of Psychiatry, Montreal Children's Hospital, 4018 St. Catherine Street, Westmount, PQ H3Z 1P2, Canada;* Aline Drapeau, M.S.C.

SUMMARY:

The relations among family trauma, emotional disorder in the children, and meditating variables such as parental depression and family conflict, were studied in 156 school-age children from Southeast Asia and Central America and in 158 young adolescents from the same regions. Both quantitative and ethnographic approaches were used. Results suggest that culture influences the way in which the impact of trauma is mediated both through family variables and through implicit and explicit familial discourse around trauma. The developmental stage of the child also appears to interact with the different modes of familial transmission of trauma.

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SYMPOSIUM 18—NOVEL PREDICTORS OF VULNERABILITY TO MAJOR DEPRESSION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: develop a multidimensional view of vulnerability to major depression, and learn how novel, targeted research strategies can be used to assess vulnerability to depression.

No. 18A
PRECLINICAL BEHAVIORAL PREDICTORS OF ANHEDONIA

Franco J. Vaccarino, Ph.D., *Department of Research, Clarke Institute, 250 College Street, Toronto ON M5T 1R8, Canada;* Zindel V. Segal, Ph.D., Robert D. Levitan, M.D., Sidney H. Kennedy, M.D.

SUMMARY:

Objective: The present study is aimed at determining the behavioral characteristics and pharmacological responsivity of animals who display behavioral profiles that are consistent with low "hedonic" tone (i.e., anhedonia).

Method: Animals were tested in a variety of anhedonia-relevant behavioral paradigms. Following screening, the degree to which low scores on one behavioral dimension predicted low scores on other behavioral dimensions was determined, as was responsivity to psychostimulants and antidepressants.

Results: Animals with low responsivity on one test tended to be low on the other tests. The behavioral profile of this subgroup of animals is viewed as a preclinical model of anhedonia and that the anhedonia-like profile could be normalized with acute psychostimu-

lant treatment. Interestingly, antidepressants were relatively ineffective. Results further showed that these animals also had elevated anxiety scores.

Conclusion: These results indicate that in a subgroup of animals a behavioral profile exists suggestive of vulnerability to anhedonia. Furthermore, this behavioral profile predicts response to a particular pharmacological interaction.

No. 18B
COGNITIVE RESPONSE TO A MOOD PRIME PREDICTS DEPRESSIVE RELAPSE

Zindel V. Segal, Ph.D., *Clark Inst. of Psychiatry, 250 College Street, Toronto ON M5T 1R8, Canada;* Michael Gemar, Ph.D., Susan Williams, M.Sc.

SUMMARY:

Two studies examined the nature of cognitive reactivity to a mood induction in formerly depressed patients. In the first study, patients receiving either cognitive therapy (CBT, N = 15) or pharmacotherapy (PT, N = 17) completed self-reported ratings of dysfunctional attitudes before and after a negative mood induction procedure. Consistent with recent findings using this paradigm, PT patients showed a significant increase in dysfunctional cognitions following the mood induction; in contrast the CBT group showed no change. A follow-up study re-assessed 30 patients several years after initial testing. Logistic regression analysis indicated that patients who showed the greatest magnitude of cognitive response to the mood induction procedure were the most likely to have relapsed over the follow-up, regardless of original treatment modality. These findings argue for differential effects of treatment on cognitive reactivity to mood induction, and for the link between such reactivity and risk for later depressive relapse.

No. 18C
CHILDHOOD ABUSE PREDICTS MAJOR DEPRESSIVE SUBTYPES IN ADULTS

Robert D. Levitan, M.D., *Mood Disorders, Clarke Institute, 250 College Street, Room 1135, Toronto ON M5T 1R8, Canada;* Sagar V. Parikh, M.D., Alain D. Lesage, M.D., Kathleen Hegadoren, Ph.D., Martha Adams, M.D., Sidney H. Kennedy, M.D., Paula N. Goering, Ph.D.

SUMMARY:

We examined whether a history of physical or sexual abuse in childhood was associated with particular subtypes of major depression, as defined by neurovegetative symptoms and/or mania, in individuals 15 to 64 years of age. A total of 8,116 individuals in Ontario were interviewed using the World Health Organization Composite International Diagnostic Interview (CIDI). In the 653 cases of major depression, we compared rates of physical and sexual abuse in depressive subgroups defined by typical and reversed neurovegetative symptom patterns (i.e., decreased appetite, weight loss, and insomnia vs. increased appetite, weight gain, and hypersomnia), and by the presence or absence of mania lifetime, in females and males separately. The results indicated that early abusive experiences were associated with particular subtypes of major depression, with markedly different findings in the two sexes. In females, having either physical or sexual abuse in childhood was associated with major depression with reversed neurovegetative features. This finding was enhanced when subjects with mania were excluded from the analysis. In males, a very strong relationship between mania and childhood physical abuse was found. We conclude that the experience of physical and/or sexual abuse in early development is associated with particular subtypes of major depression in subsequent years. It appears that gender-specific mechanisms may be involved in the association between early trauma and the later expression of depression.

No. 18D
NEGATIVE ATTRIBUTIONAL STYLE AS A PREDICTOR OF TREATMENT RESPONSE IN SEASONAL AND NONSEASONAL DEPRESSION

Neil Rector, Ph.D., *Department of Psychiatry, Clarke Institute, 250 College Street, Toronto, ONT M5T 1R8, Canada;* Robert D. Levitan, M.D., Michael Bagby, Ph.D.

SUMMARY:

There is a significant relationship between dysfunctional cognitions and the clinical course of major depression. This study examined whether this association extends to patients with seasonal affective disorder. A revised version of the Attributional Style Questionnaire was used to assess the role of negative attributional style (i.e., the tendency to make stable and global attributions to negative situations) in treatment response in a sample of depressed outpatients, 26 with seasonal type (SAD) and 30 with nonseasonal, unipolar major depression (non-SAD). Pre-treatment negative attributional style scores did not differ between SAD and non-SAD patients. Negative attributional style predicted poor response to pharmacotherapy in the non-SAD group, but did not predict light therapy response in SAD patients. These results indicate that negative attributional style may play a lesser role in SAD than in non-SAD depression, and suggests that cognitive vulnerability models may not apply to all subtypes of major depression. The results are also consistent with current formulations of SAD, which emphasize biological factors in its course and treatment, and the DSM-IV description of SAD, which excludes psychosocial factors by definition.

No. 18E
PSYCHOBIOLOGICAL PREDICTORS OF PARTIAL DRUG RESPONSE

Sidney H. Kennedy, M.D., *Psychiatry, Clarke Institute of Psych, 250 College Street Room 1125, Toronto, ONT M5T 1R8, Canada;* Michael Bagby, Ph.D., Zindel V. Segal, Ph.D., Kenneth R. Evans, Ph.D., Robert D. Levitan, M.D., Franco J. Vaccarino, Ph.D.

SUMMARY:

Partial antidepressant response is associated with a rapid rate of relapse following drug discontinuation. Despite this, little is known about predictors of partial response. In evaluating 130 patients with major depression who received standard antidepressant therapy with paroxetine, sertraline, or venlafaxine for up to 14 weeks, approximately 40% were full responders, 40% partial responders, and 20% nonresponders. In most instances, the partial group fell in the middle range between full and nonresponders on a range of baseline measures. Significant differences were found in age (but not number of prior episodes), baseline HRSD score, and level of distraction as assessed by Response Style Questionnaire (RSQ). The level of self-criticism was significantly higher in partial responders than either full or nonresponders. A subgroup of 30 patients received PET/FDG scans before and after paroxetine treatment. Preliminary results indicate that partial and full responders differ. Full responders had a larger decrease in metabolic activity in frontal, caudate, and cingulate areas relative to partial responders. Profiles of increased metabolic activity also differed, such that full responders showed larger increases in the parietal and cerebellar areas than did partial responders. In a controlled comparison of lithium augmentation and CBT additional therapy for partial responders, lithium produced a more favorable outcome. Additional predictors of response to either treatment were years of education, lower baseline BDI (but not HRSD), lower

self-criticism and higher gregariousness, and activity within the extraversion subscale of the NEOPI. Duration of illness and psychological measures including self-criticism and extraversion predicted response.

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SYMPOSIUM 19—LATE-ONSET SCHIZOPHRENIA: NEW INSIGHTS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The audience will learn about the diagnostic criteria, clinical features, neuropsychological and brain imaging characteristics, course, and treatment of late-onset schizophrenia. The participants will know the most recent research findings in this area from a group of experts from across the world.

No. 19A
IS LATE-ONSET SCHIZOPHRENIA REALLY SCHIZOPHRENIA?

Dilip V. Jeste, M.D., *Department of Psychiatry, Veterans Affairs Medical Ctr., 3350 La Jolla Village Drive, San Diego CA 92161-0001;* M. Jackuelyn Harris, M.D., Laurie A. Lindamer, Ph.D., Barton W. Palmer, Ph.D., Julie A. Gladsjo, Ph.D., Jovier D. Evans, Ph.D., Robert K. Heaton, Ph.D.

SUMMARY:

Objective: To compare outpatients with late-onset schizophrenia (LOS) with age-comparable outpatients with early-onset schizophrenia (EOS) on clinical and neuropsychological measures.

Methods: We used the SCID to make DSM-III-R or DSM-IV diagnosis of schizophrenia, and employed additional research criteria to diagnose LOS (with onset of prodromal symptoms at age 45 and over). Standardized clinical rating scales as well as neuropsychological tests were given, and the patients were followed longitudinally.

Results: A total of 51 patients with LOS were compared with 181 patients with EOS, all the subjects being 45 and over. The LOS group had significantly more women, more patients with paranoid schizophrenia, and were on lower mean doses of neuroleptics than the EOS group. Negative symptoms were less prominent in LOS patients. The two groups were similar in terms of positive symptoms, family history, and gross structural brain abnormalities on MRI. Neuropsychologically, the pattern of impairment was similar, but the LOS patients had less severe deficits in learning, abstraction, and motor skills than the EOS subjects. On longitudinal follow-up, very few patients in either group developed diagnosable dementia.

Conclusion: The results suggest that LOS is very likely a type of schizophrenia, but nonetheless, a neurobiologically distinct form of the disorder.

No. 19B
CAN SCHIZOPHRENIA BEGIN AFTER THE AGE OF 60?

Robert J. Howard, M.D., *Department of Old Age, Inst. of Psychiatry, De Crespigny Park Camderwell, London, United Kingdom*

SUMMARY:

Within the European psychiatric tradition, onset of schizophrenia or a schizophrenia-like psychosis after the sixth or seventh decade of life has long been accepted. Although use of the term "late paraphrenia" to describe cases with onset after 60 years has been largely abandoned, few workers doubt the existence of a group of mostly female patients, often with sensory impairments and social isolation who develop a florid, essentially schizophrenic illness in late life. Phenomenologically, these patients have all the positive symptoms encountered in younger schizophrenics with the notable exception of disorders of the form of thought. The lifetime morbid risk of schizophrenia in first-degree relatives of such patients is not raised. Structural brain imaging studies have demonstrated enlarged lateral and third ventricle volumes analogous to the situation in early-onset cases. These patients respond favorably to lower doses of antipsychotic medication than younger patients or early-onset schizophrenics who have grown old. The relationship of such cases to more typical early-onset schizophrenia is still unclear. What is clear, however, is that these patients do not have an "organic" psychosis in the sense that individuals with Alzheimer's disease may be considered to be psychotic. The phenotypic similarities to early-onset schizophrenia, but the differences in terms of phenomenology, risk factors, and treatment response, justify recognition of these cases as late-life onset schizophrenia-like psychoses.

No. 19C
SCHIZOPHRENIFORM DISORDER IN ELDERLY PUBLIC HOUSING RESIDENTS

Peter V. Rabins, M.D., *Department of Psychiatry, Johns Hopkins Hospital, 600 N. Wolfe Street/Meyer 279, Baltimore MD 21287-7279;* Betty S. Black, Ph.D.

SUMMARY:

The ECA study reported that the lifetime prevalence of schizophrenic disorders in persons older than age 64 is 0.3%. In a study of 872 public housing residents 60 and older, 23 residents (2.6%) were diagnosed as having a schizophrenic disorder using the SCID. A total of 8 individuals met criteria for schizophrenia, while 15 met criteria for schizophreniform disorder. There were no significant differences between these two groups based on demographic characteristics (i.e., age, sex, education), social support, health and functional status, or use of medical health care services. Compared with residents with schizophreniform disorder, those with schizophrenia were more likely (OR = 8.3, 95% Cl = 1.2, 59.0) to receive mental health care in the previous six months.

No. 19D
SCHIZOPHRENIA OF LATE-ONSET: SIMPLY A VARIANT OF EARLY-ONSET DISORDER?

David J. Castle, M.D., *Department of Psychiatry, Univ. of W. Australia, 50 Murray St. Royal Perth Hosp, Perth 6000, Australia;* Robert J. Howard, M.D., Robin M. Murray, M.B.

SUMMARY:

Many researchers and clinicians believe that schizophrenia rarely, if ever, begins in very late life, and that such individuals merely have a delayed variant of early-onset disorder. This presentation aims to debunk these myths, by defining the epidemiology, phenomenology, premorbid, and risk factors in patients with the first manifestation of a schizophrenia-like illness across the life span.

The sample consisted of all contacts for a non-affective psychotic illness across all ages of onset, ascertained through a psychiatric case register. Patients were rediagnosed according to operationalized criteria for psychotic illness.

Age-at-onset distributions clearly delineated a group of patients with onset of illness in very late life (>60 years). SKUMIX analysis revealed two peaks of onset in males, with modal onsets at 21 and 39 years, and three peaks for females, with modal onsets at 22, 37, and 62 years.

Very-late-onset patients (n = 72) were, compared with their very-early-onset counterparts, (n = 192) more likely to be female, have good premorbid functioning and developmental history, and to exhibit persecutory delusions and hallucinations. They were less likely to have negative schizophrenic symptoms, to have a positive family history of schizophrenia, or have suffered pregnancy or birth complications.

These results highlight that a group of patients (mostly female) do manifest a schizophrenia-like illness in very late life, and that they differ from their early-onset counterparts in terms of premorbid, etiological, and phenomenological parameters. This group of patients should not be ignored: indeed, their detailed study can inform research into psychotic illnesses in general, and can be usefully integrated with the literature on development and degeneration of the human brain, with particular reference to sex differences in these domains.

No. 19E
IS LATE-ONSET SCHIZOPHRENIA AN ORGANIC MENTAL DISORDER?

Perminder S. Sachdev, M.D., *Dept. of Neuropsychiatry, Univ. of New South Wales, NPI Prince henty Hospital, Little Bay, NSW 2036, Australia* Henry Brodaty, M.D., Noelene Rose, M.C.

SUMMARY:

Background: Schizophrenia with a late onset has been suggested to have a basis in age-related coarse brain disease, but empirical support for this is conflicting.

Method: We compared groups with DSM-III-R defined schizophrenia with onset ≥ 50 years (late-onset schizophrenia; LOS) (N = 30), onset < 35 years (early-onset schizophrenia; EOS) (N = 31), and a healthy comparison (CNT) group (N = 34), matched for age and gender, on their current neurological status, neuropsychological test performance, and brain MRI, and followed the subjects for a mean of 19.2 months.

Results: The schizophrenic groups had more soft neurological signs and drug-induced movement abnormalities. LOS had more hearing abnormalities than EOS but not CNT. The schizophrenic groups performed poorly on neuropsychological tests assessing speed of information processing, memory, and frontal executive functioning when compared with CNT, but did not differ from each other statistically. On MRI, LOS had more cortical atrophy, but not ventricular dilatation, than CNT. They also had more signal hyperintensities in periventricular and centrum semi-ovale white matter and subcortical nuclei than CNT, but not the EOS (after age correction). LOS subjects did not demonstrate significant cognitive decline.

Conclusion: Our study did not support an organic basis for DSM-III-R defined schizophrenia of late onset.

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SYMPOSIUM 20—AGITATION IN THE ELDERLY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To inform clinicians regarding state-of-the-art clinical management of agitation in the elderly patient.

No. 20A
GUIDELINES AND THE TRANSMISSION OF KNOWLEDGE

John P. Docherty, M.D., *Department of Psychiatry, New York Hospital/Cornell, 21 Bloomingdale Road, New York NY 10605*

SUMMARY:

The effective transmission of new knowledge for the benefit of patient care represents a major problem for contemporary health care. There is an unduly long length of time and inconsistency in which new knowledge is effectively brought to the relief of illness and suffering. Three critical issues produce the "knowledge gap": (1) the problem of translating and extrapolating from highly controlled studies a narrowly defined group of patients to individual patient care decisions, (2) inconsistency of knowledge, revealed in the wide variations in practice patterns described in the work of Wennberg and others, and (3) the enormous growth of knowledge, reflected in the fact that the National Library of Medicine processes over 30,000 new peer reviewed journal articles each month. New methods are required in order to capture the benefit of this new knowledge. The purpose of guidelines is to serve as a tool to facilitate the transmission and application of state-of-the-art knowledge in patient care. The development of guidelines represents a new area of scientific work for medicine, and is evolving rapidly. The history of this evolution will be briefly reviewed, and will include a discussion of early informal methods of guideline development, scholar consensus methods such as the NIH Consensus Conference and the DSM-IV process, and the contributions of the Rand Appropriateness techniques to guideline methodology. The limitations of these previous methods of guideline development, and the problems with implementation to which they have given rise, will be discussed.

Against this background, the "next step" evolution of the Expert Consensus Methodology for the development of guidelines will be described, including the specific advantages for implementation that this methodology provides: (1) enhanced credibility based on the broad representativeness and impartiality of the process, (2) adaptability to the different patient care settings, (3) the quantitative nature of the guidelines and the ability to verify and replicate findings, (4) the capacity to test the validity of the recommendations as they are

applied in typical clinical settings, and (5) the practical nature of the guidelines and their ready application to highly individual clinical situations. Limitations of the Expert Consensus method will also be discussed to aid the clinician in a critical interpretation of the recommendations, and more effective application of the Expert Consensus Guidelines to the care of his or her individual patients.

No. 20B METHODOLOGY OF EXPERT CONSENSUS GUIDELINES

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

SUMMARY:

The Practice Guideline for the Treatment of Agitation in the Elderly presented in this symposium is based on a new method of establishing expert consensus and of translating that consensus into a more user-friendly guideline. The first step in this process was to develop a model for the clinical management of agitation in the elderly, with key decision points identified where the clinical trials literature is scant or absent but where there is a wealth of clinical expertise in the field. A questionnaire was then developed, which systematically queried experts as to the appropriateness of several reasonable treatment approaches to specifically defined clinical situations. The questionnaire was then mailed to 101 nationally known experts in the management of agitation in the elderly, and 84 responded. Statistics of agreement and analyses aimed at identifying patterns of random responding were used to quantify areas where the experts reached a consensus. Summary statistics for each treatment option were calculated, including the mean and 95% confidence interval. The consensus rating of the experts was defined according to where the confidence interval fell on the 9-point scale. Once the consensus of the experts was identified, the results were used to inform a practice guideline based on the consensus of the experts. The extent to which the results are replicable and, in that sense, reliable was calculated using the intraclass correlation statistic (Shrout and Fleiss, 1979). Preliminary analyses suggest these results are very reliable and should be considered stable representations of expert opinion.

No. 20C AGITATION OF DEMENTIA: TREATMENT PRINCIPLES

George S. Alexopoulos, M.D., *Department of Psychiatry, Cornell University Medical Col, 21 Bloomingdale Road, White Plains NY 10605*

SUMMARY:

Agitation is a frequent complication of dementing disorders. Agitated behavior compromises the quality of life of demented persons, increases the burden of caregivers, and necessitates high intensity of care.

The Expert Consensus Guideline is built on the central clinical concept that agitation occurring in dementing disorders has many causes. These causes fall into three major classes: medical comorbidities, psychiatric comorbidities, and the dementia itself.

Frequent medical causes of agitation include delirium, chronic pain, sleep deprivation, congestive heart failure or chronic obstructive pulmonary disease, or discomfort resulting from medical disorders, most frequently urinary tract or respiratory infections. Psychiatric syndromes often accompany dementing disorders and can cause agitation. The most likely psychiatric syndromes to cause agitation in demented patients are psychosis, depression, and anxiety. The heterogeneity of agitation necessitates a thorough medical and psychiatric evaluation focusing on the most frequent causes of agitation. Once identified, most medical illnesses can be etiologically treated or compensated. Similarly, psychosis, depression, or anxiety complicating dementing disorders often respond to sharply focused treatment.

In a significant number of cases, agitation is a direct sign of the underlying dementing disorder and cannot be attributed to other causes. In such cases, successive trials of single pharmacological agents and observation over long periods of time offer the most promising strategy. The role of PRN medications in these patients will be reviewed, but the mainstay of treatment is consistently pharmacotherapy, appropriate due to the wide fluctuation of agitation. Neuroleptics, mood stabilizers, SSRI's, buspirone, benzodiazepines, and β-blockers may reduce agitation in some demented patients. Combination of these agents has limited usefulness in agitated demented patients as it may lead to delirium or other adverse medical events that may further increase agitation and endanger the patients' health. The specific recommendation of the Expert Consensus Guideline for the use of these agents will be presented and discussed.

No. 20D AGITATION: A NEUROPSYCHIATRIC PERSPECTIVE

Jonathan M. Silver, M.D., *Department of Psychiatry, Lenox Hill Hospital, 1430 Second Avenue, New York NY 10021*

SUMMARY:

Agitation and aggressive behavior occur in many neuropsychiatric disorders, including traumatic brain injury, schizophrenia, and mental retardation. It is these behaviors that are of most concern to families and caregivers, and often result in restrictive levels of care. In contrast with those individuals with dementia, these populations are mostly younger individuals who do not have complicating medical conditions.

Specific treatment strategies have been developed for the assessment and treatment of agitation and aggression in this population, which have useful and direct implications for the care of agitation in the elderly. Careful assessment of the etiology of agitation, including the role of medications in producing or exacerbating the condition, and documentation of the behaviors is required. The pharmacotherapy of aggression is divided into two stages. Medications may be required for PRN use when there are acute or severe episodes of aggression, with the focus on the sedating properties of these medications. When agitation persists, long-term treatment should be with medications that alleviate these behaviors without significant deleterious effects on cognition or altertness. Trials of anticonvulsants, mood stabilizers, serotoninergic antidepressants, buspirone, beta blockers, and antipsychotic drugs have been found to be effective. The specific contribution of research experience in agitated neuropsychiatric populations to treatment approaches of agitated demented patients will be discussed.

No. 20E SUMMARY OF THE PRACTICE GUIDELINES

David A. Kahn, M.D., *Department of Psychiatry, Columbia Univ/Presb. Hospital, 180 Ft. Wash. Ave/Harkness Pav, New York NY 10032*

SUMMARY:

This presentation summarizes the Expert Consensus Practice Guideline for Agitation in Elderly Patients with Dementia. Guideline 1 describes the diagnostic algorithm used to point toward specific treatments. Clinicians are advised to follow a hierarchy proceeding from general medical factors including delirium, through medication-

induced mental status changes, and then to specific neuropsychiatric problems including psychosis, depression, anxiety, insomnia, sundowning, and finally a residual category of generalized agitation including aggression. Guideline 2 recommends that it is usually appropriate to combine medication and environmental strategies, with a few exceptions. Guideline 3 highlights the selection of different environmental strategies depending on the severity of agitation. Guideline 4 is the core psychopharmacology guideline, providing differential therapeutic strategies for the specific subtypes of problems mentioned in the first guideline. Guideline 5 deals with inadequate response to initial medication, including when and how to combine or switch medications. Guideline 6 describes principles for wise, long-term use of medication, including when and how to discontinue. Guideline 7 discusses selection based on safety and tolerability, particularly when there are comorbid general medical conditions. Guideline 8 describes expert preferences within classes of medication, and Guideline 9 provides guidelines for dosing in the initial and later phases of medication trials.

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SYMPOSIUM 21—THE BURDEN OF WORLD MENTAL HEALTH: THE WORLD HEALTH ORGANIZATION AND THE WORLD FEDERATION FOR MENTAL HEALTH RESPONSES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The goal of this symposium is to educate and familiarize participants with current global mental health problems and demonstrate WHO and WFMH responses to this health burden.

No. 21A
NATIONS FOR MENTAL HEALTH: TACKLING THE GLOBAL BURDEN OF MENTAL DISORDERS

Rachel Jenkins, M.D., *Health, Wellington House, 133-135 Waterloo Road, London S31 84G, United Kingdom*

SUMMARY:

The overall pattern of health needs across the world is undergoing very major changes. Noncommunicable diseases are fast replacing infectious diseases and malnutrition as the leading causes of disability and premature deaths in developing countries. Much evidence in the last few years of the massive global public health burden of mental health and related disorders that already exists has resulted in the launch of a UN collaborative initiative, led by WHO, and involving all UN agencies to improve the mental health of the world's underserved population. This initiative, "Nations for Mental Health," is raising the awareness of the world's policymakers, supporting countries, and preparing and implementing mental health policies and promoting international collaboration and technical support between countries about mental health programs and services.

This talk will describe the progress of the initiative so far, and will discuss the various elements of overall mental health policy that are needed to tackle disability and death from mental illness.

No. 21B
WORLD FEDERATION FOR MENTAL HEALTH IN WORLD MENTAL HEALTH: SCIENCE, CONSUMERS AND PROVIDERS

Marten W. deVries, M.D., *Department of Psychiatry, Maastricht University, PO Box 616, 6200 MD Maastricht 00220, Netherlands*

SUMMARY:

International agencies such as WFMH have realized that a significant part of the world health burden is due to mental health problems; research, interventions, and prevention of behavioral and mental health problems have been called for. WFMH has responded to this call by upgrading its grassroots organization to be more action oriented, regional responsive, scientifically informed, and interactive with the full range of partners in mental health. Collaborating centers, regional councils, programs, and activities in key areas such as prevention, the elderly, drugs, refugees, mental health advocacy, and human rights have been strengthened. Two important factors guide WFMH activities, one demographic and the other epidemiological. First of all, is the demographic shift in the world population toward a doubling of the population in areas of the world that are already underserved such as Africa and Asia. Secondly, the fact that most psychiatric illnesses are chronic and relapsing renders prevention imperative. Service and policy development in underserved areas together with WHO as well as worldwide prevention in both developed and underdeveloped countries, are some key WFMH priorities. Specific research and implementation projects in prevention, evaluation of care, and the development of a culturally- and person-sensitive knowledge base will be illustrated. This research and implementations are meant to effectively treat patients as well as being responsive to the local conditions contributing to mental illness and empowering the ill individuals toward seeking solutions to their own mental health.

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SYMPOSIUM 22—STRESS AND PERSONALITY DISORDERS
Joint Session With the Association for Research in Personality Disorders

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of the symposium the participant should be able to recognize different pathways of interaction between stress and personality and be familiar with some of the ongoing research in the area.

No. 22A
EFFECT OF TREATMENT OF PANIC ON PERSONALITY

Stefan Hofmann, Ph.D., *Department of Psychology, Boston University, 648 Beacon Street 6th Floor, Boston MA 02215;* David H. Barlow, Ph.D., M. Katherine Shear, M.D., Scott W. Woods, M.D., Jack M. Gorman, M.D.

SUMMARY:

This report examines the relationship between panic disorder symptoms and personality traits throughout a treatment process for panic disorder. Ninety-four patients with panic disorder and mild or no agoraphobia were treated for their panic disorder using either 11 weekly sessions of individual cognitive-behavioral therapy or imipramine, followed by six monthly maintenance sessions. The patients' panic disorder symptomatology was assessed before (pre-treatment) and after 11 weekly sessions (post-acute). In addition, patients were asked to fill out the Wisconsin Personality Disorders Inventory (WISPI) at pre-treatment, at post-acute, and after the six-month maintenance sessions (post-maintenance).

Multivariate analyses were conducted to study the changes in the 11 personality scales of the WISPI from pre-treatment to post-acute assessment to post-maintenance assessment. The results showed a significant reduction in the personality scales from the pre-treatment to post-acute assessment and from post-acute assessment to post-maintenance assessment. The responder status, treatment condition, or any of the interaction effects had no effect on the changes in personality traits from pre-treatment to the post-acute assessment ($p>.17$). These findings raise the possibility that the level of personality traits may covary with the treatment of panic disorder. This raises the questions of how this association affects treatment of panic disorder and eventual functioning.

No. 22B
PERSONALITY DYSFUNCTION APPEARING UNDER STRESS

James H. Reich, M.D., *2255 North Point Street, #102, San Francisco CA 94123*

SUMMARY:

Objective: It is known that certain measures of personality pathology measure an apparent increase in personality pathology when Axis I symptoms increase (for discussion purposes an "acute" personality disorder.) To better understand this phenomenon, those with "acute" personality disorders were compared with those with "longer term" personality disorders (those dysfunctional personality traits that have persisted for many years.)

Methods: Subjects were psychiatric outpatients. Those with longer term personality difficulties were identified by personality characteristics measured by the Personality Diagnostic Questionnaire (PDE). Those with "acute" personality disorders were identified on the Personality Diagnostic Questionnaire (PDQ) and the Millon Multiaxial Measurement Inventory (MCMI). Groups were compared on Axis I symptoms, personality variables, and family history.

Results: Different profiles for the two groups were found on Axis I symptoms, personality variables, and family history.

Conclusions: There appears to be a subset of patients who will develop "acute" personality disorders under the stress of an Axis I illness. This finding could have important treatment implications.

No. 22C
EARLY ABUSE, LATER PERSONALITY DISORDERS

David P. Berstein, Ph.D., *Department of Psychiatry, Bronx VAMC (116-A), 130 Kingsbridge Road, Bronx NY 10468*

SUMMARY:

Rationale: The goal of this study was to examine the impact of childhood trauma on personality disorders.

Methods: A total of 359 drug or alcohol dependent patients were given self-report inventories, including the Personality Diagnostic Questionnaire-Revised (PDQ-R) and the Childhood Trauma Questionnaire (CTQ), a reliable and valid retrospective measure of child abuse and neglect. The CTQ consists of five scales: physical, sexual, and emotional abuse, and physical and emotional neglect. Studies demonstrate that self-reports on the CTQ are highly stable over time and show good agreement with structured trauma interviews. Moreover, self-reports on the CTA have usually been confirmed, when independent corroborative data are available.

Results: Structural equation modeling (SEM) revealed several significant paths between child maltreatment variables and adult personality disorders. Child physical abuse and physical neglect were predictive of personality disorders characterized by aggression (antisocial and sadistic personality disorders). Child emotional abuse was predictive of personality disorders characterized by oddness (paranoid, schizotypal), emotional lability (histrionic, borderline, narcissistic), and anxiety (avoidant, dependent, obsessive-compulsive, and passive-aggressive). Child emotional neglect was predictive of schizoid personality disorder, which is characterized by emotional aloofness. Child sexual abuse was not significantly related to any personality disorder, a finding that may be attributable to the predominantly male sample.

Conclusions: These findings support the view that childhood trauma is associated with increased risk for personality disorders.

No. 22D
PTSD PREDISPOSING TO PERSONALITY DISORDERS

Charles R. Marmar, M.D., *Department of Psychiatry, VAMC (116-A), 4150 Clement Street, San Francisco CA 94143*

SUMMARY:

Objective: The nature of the relationship between personality disorders and the development of post-traumatic stress disorder (PTSD) is one that has been long debated in psychiatry. The major focus of this discussion has been whether there is a personality predisposition toward developing PTSD. However, there is another possible association. That is that, in certain cases, the stress of PTSD could predispose toward development of a personality disorder. This hypothesis is the focus of this report.

Methods: Case material on PTSD from the Veterans Administration Collaborative Center for the Study of PTSD in San Francisco was reviewed by an expert in the diagnosis and treatment of PTSD. A search was made for cases that appeared to have developed a personality disorder after PTSD.

Results: A number of cases appearing to fit the hypothesized link were found. Examples of these cases will be presented and key variables discussed.

Conclusions: There is preliminary support for the hypothesis that some PTSD patients develop a secondary personality disorder.

No. 22E
PERSONALITY AND STRESS AMONG YOUNG PHYSICIANS: A LONGITUDINAL STUDY

Per Vaglum, M.D., *Behavioral Sciences, University of Oslo, PO Box 1111 Blindern, Oslo N-0317, Norway;* Reidar Tyssen, M.D., Oivind Ekeberg, M.D., Nina Gronvold

SUMMARY:

The transition from medical school to internship represents a stressful event for most young physicians. Because most studies have been cross-sectional, it is still unclear whether and in what way personality is related to this increased stress (literature will be reviewed). This question is explored in a longitudinal study starting out with a nationwide representative sample of students in the last term (n = 522) and following them through internship and further on, using Job Stress Questionaire -20 (Cooper) at the end of the intern year, and Perceived Medical School Stress (PMSS) (Vitaliano), Ways of Coping Checklist, and SCL-5 in the last medical school term. Personality was measured by Basic Character Inventory (Torgersen). Of the four personality dimensions, only two were bivariately related to job stress: vulnerability (r = .38), and poor reality orientation (r = .26). Of the five coping subscales, four were related to job stress: problem focused coping (r = –.17), wishful thinking (r = .32), blaming oneself (r = .24), and avoidance (r = .19). Multivariate analyses showed that vulnerability was still independently related to later high job stress at the end of the internship when controlled for age, sex, ways of coping, and SCL-5 measured as student. Only wishful thinking among the coping variables was independently related to later high job stress when controlled for age, sex, and the personality variables. These and related findings have implications for prevention of a high experienced job stress among young physicians, and underlines the importance of focusing on personality variables.

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SYMPOSIUM 23—PERSONALITY: NEUROBIOLOGY AND LIFE EXPERIENCE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand how neurobiology and life experiences may each contribute to personality, and recognize various possible ways in which they interact.

No. 23A
NEUROMODULATORS AND DEVELOPMENT OF PERSONALITY DISORDERS

Larry J. Siever, M.D., *Department of Psychiatry, Mount Sinai School of Medicine, 1 Gustave L. Levy Place, New York NY 10029*

SUMMARY:

Individual differences in key brain systems modulated by neurotransmitters and hormones appear to play a critical role in personality disorder pathogenesis. For example, reduced efficiency of the serotonin system has been implicated in impulsive aggression in the personality disorders in neuroendocrine, imaging, and genetic studies. Abnormalities in cognitive organization associated with prefrontal and temporal cortical dysfunction and abnormal regulation of dopamine is central to the isolation and eccentricity of the schizophrenia spectrum personality disorders. Affective instability as reflected in heightened emotional reactivity to both pharmacologic and psychologic stimuli apparently mediated in limbic cortex is fundamental to the relational instability and rejection sensitivity of borderline and related personality disorders. Recent research into the neurobiologic underpinnings of these dimensions and their implications for psychosocial development and achievement of basic psychologic landmarks such as the capacity for trusting relationships, the mastery of aggression and separation issues, and the formation of mature identifications will be discussed. Possible interactions of genetic factors as well as environmental factors such as trauma will be presented in the context of new research from our laboratories suggesting altered relationships between serotonin and the hypothalamo-pituitary-adrenal (HPA) axis in relation to a history of sexual or physical abuse and neglect.

No. 23B
SEROTONIN-RELATED GENES AND IMPULSIVE AGGRESSION

Antonia S. New, M.D., *Department of Psychiatry, Mt. Sinai/Bronx VAMC, Box 116A, 130 West Kingsbridge Road, Bronx NY 10468;* Joel Gelernter, M.D., Robert L. Trestman, M.D., Harold W. Koenigsberg, M.D., Larry J. Siever, M.D.

SUMMARY:

Decreased serotonergic function has been associated with impulsive aggression in a number of populations as demonstrated by a range of measures from CSF 5-HIAA to challenge with serotonergic enhancing agents such as fenfluramine. As both twin and adoption studies suggest a partially heritable basis for irritable aggression, it is logical to investigate whether genetic differences in determinants of serotonergic function may contribute to different susceptibilities to impulsive aggression. Polymorphisms in human genes involved in serotonin functioning have been identified, including tryptophan hydroxylase (TPH) (Nielsen et al, 1994) and the serotonin transporter (SLC6A4) (Lesch et al, 1994). TPH: The "L" allele of a biallelic polymorphism in the TPH gene has been associated with reduced CSF 5-HIAA concentrations and a history of suicide attempts (Nielsen et

al, 1994). Our data suggest that the "LL" genotype is associated with higher scores on the Buss-Durkee Hostility Inventory (BDHI) in Caucasian personality disorder patients (45.3 ± 9.8) compared with those with the "UL" or "UU" genotypes (32.9 ± 13.5; t-2.38, df = 19; p < .03) in males but not in females. No significant association was found between the "LL" genotype and a history of suicide attempt. Patients with the "LL" genotype demonstrated nonsignificantly lower prolactin response to fenfluramine compared with the "UL" or "UU" genotypes (9.4 ± 5.0 vs 13.5 ± 10.3; n = 16, t = 1.05, df = 14; p = ns). HTT: A polymorphism in the serotonin transporter gene (SLC6A4), with allelic variation consisting of 9, 10, or 12 copies of a 17-base repeat, has been identified (Lesch et al., 1994). Pilot data in a population of Caucasian personality disorder patients about the relationship between SLC6A4 genotype and: (1) impulsive aggression (as measured by the BDHI), (2) anxiety related personality traits (as measured by the Tridimensional Personality Questionnaire), (3) suicide history, and (4) self-mutilation, will be presented. Our preliminary data suggest an association between the 10 repeat allele of SLC6A4 and clinical measures related to impulsive aggression in Caucasian patients with personality disorders. The identification of genes associated with impulsive aggression could elucidate specific mechanisms involved in these behaviors and lead to the development of targeted treatment strategies.

No. 23C
BIOLOGICAL AND PSYCHOSOCIAL CORRELATES OF AFFECTIVE INSTABILITY

Harold W. Koenigsberg, M.D., *Department of Psychiatry, Cornell Med Center/NY Hospital, 21 Bloomingdale Road, White Plains NY 10605*

SUMMARY:

In spite of its prevalence and powerful impact upon subjective experience and interpersonal functioning, affective instability, a core feature of the borderline personality disorder, remains a poorly characterized symptom. The term "affective instability" has been used to describe rapidly changing affect, unpredictable shifts of affective state, extreme excursions of affective intensity, impaired return of intense affect to baseline, and high reactivity to psychosocial stimuli. It remains unclear whether these features always cluster together, or separately characterize personality, affective, and neurologic disorders. Emerging evidence suggests that in the personality disorders affective instability may be influenced by neurobiologic regulatory mechanisms possibly involving cholinergic, noradrenergic, opioid, and hormonal systems. These dysregulations may be either inherited or acquired in response to life experiences. Attempts to cope with unstable affective systems may lead to intense efforts to maintain interpersonal attachments, as well as the use of self-mutilation or psychoactive substances for mood regulation. State-dependent learning processes may operate in persons with affective instability to generate starkly contradictory schemata of interpersonal relations and personal identity. This presentation will review evidence from challenge and neuro-imaging studies for neural mechanisms for affective instability and will examine the relationship between affective instability and identity disturbances.

No. 23D
THE PSYCHOBIOLOGY OF DEVELOPMENTAL TRAUMA

Bessel A. van der Kolk, M.D., *Department of Psychiatry, Boston University, 227 Babcock Street, Brookline MA 02146*

SUMMARY:

Early in life, caregivers play a critical role not only in buffering children against the impact of stressful situations, but in helping them build the biological capacities to deal with later stressors. As children mature, caregivers need to be less constantly and immediately available to help modulate their arousal: most children learn that coping with stress involves mobilizing the skills they have developed or asking for help when their own resources are insufficient. Adequate caregivers maintain optimal levels of physiological arousal: unresponsive or abusive parents may promote chronic hyperarousal, which may have enduring effects on children's ability to modulate strong emotions. Post-traumatic psychopathology involves repetitive involuntary re-living of the trauma (intrusions), inability to calm one's body (hyperarousal), and loss of capacity to engage in love and work with pleasure and zest (avoidance and numbing). Childhood trauma sets the stage for people meeting diagnostic criteria for trauma-related psychiatric disorders including borderline personality disorder, somatization disorder, dissociative and eating disorders, and substance abuse. Recent research has shown that as many as 80% of abused infants and children have disorganized/disoriented attachment patterns, and has begun to elucidate biological abnormalities in traumatized children and adults with histories of trauma—in cerebral lateralization, hormonal responses to stress, and sexual maturation. This presentation will critically review these findings and discuss their treatment implications.

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SYMPOSIUM 24—GENDER ISSUES IN CANCER TREATMENT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to: (1) understand gender-specific psychosocial issues resulting from cancer treatment in adolescents and adults; (2) recognize common medical, psychological, and social impact of cancer treatment; and (3) implement effective counseling strategies for cancer patients and their families.

No. 24A
ADOLESCENTS WITH CANCER: GENDER AND INTIMACY

Daniel Shapiro, Ph.D., *Department of Psychiatry, University of Arizona, Box 245002, North Campbell Ave, Tucson AZ 85224;* Joan Haase, Ph.D.

SUMMARY:

While survivors of adolescent malignancies appear to do as well as healthy peers following treatment in most spheres, long-term follow-up studies have noted that survivors marry at lower rates,

divorce more frequently, are less satisfied with intimate relationships, and may have less motivation to develop intimate relationships. These findings are likely explained by a variety of factors. We explore one here. We speculated that one untoward result of treatment is that adolescents may learn that they are resilient and need not rely on peers for information about their self-worth. As a result they may have more patience in developing and selecting intimate partners. Adolescents (n = 130) currently in treatment for malignancies were enrolled in a questionnaire-based study at four sites. Results supporting this supposition suggest that family cohesion, family adaptability, physical health, uncertainty of illness, and perceived effectiveness of coping were strong predictors of self-esteem, while satisfaction with peer support, as predicted, was not. Unlike healthy adolescents, adolescents with cancer do not appear to look to peers to inform their self-worth. Instead, in constructing their sense of self-esteem they appear to rely on their perceptions of how effectively they cope and on family and illness related variables. These results were consistent across gender groups.

No. 24B
COUNSELING MEN WITH TESTICULAR AND PROSTATE CANCER

Patricia P. Rieker, Ph.D., *Department of Sociology, Dana Farber Cancer Inst., 300 The Fenway, Boston MA 02115*

SUMMARY:

This paper discusses approaches to counseling men with testicular and prostate cancers. It is based on empirical data from both retrospective and prospective studies of quality of life outcomes after treatment for these cancers. While the peak incidence of the two cancers occur at very different stages across the adult male life cycle, the disease still interrupts personal and career goals for both groups. And, its very location threatens the integrity of the body and an organ that is associated with self-image, sexuality, and masculinity. But not all men are affected equally by the traumatic experience. The stresses perceived by the patient (and those close to him), and his available strategies for coping with the psychological challenges imposed by the disease and treatment complications, form the core of the psychosocial issues confronting each patient. Effective counseling depends on understanding the illness trajectory and four psychosocial domains: the context of patients' lives, the assault on the sense of self, the impact on intimate relationships, and treatment options and psychosexual effects.

No. 24C
SEQUELAE OF TREATMENT IN WOMEN'S CANCERS

Debra L. Fertig, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston MA 02115*

SUMMARY:

One of the many challenges facing a woman following treatment for breast or gynecological cancer involves adapting to the sequelae of surgery, radiation, and chemotherapy. Surgical scars and/or loss of a breast are constant reminders of a possible recurrence in the future, and can produce lasting effects on body image. Lymphedema and scarring resulting from radiotherapy can adversely affect quality of life. Menopause induced early through chemotherapy can be associated with symptoms of anxiety and depression. This paper examines the complex hormonal and psychological factors that are at play in a woman's adjustment to completion of treatment for cancer. New research and case examples are presented.

No. 24D
GROUP THERAPY THAT NARROWS THE GENDER GAP

Genevieve A. Mason, M.S.W., *Dana Farber Cancer Institute, 44 Binney Street, Room S119, Boston MA 02115*

SUMMARY:

In the medical arena, deeply rooted gender roles have had a significant impact on the unique ways in which women have mobilized to fight breast cancer and men have battled prostate cancer. Although the number of deaths each year is nearly the same for these sexually threatening diseases, breast cancer takes a huge lead in research funding over prostate cancer. Gender differences in thinking about our health, talking about our feelings, and social conditioning around our sexual ideals have been major factors influencing public awareness of these cancers. Fortunately, in response to results of women's activism, men in high-profile positions are speaking more openly about their experience with prostate cancer, testing, and treatment options.

Men with prostate cancer have come to appreciate the value of the women's "Y-Me" support group for breast cancer and use it as a model for their nationwide group "US-Too." The focus of this paper is on a psycho-educational support group for men with Advanced Prostate Cancer and the Women Who Love Them, which has been meeting monthly for two years. The group has challenged the gender-defined roles, as couples grapple with this life-threatening illness, and treatment that cuts to the core of "maleness."

No. 24E
GENDER ASPECTS OF MARITAL STRAIN IN ONCOLOGY

John R. Peteet, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston MA 02115-6195*

SUMMARY:

Cancer and its treatment often result in marital strain and may precipitate crises in vulnerable relationships, for example those that are immature, estranged, hostile-dependent, or abusive. Gender-specific issues that clinicians need to help address include financial inequality and potential coercion by the working partner, difficulties in handling the loss of gender-specific roles, competition in caring (e.g. between a wife and mother in law), problems in caring for young children (e.g. faced by a mother with terminal illness), difficulties in achieving effective support for male spouses, and partners' attitudinal differences in caring for and burdening each other. This paper will offer case examples to illustrate the roles that identity and other gender-related characteristics—not only sexual functioning and attractiveness—play in patients' and their partners' experiences of illness and treatment.

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SYMPOSIUM 25—CONUNDRUMS OF COMORBIDITY
Collaborative Session With the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) recognize the issues of etiology, assessment, and treatment of comorbid psychiatric disorders and substance abuse; (2) assess suitability for a variety of treatment approaches, and (3) implement appropriate pharmacological and/or psychosocial intervention.

No. 25A
TREATMENT OF PTSD AND SUBSTANCE USE DISORDERS

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

SUMMARY:

Recent data from both epidemiologic and studies of individuals in treatment indicate that post-traumatic stress disorder (PTSD) and substance use disorders commonly co-occur. Prevalence data from the studies addressing this issue will be presented. The appropriate treatment of individuals with comorbid PTSD and substance use disorders remains controversial. While one approach has been to defer treatment of trauma-related issues in individuals during substance abuse treatment, recent data indicate that untreated PTSD can worsen the course of substance use disorders. Data from clinical trials in individuals with PTSD indicate that exposure therapy is effective in individuals with PTSD who do not have a substance use disorder. Exposure therapies are thought to be contraindicated for substance users because of the belief that they may precipitate relapse. In this presentation, the controversies in the appropriate treatment of comorbid PTSD and substance use disorders will be discussed. The development of specific pharmacotherapeutic and psychotherapeutic treatment for individuals with comorbid substance use and PTSD will be described. Preliminary outcome data on the use of an exposure-based cognitive behavioral therapy manual for individuals with comorbid PTSD and cocaine dependence will be presented.

No. 25B
EVALUATION OF DEPRESSION IN SUBSTANCE ABUSERS

David M. McDowell, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York NY 10032;* Frances R. Levin, M.D., Edward V. Nunes, M.D., Angela Serracini, Ph.D., Herbert D. Kleber, M.D.

SUMMARY:

Drug and alcohol problems often exist alongside depression. This presentation will focus on the difficulties in treating individuals with both cocaine dependence and depression. Taking an accurate history is vital and should include: (1) precipitating events, (2) onset and pattern of drug use over the patients' lifetime, (3) positive and negative consequences of drug use for the patient, and (4) onset and course of psychiatric comorbidity in relation to course of substance use. It is often the patients with comorbid psychiatric symptoms who are the most difficult to keep abstinent. It has been hypothesized that features of the history and presentation can indicate if a comorbid condition is primary or independent of substance use and warrants specific treatment. These include: (1) depression that is chronologically primary, (2) depression that persists during past periods of abstinence, (3) chronic psychopathology, (4) emergence of depressive symptoms during periods of stable substance use, (5) positive family history of similar depression, and (6) uniqueness of the psychiatric symptoms. A flexible approach to the etiology of dual diagnosis is recommended, one that is open to the possibilities that either disorder may be primary or co-existing independently. Focus will be on treatment and etiology of this comorbidity.

No. 25C
DIAGNOSIS AND TREATMENT OF SUBSTANCE ABUSERS WITH ADHD

Frances R. Levin, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 66, New York NY 10032;* David M. McDowell, M.D., Suzette Evans, Ph.D., Herbert D. Kleber, M.D., Daniel J. Brooks, M.A.

SUMMARY:

Attention-deficit/hyperactivity disorder (ADHD) is a disorder characterized by inattention, hyperactivity, and impulsivity. Adults with ADHD are at greater risk for having a substance use disorder than adults who do not have additional psychopathology. Similarly, adult ADHD is overrepresented among substance abusers seeking treatment. The diagnostic assessment can be complicated by factors that may lead to both under- and over-diagnosis of the disorder. Some commonly asked questions include: (1) Should patients be considered to have ADHD if they cannot recall having ADHD prior to the age of 7 but can remember having impairing symptoms while in elementary school? (2) How can other psychiatric disorders, e.g., bipolar illness, be distinguished from adult ADHD? Approaches to handle such questions will be presented. Once the diagnosis is established, both targeted pharmacologic and nonpharmacologic treatment strategies may need to be implemented if this subgroup is to succeed in substance abuse treatment. An overview of these therapeutic approaches will be discussed. Further, the current controversies regarding the use of certain pharmacologic approaches for substance abusers with adult ADHD will be discussed.

No. 25D
OVERCOMING OBSTACLES FOR TREATING DUAL DISORDERS

Andrew L. Shaner, M.D., *Department of Psychiatry, Veterans Affairs Medical Cntr., 11301 Wilshire Blvd., B151Z, Los Angeles CA 90073;* Lisa J. Roberts, M.A., Thad Eckman, Ph.D., John W. Tsuang, M.D., Andrew P. Ho, M.D.

SUMMARY:

Developing treatments for dual disorders requires stepwise solution of a series of problems. Some of these problems are common to all dual disorders, while others are specific to the particular mental illness and substance abuse comorbidity. This presentation illustrates this problem solving approach by describing the development and testing of treatment for chronically psychotic stimulant abusers at a VA medical center. Among the common problems encountered were diagnostic heterogeneity, diagnostic uncertainty, traditionally separate mental health and substance abuse disciplines, and a high rate of clinical attrition. These were partially solved through the establishment of a treatment program with the following characteristics: (1)

dedicated to the target population; (2) clinical guidelines that tolerate diagnostic uncertainty; (3) simultaneous and integrated treatment of substance abuse and mental illness, and (4) use of assertive case management. Problems specific to the target population included learning deficits in chronically psychotic patients and disability income that facilitated monthly cycles of cocaine abuse and psychotic exacerbations. These problems have been partially solved by (1) modifying traditional cognitive-behavioral drug relapse prevention strategies using a skills training method originally developed to teach social and independent living skills to schizophrenics, (2) developing a close working relationship between clinicians and representative payees, and (3) using a variety of contingency management techniques.

No. 25E
COMORBIDITY AND OUTCOMES IN SUBSTANCE ABUSERS

John S. Cacciola, Ph.D., *Department of Psychiatry, University of Pennsylvania, 3900 Chestnut Street, Philadelphia PA 19104;* Arthur I. Alterman, Ph.D., Megan J. Rutherford, Ph.D., James R. McKay, Ph.D.

SUMMARY:

Studies have shown that substance abusers with comorbid nonsubstance use Axis I disorders or personality disorders have less favorable treatment outcomes than patients with substance use disorders alone. Considering only Axis I or Axis II diagnoses, as has been previously done, may have diminished the relationship of psychopathology to treatment outcomes in earlier work. The present investigation will examine the relationship of comorbid nonsubstance use psychiatric disorders, both Axis I and II, to six-month treatment outcomes in the following three samples: 290 patients entering methadone maintenance, 140 alcohol dependent men admitted to rehabilitation treatment, and 136 women admitted to treatment for cocaine dependence. It is hypothesized that there will be an ordering of outcomes related to the extent of diagnosed psychopathology. Specifically, patients with no additional psychiatric disorders will have the most favorable outcomes. Patients with either Axis I or Axis II disorders will have intermediate outcomes. Finally, in light of previous findings that antisocial, opiate-dependent patients with major depression have worse outcomes than those with antisocial personality disorder alone, outcomes of common diagnostic combinations will also be examined.

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SYMPOSIUM 26—CONTROVERSY IN CORRECTIONAL PSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the audience will (1) appreciate the impact of deinstitutionalization on mentally ill prisoners, (2) learn about the new ''punk'' prisons, and learn about (3) the impact of *Kansas v. Hendricks* on mental health systems.

No. 26A
MENTAL ILLNESS AND DELINQUENCY

Norman E. Alessi, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor MI 48109;* James Dillon, M.D., Euphemie A Brown, M.D.

SUMMARY:

The inception of juvenile courts in the United States early in this century closely paralleled the advent of the profession of child and adolescent psychiatry. Antisocial behavior among young people was thought to reflect psychological maladjustment to social adversity, managed better by the ministrations of therapeutic environments and psychotherapists than by the punitive arm of corrections. Epidemiologic data beginning with the Isle of Wight study would later show strong associations between conduct disturbances and individual traits of hyperactivity and inattention, while systematic studies among delinquents of so-called ''Axis I'' disorders revealed unexpectedly high rates of emotional disorder such as major depression.

Criminalization of younger offenders jeopardizes their access to increasingly effective mental health interventions. This presentation reviews the literature on the prevalence of psychiatric disorder among delinquent youth, with special emphasis on psychopathology for which effective treatments are available. It is argued that humane treatment of antisocial youth, whether in institutions formally designated civil or criminal, will continue to require substantial investments in mental health consultation, treatment, and research.

No. 26B
IMPLICATIONS OF MANDATORY STATUTES

Peter Ash, M.D., *Grady Memorial Hospital, P.O. Box 26238, Atlanta GA 30335*

SUMMARY:

The legislative responses to the striking increase in adolescent violence over the past decade have been in the direction of holding violent youth responsible as adults. Fifteen years ago, youth were generally waived to adult court only after a hearing in juvenile court in which the mental state of the adolescent and likelihood of rehabilitation were considered, an assessment that frequently required mental evaluation. In response to the wave of juvenile violent crime, by 1995 22 states had laws that automatically placed a juvenile in adult court, subject to adult penalties, for certain violent offenses, while many others had increased the number of crimes for which a juvenile could be waived at the discretion of the district attorney or following a judicial hearing. Implications for forensic psychiatry will be discussed: in adult court, classic forensic questions of competence to stand trial and insanity defenses become relevant. ''Due process'' in adult court tends to mean slow process when compared with juvenile proceedings, with unintended consequences such as

surprisingly low conviction rates. Rehabilitation and attendant mental health services are de-emphasized. There is some evidence that incarceration as an adult tends to increase recidivism rates.

No. 26C
PUNK PRISONS AND JUVENILE JUSTICE REFORM

Lee H. Rome, M.D., *3511 Bemis Road, Ypsilanti MI 48197*

SUMMARY:

Over the past few decades, there has been increasing public concern regarding violent crimes committed by juvenile offenders. This distress has been associated with an accelerating trend of legal jurisdictions to divert adolescent and pre-adolescent violent felony offenders from the juvenile justice system into the adult criminal justice system. Michigan is no exception; its Juvenile Justice Act of 1996 is representative of changes occurring in many states. As increasing numbers of younger offenders are tried as adults and sentenced to prison, forensic evaluation programs and correctional mental health programs are confronting a new set of challenges. The legal history of the juvenile justice system to its current evolution in Michigan will be reviewed. Discussion will include issues facing program supervisors and clinicians, such as informed consent; specialized screening, diagnostic, and treatment needs of this juvenile population; and specialized training, staff competency, and physical plant/custody resources requirements.

No. 26D
PSYCHIATRY, PREDATORS AND THE LAW

Melvin Guyer, Ph.D., *J.D., Child & Adol Psych Hosp., Univ. of Michigan Medical Ctr., 1500 East Medical Center Drive, Ann Arbor MI 48109*

SUMMARY:

This presentation will review the line of appellate cases dealing with the involuntary civil commitment of persons charged with criminal acts. The line of cases ends, for now, with *Kansas v Hendricks*, the 1997 Supreme Court case that finds permissible the indefinite civil incarceration of "sexually violent predators."

In reviewing the historical lineage leading up to *Hendricks*, we note that the tension between two opposing interests is always revisited: the liberty interest of the individual as a fundamental constitutional right is balanced against the avowed public need to protect the impaired and to advance public safety. How the balancing of individual liberties against the public's interest comes out is shown to be affected by the socially perceived heinousness of the individual's actions. It can be argued that psychiatry, in the service of this judicial balancing, is made to be the gatekeeper of the public good, for in deciding the proper mix of individual liberty as against the state's police power, the courts, albeit with some reluctance, turn to psychiatry to justify or assist in the setting of broad social policy.

The reluctance toward heavy reliance upon psychiatry by the courts is shown by the courts' continuing preoccupation with its assigned gatekeeper. The limitations of psychiatric diagnosis, the effectiveness of treatment interventions, and the validity of psychiatric predictions of dangerousness are routinely invoked on both sides of the judicial debate. In discussing the case law, we will examine the courts' ambivalent and differing views of psychiatry, as well as the profession's own varying claims of its gatekeeper competency.

No. 26E
IMPLICATIONS OF SEXUAL PREDATOR LAWS

Lee H. Rome, M.D., *3511 Bemis Road, Ypsilanti MI 48197*

SUMMARY:

The recent *Kansas v. Hendricks* U.S. Supreme Court decision has significant implications for forensic and correctional mental health programs. The *Hendricks* decision upheld the Kansas Sexually Violent Predator Act, which established procedures for the civil commitment of persons who due to a "mental abnormality" or a "personality disorder" are likely to engage in "predatory acts of sexual violence." Similar laws allowing the post-prison sentence commitment of non-mentally ill sex offenders are in place or being proposed in other states. This legal approach of indefinite incapacitation of sex offenders in part serves as a substitute for long-term, front-end indeterminate prison sentences, which many criminal justice systems abandoned in the past. Potential issues include diversion of resources from mentally ill patients requiring treatment in forensic and correctional mental health programs; future broadening of this precedent to other non-mentally ill, predatory persons committing non-sexual crimes; and ethical, clinical, training, and resource concerns for clinicians regarding treatment and court testimony. Legal history and sex offender typology and treatment will be reviewed along with strategies for program supervisors and front-line clinical staff.

No. 26F
TREATMENT OF SEXUAL PREDATORS AFTER THE SUPREME COURT RULING ON KANSAS VERSUS HENDRICKS

Gene G. Abel, M.D., *Behav Med Inst of Atlanta, Suite T-30 West Wing, 3280 Howell Mill Road, NW, Atlanta GA 30327*

SUMMARY:

The recent *Kansas v. Hendricks* decision will place psychiatrists in a pivotal role involving the assessment and treatment of sexual predators. The most current evaluation and treatment methods will be outlined with specific references to (1) methods to predict recidivism, (2) visual reaction time and plethysmography as methods of assessing interest in sexual violence, (3) the treatment components of cognitive-behavioral treatment with relapse prevention, (4) the advantages and disadvantages of specific serotonin reuptake inhibitor and hormonal treatments for sexual predators, and, (5) how to access clinicians already skilled in the assessment and treatment of sexual predators.

No. 26G
CRIMINALIZATION OF THE MENTALLY ILL: IS IT SUCH A BAD IDEA?

James E. Dillon, M.D., *Child & Adol Psych Hosp., Univ. of Michigan Medical Ctr., 1500 East Medical Center Drive, Ann Arbor MI 48109*

SUMMARY:

Important social forces have virtually banished the mentally ill from state hospitals. The community mental health movement held that the mentally ill could be treated more effectively in community settings than in asylums. The civil liberties movement, stoked in the embers of racial desegregation but soon emerging as a mental health inferno in its own right, produced another assault on institutional psychiatry. Patients became legal adversaries, while regulators propelled hospital budgets to levels assuring spontaneous combustion. The *coup de grace* was the growth of managed health care, beginning in the private sector but soon catching fire in academic centers and public mental health systems. Result? Increasingly, the pathetic

refuse of good intentions run amok is finding a home on the wrong side of barbed-wire fences.

Many would see this outcome as tragic. But is it necessarily so? This presentation will argue that, at least in principle, penal institutions need not be wholly adverse environments, and that for individuals who require "structure" to function optimally, they can hardly be surpassed. Effective mental health care *is* being delivered behind prison walls, under conditions that are remarkably similar to those of traditional psychiatric institutions. Expansion of compassionate treatment and humane living conditions within correctional settings may prove the path of least resistance in achieving traditional aims of both mental health treatment and the criminal law.

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SYMPOSIUM 27—EMERGING TRENDS IN THE TREATMENT OF DEMENTIA

EDUCATION OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation the participant will be able to describe the emerging treatments for the cognitive impairment and behavior disturbances of dementia.

No. 27A
HORIZON DRUGS AND THE CONCEPT OF EXCESS DISABILITY

Gary J. Kennedy, M.D., *Department of Psychiatry, Montefiore Medical Center, 111 East 210th Street, Bronx NY 10467*

SUMMARY:

The prospects for either curing or preventing dementia remain elusive. Nonetheless the introduction of psychopharmacologic agents with low levels of toxicity presages a new horizon for the symptomatic treatment of the dementias. Added to the newer antidepressants and antipsychotics, which reduce the psychological and behavioral symptoms of dementia, are cognitive (cholinergic) enhancers, which have modest but measurable effects on measures of mental function. The use of antioxidants to reduce the disability of dementia despite having little effect on cognition has demonstrated the value of broadening effectiveness criteria beyond increased cognitive performance. As a reduction in disability became the focus of study, it was recognized that later stages of dementia should not preclude patient participation. Thus, the functional impairment of dementia, once thought to be intractable, may indeed be seen in the short run to be excess or modifiable disability. Even a modest delay in the loss of personal autonomy has substantial social implications given the prevalence of the illness and the increasing number or persons at risk. The greater costs of newer pharmacologic agents may well be offset by forestalling the onset of home care services or nursing home admission. The less tangible benefits to the patient and family, in short having time to adjust and prepare, are no less substantial. When coupled with the concept of excess (avoidable) disability, newer medications on the horizon promise a genuinely comprehensive approach to the symptomatic treatment of dementia.

No. 27B
ESTROGEN REPLACEMENT THERAPY FOR DEMENTIA: PROPHYLAXIS OR REPAIR?

Gary J. Kennedy, M.D., *Department of Psychiatry, Montefiore Medical Center, 111 East 210th Street, Bronx NY 10467*

SUMMARY:

Estrogen replacement therapy reduces menopausal vulvovaginal atrophic changes, osteoporosis, vasomotor disturbances, insomnia, and lowers the risk of myocardial infarction, stroke, and cardiovascular death among women. Thus, the somatic benefits of estrogen replacement for a sizable number of women without contraindications may well outweigh the risks. However, the potential of estrogen to combat late-life mental illness is more difficult to support. Animal studies indicate that estrogen affects synaptic plasticity and participates in the regulation of cholinergic function. Epidemiologic evidence suggests that replacement therapy with estrogen may prevent dementia or delay the progression of cognitive decline. Estrogen may also improve verbal memory in nondemented post-menopausal women. And long-term hormonal replacement may also decease the risk of depressive symptoms after age 60. Although the central nervous system benefits of estrogen are not well substantiated, the use of estrogen by older women without neoplastic or thromboembolic risk factors as adjunctive treatment for depression or dementia seems reasonable. Nonetheless, as more women pursue the benefits of estrogen, the frequency of adverse reactions will increase even if the percentage remains low. A better appreciation of the value of estrogen will emerge from the Women's Health Initiative, sponsored by the National Institute of Health. Presently physicians who consider recommending estrogen must rely on case reports and epidemiologic inference.

No. 27C
COGNITIVE ENHANCERS IN THE CLINIC AND ON THE HORIZON

Trey Sunderland, M.D., *Dept. of Geriatric Psych., Nat'l Inst. of Mental Health, 10 Center Dr. MSC1264, 10-3D41, Bethesda MD 20892*

SUMMARY:

With the recent increase in pharmaceutical development in Alzheimer's disease (AD) research comes renewed excitement and the need to classify the various types of treatment approaches. The two FDA-approved drugs tacrine and donexepil cholinesterase inhibitors are generally considered **symptomatic drugs** with relatively short-term effects, although the long-term effects on the course of illness are yet to be carefully studied. Given the success of these initial cholinesterase inhibitors, there are now several other similar cholinergic agents in various stages of scientific and administrative review for clinical use. In addition, testing the therapeutic effects of other symptomatic drugs on the noncognitive aspects of AD is still under development within research centers around the world. Another treatment approach currently under investigation for cognitive impairment is the attempt to modify the course of illness, either to delay the onset of illness in at-risk subjects or slow the rate of deterioration in affected individuals. Drug classes being tested in preclinical and clinical settings include antiinflammatory agents, hormonal replacement, antioxidants, and growth factors. Even more speculative is the possibility of preventative or curative therapy. While this goal may seem far-fetched given the current state of the clinical art, the underlying molecular biology of AD is advancing rapidly. Since known

genetic mutations identified in numerous AD families account for only a small percentage of the total demographic epidemic, it is possible that many other additional genes or a generalizable mechanism of neuronal destruction will be discovered. In either case, drug development strategies to block specific genes or common post-translational gene products may well be a future treatment approach. Furthermore, it is possible that such a devastating neurodegenerative disorder as AD will require combinations of drug treatment approaches across several categories (i.e., cholinesterase inhibitors plus modifying drugs and preventative agents when available) to achieve synergistic effects in long-term therapeutic studies. The prospect of such longitudinal combination studies on the therapeutic horizon presents both scientific and ethical dilemmas that are just beginning to be addressed in AD research.

No. 27D
ANTIPSYCHOTICS IN THE TREATMENT OF DEMENTIA COMPLICATED BY PSYCHOSIS

Davangere P. Devanand, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 722 West 168th Street, Box 72, New York NY 10032-2603;* Kristin Michaels, M.A., Harold A. Sackeim, Ph.D., Karen Marder, M.D., Richard P. Mayeux, M.D.

SUMMARY:

Patients with Alzheimer's disease (AD) often develop behavioral disturbance, e.g., agitation, or psychotic features, e.g., delusions. There are limited extant data with typical neuroleptics in this patient population. Prior meta-analyses of these few studies suggest moderate efficacy for this class of medications. This efficacy applies to both symptoms of psychosis and behavioral changes, and there is a lack of clear evidence to indicate that neuroleptics are more specific for the treatment of psychosis compared with behavioral changes like aggression and agitation.

In an initial pilot study, we found that doses of haloperidol above 4–5 mg daily could not be tolerated due to extrapyramidal side effects (EPS). In a subsequent double-blind study, haloperidol in doses of 2–3 mg daily was more efficacious than both haloperidol 0.5 to 0.75 mg daily and placebo, which were indistinguishable from each other on measures of both efficacy and side effects. In this study, symptoms of agitation and aggression responded as well as symptoms of delusions and hallucinations. Approximately one-fourth of the AD sample on the higher dose (2–3 mg daily) developed moderate to severe EPS, but there were no clear predictors of patient susceptibility to EPS. Based on these findings, a starting dose of haloperidol 1 mg daily is recommended, with gradual, upward dose titration while assessing target symptoms and monitoring side effects. Currently, differential side effect profiles tend to determine the choice of neuroleptic, e.g., atypical neuroleptics like risperidone or olanzapine may be preferred in patients at risk for EPS, and high potency neuroleptics like haloperidol may be preferred in patients at risk for orthostatic hypotension, which can lead to falls and fractures.

No. 27E
COMORBIDITY OF DEPRESSION IN DEMENTIA

Patricia Parmelee, Ph.D., *Dept. of Epidemiology, Univ. of Pennsylvania, 733 Blockley Hall, Philadelphia PA 19104*

SUMMARY:

After a great deal of debate about the separability of depression and dementia, it is now clear that the two are distinct but intricately interrelated disorders. An emerging literature suggests that depressions occurring in the presence of cognitive dysfunction differ qualitatively and quantitatively from those observed in cognitively intact individuals. Similarly, among demented persons, the prevalence, etiology, and prognosis of depression vary as a function of type and stage of dementing illness. This presentation uses a review of the current literature on these issues to introduce a data-based exploration of the structure and prognosis of depression among demented and nondemented long-term care patients. Responses of 469 skilled nursing home and congregate apartment residents (199 cognitively impaired, 270 cognitively intact) to a DSM-IV checklist of depressive symptoms were factor analyzed separately to examine the structure of depression. Clearly different factor structures emerged, suggesting a more unitary mood disturbance in the intact group, as compared with clearer differentiation of depression and anxiety in cognitively impaired individuals. Additional analyses address the differential associations of these factors with physical health and functioning. Baseline and one-year follow-up data will be used to document the association of cognitive status with prevalence, incidence, and course of depression, illustrating the greater variability of depressive syndromes among demented as opposed to intact individuals. Results are discussed in terms of generalizability and implications for treatment.

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SYMPOSIUM 28—THE CHANGING ROLE OF PSYCHIATRISTS IN THE HOSPITAL
APA Consultation Service Board

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) recognize the challenges in the relationship between psychiatrists and hospitals; (2) appreciate the evolution in the roles for psychiatrists and hospitals; (3) position themselves to survive and prosper in this era of cost containment and accountability.

No. 28A
THE CHANGING ROLE OF CLINICIANS IN HOSPITALS

Benjamin Liptzin, M.D., *Department of Psychiatry, Baystate Medical Center, 140 High Street, Springfield MA 01199-0001*

SUMMARY:

This paper will address how managed care is affecting the role of psychiatrists as clinicians in hospitals. As reimbursement shrinks and paperwork and other overhead expands, clinicians find them-

selves working harder just to stay even. Job security is undermined by fiscal pressures and fee schedules that don't reflect the training, experience, and expertise of psychiatrists compared with other clinicians (e.g. MSW's or MSN's with prescribing privileges). Various strategies for coping with the pressures of hospital-based practice will be described.

No. 28B
EMPLOYEE TO PARTNER: HOSPITAL PSYCHIATRIST IN TRANSITION

Steven S. Sharfstein, M.D., *Sheppard Pratt, 6501 N. Charles Street, Baltimore MD 21285*

SUMMARY:

For over 100 years, Sheppard and Enoch Pratt Hospital was a "closed medical staff," with psychiatrists as employees. In the era of fee-for-service retrospective reimbursement and long average lengths of stay, this worked well for the hospital and for the approximately 40 employed physicians who were able to treat patients during the inpatient stay and then discharge these patients into their "private" outpatient practice. Decision-making was top-down, paternalistic, and the medical staff, although called "the active medical staff," was dubbed "passive" with monthly medical staff meetings noteworthy for a lack of aggressive participation in hospital or clinical policies. With the advent of the new medical marketplace, new contracts with physicians were renegotiated based on a productivity model called "relative value units." More recently, in a contentious and more active process, contracts were again renegotiated based on a "percentage of collections." Private practice independent of the hospital was no longer permitted. Negotiations have begun with senior clinicians interested in an equity partnership with the hospital so that contracts in the public and private sector based on prospective payment and capitation would grow and new approaches to the treatment of mental illness and substance abuse would develop. This paper will describe this extraordinary change.

No. 28C
THE PSYCHIATRIST AS EMPLOYER AND ACADEMICIAN

Sheldon I. Miller, M.D., *Department of Psychiatry, Northwest Memorial Hospital, 303 East Superior, Chicago IL 60611-3015*

SUMMARY:

The chairman of an academic department of psychiatry confronts a split responsibility between maintaining a fiscally responsible practice plan and an academically productive department. In the past, these two missions worked in concert; now they are in conflict. How do you maintain a faculty in the face of these increasingly conflicting tasks? In this presentation, this conflict will be explored and clarified and suggestions will be made to help psychiatrists managed.

No. 28D
THE PSYCHIATRIST AS EMPLOYER OR ORGANIZATION MAN

Peter J. Panzarino, Jr., M.D., *Chairman Dept of Psych, Cedars Sinai Medical Center, 8730 Alden Dr Ste TH-C306, Los Angeles CA 90048*

SUMMARY:

Physicians, in general, and psychiatrists, in particular, have traditionally functioned relatively autonomously. They were most concerned with the needs of their patients and their professional values and integrity. Their financial success and security was based on the quality of care delivered as judged by their patients and their families, and referral sources in the community.

As a member of a paid hospital medical staff, or staff model medical group, psychiatrists are also employees. Often they report to nonphysicians who may be younger, less experienced, less knowledgeable about medicine, and who may share different values. The question of how to function in an organization—how this creates ethical and value conflicts—causes great anxiety for the employed psychiatrist. Resolving the inherent conflicts of the employed physician requires a letting go of some past notions and creating a new self-esteem paradigm based on a renewed commitment to professional values within an organizational content.

No. 28E
THE PSYCHIATRIST AS TEACHER

Robert Michels, M.D., *Department of Psychiatry, Cornell Medical College, 525 East 68th Street, Box 170, New York NY 10021*

SUMMARY:

As the role of the psychiatric hospital in the practice of psychiatry has changed, the role of the psychiatrist educator working in the hospital must change as well. The hospital is no longer the setting for the care and treatment of most patients, but rather a site of brief episodes in the extended course of such care. As a corollary, clinical education, once largely based in the hospital, must shift to accompany the patient through the multiple settings of contemporary psychiatry. Modern psychiatric educators may work in hospitals, but they must work outside of hospitals as well, or the training they provide will be fragmented and discontinuous.

They must also be alert to the role of the health care system, with its powerful and at times intrusive regulation, oversight, and control, in shaping not only the patient's treatment but also the student's experience. Apprentice psychiatrists are acutely aware, often preoccupied, with the social and economic context of their clinical work. The psychiatric educator, working inside and outside of the psychiatric hospital, must embody the core values and knowledge of the profession while being sensitive to the changing context and its impact on students.

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3. Morgan W. McCall JR MW, Clair JA: Why physician managers fail—part one, Physician Executive, May-June 1990; pp 6–10.
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SYMPOSIUM 29—BIOLOGICAL RHYTHMS: NEW FRONTIER FOR PSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: diagnose, understand, and treat biological rhythm disorders that psychiatrists encounter.

No. 29A
SEASONALITY OF MOOD AND RELATED SYMPTOMS

Anthony J. Levitt, M.D., *Department of Psychiatry, Sunnybrook Hospital, 2075 Bayview Avenue, North York ON M4N 3M5, Canada;* Michael Boyle, M.S.W.

SUMMARY:

Community surveys have consistently demonstrated that depressive symptoms vary with the seasons, and this effect diminishes with age, is more pronounced in females, and increases with increasing latitude. All these community surveys have used the Seasonal Pattern Assessment Questionnaire (SPAQ) to evaluate changes in depressive symptoms across the seasons. However, the SPAQ is not designed to evaluate all nine DSM-IV criteria for depression. The current study used the Depression and Seasonality Interview (DSI), an interview designed to be administered by phone, and to examine not only the seasonal change in all nine depressive criteria, but also the possible pathological nature of these symptoms. This study sampled the Province of Ontario, Canada, across eight strata of 1 degree of latitude each (42°N–50°N), with equal sampling across strata. Random digit dialing of phone numbers from the Ontario teledirect directory was used to ascertain the study sample. From 2,078 eligible households contacted, 1,605 subjects completed the interview. Using Pearson correlation coefficients, age was significantly ($r = -.1$ to $-.2$, $p < .0001$ for all) negatively correlated with seasonal severity of all depressive symptoms except suicidal ideation. However, only severity of "energy" change with the seasons was significantly correlated with latitude ($r = -.05$, $p < .05$); that is, with increasing latitude, severity of change in energy declined. Using t-tests, severity scores were significantly higher in females ($t = 2.5$ to 5.3, all $p < .01$) for all symptoms except suicidal ideation, concentration, and sleep. These findings suggest that, while age and gender are powerful determinants of seasonal behavior, latitude, at least from 42 to 50 degrees north, is not.

No. 29B
CIRCADIAN ALTERATIONS IN PREMENSTRUAL DYSPHORIC DISORDER

Barbara L. Parry, M.D., *Department of Psychiatry, University of California, 9500 Gilman Drive, La Jolla CA 92093;* Richard L. Hauger, M.D., J. Christian Gillin, M.D., Jeffrey Elliott, Ph.D.

SUMMARY:

Disturbances in circadian rhythms may contribute to the symptoms of premenstrual dysphoric disorder (PMDD). One of the best markers for circadian rhythmicity in humans is melatonin. Our laboratory has measured the plasma nocturnal melatonin profile in patients with PMDD. Compared with normal control subjects, PMDD patients have blunted rhythms and altered timing disturbances, particularly in the offset time of melatonin secretion. When pulsed with bright morning light to test the hypothesis that these decreased melatonin levels (a finding that was replicated in a larger sample size) reflect disturbances in the underlying circadian pacemaker, we found that PMDD patients compared with controls, had a blunted phase-advance response in melatonin offset time during the symptomatic luteal, but not the asymptomatic follicular phase. This suggests a maladaptive response to the critical timing cue of bright morning light. Such a lack of responsiveness may contribute to desynchronization of biological rhythms in these patients, and thereby to mood disturbances. Therapeutic interventions of light and sleep deprivation, by enhancing environmental input to the circadian clock (zeitgebers), have improved mood in these patients, and the findings are replicated in independent studies. Other circadian neuroendocrine effects (on prolactin, TSH, cortisol) of these interventions will be reviewed.

No. 29C
SEROTONIN AND SAD: IMPLICATIONS FOR TREATMENT

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

SUMMARY:

Seasonal affective disorder (SAD) is a depressive subtype characterized by recurrent major depressive episodes in the fall and winter, and spontaneous remissions in the spring and summer. A total of 15% to 20% of patients with mood disorders have a seasonal pattern, and up to 5% of the general population may have significant functional impairment in winter because of SAD. Bright light therapy and antidepressant medications are effective in treating SAD, but the etiology of SAD and the mechanism of action of light therapy remain elusive. One major theory of SAD is the serotonin hypothesis. This presentation will focus on the converging evidence for serotonergic dysregulation in SAD, including studies of seasonal variability in serotonin metabolism, specificity of atypical depressive symptoms, neuroendocrine data, and treatment using serotonergic drugs in SAD. Results from our recent studies of SSRI antidepressants, serotonin challenge tests, rapid tryptophan depletion in light therapy, and tryptophan augmentation of light therapy will be presented. Implications of a serotonin hypothesis for the clinical treatment of SAD (and other "serotonin" conditions such as bulimia nervosa and premenstrual depression), both with light therapy and medications, will be discussed.

No. 29D
SHIFTING CIRCADIAN PHASE USING LIGHT AND MELATONIN

Alfred J. Lewy, M.D., *Department of Psychiatry, Oregon Hlth Science University, 3181 SW Sam Jackson Park Road, Portland OR 97201-3098;* Neil L. Cutler, B.A., Robert L. Sack, M.D.

SUMMARY:

There are two types of circadian phase disorders, the phase-advanced type and the phase-delayed type. Advanced sleep phase syndrome and east-to-west jet lag are of the phase-advanced type. Delayed sleep phase syndrome, west-to-east jet lag and winter depression are of the phase-delayed type. Shift workers also suffer from one or the other of these types of circadian phase disorders, depending on adjusting to or adjusting from the work schedule. Research is ongoing in the treatment of these disorders using appropriately timed bright light exposure and melatonin administration. These treatments are best scheduled based on the light and melatonin phase response curves according to circadian time (CT). CT is most accurately determined by measuring the onset of endogenous melatonin production under dim light conditions (DLMO), which marks CT 14. Under entrained (steady-state) conditions, sleep offset is CT 0 and sleep onset is CT 16. Bright light causes phase advances when scheduled between CT 18 and CT 6; it causes phase delays when scheduled between CT 6 and CT 18. Melatonin causes phase advances when administered between CT 6 and CT 18; it causes phase delays when administered between CT 18 and CT 6.

No. 29E
HOW DOES LIGHT REGULATE BODY AND BRAIN?

Dan A. Oren, M.D., *Department of Psychiatry, Yale University, 950 Campbell Avenue/MS 116-A, West Haven CT 06516;* Robert M. Berman, M.D., Amit Anand, M.D., Angela C. Cappiello, M.D., Dennis S. Charney, M.D.

SUMMARY:

The finding that light could suppress melatonin production in people and the rediscovery that light could successfully treat winter depression have stimulated much research into understanding the mechanisms by which light regulates human physiology. These findings assume further significance in the context of a theoretical model of light-energy absorption by humoral components and novel empirical data demonstrating that light can reset biological rhythms in humans completely independent of retinal neurons. This primer of physiology will provide a basic understanding of photobiology—a subject rarely taught in medical schools—that will prove critical to the understanding of the mechanisms of light therapy for depression, and may elucidate the mechanisms of the antidepressant effects of novel gaseous neurotransmitters such as nitric oxide and carbon monoxide. Evidence of nonvisual transmission of light signals to the brain in animals and humans and evidence of abnormal chromophores (light-absorbing molecules) in the blood of some patients with winter depression will be reviewed.

REFERENCES:

1. Rosen L, Targum S, Terman M, et al: Prevalence of seasonal affective disorder at four latitudes. Psychiatry Research 31:131–144, 1989.
2. Parry BL, et al: Blunted phase-shift responses to morning bright light. J Biological Rhythms 12(5):443–456, 1997.
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4. Lewy AJ, Sack RL: Exogenous melatonin's phase shifting effects on the endogenous melatonin profile in sighted humans: a brief review and critique of the literature. Journal of Biological Rhythms in press.
5. Oren DA: Humoral phototransduction: blood is a messenger. The Neuroscientist 2:207–210, 1996.

SYMPOSIUM 30—FAMILY VIOLENCE AND PSYCHIATRY: CANADA AND THE UNITED STATES

Joint Session With the United States Department of Justice and the APA Committee on Family Violence and Sexual Abuse

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants will have increased knowledge of laws in both the U.S. and Canada that pertain to clinic responsibility and patient rights regarding violent families. An increased understanding will take place regarding methods to implement and fund psychiatric services for violent families in both countries.

No. 30A
CANADIAN LAW: PSYCHIATRY AND FAMILY VIOLENCE

Prof. Alison Harvison Young, *Faculty of Law, McGill University, Law Inst., 3644 Peel Street, Montreal PQ H3A 1IW9, Canada*

SUMMARY:

This paper will present current legislation in Canada that pertains to family violence and psychiatric responsibilities and the rights of members of families with violence.

No. 30B
UNITED STATES LEGAL REFORMS ON CHILD AND FAMILY VIOLENCE

Howard A. Davison, J.D., *Centerfor Children, American Bar Association, 740 15th Street N.W., Washington DC 20005*

SUMMARY:

This presentation will describe recent laws in the U.S. that affect the practice of psychiatrists in cases involving child abuse, child sexual exploitation, and domestic violence. The role of the psychiatrist in criminal, juvenile, and domestic violence court proceedings will be discussed. Relevant federal and state legislation will be explained.

No. 30C
CHILD ABUSE: A REVIEW OF CANADIAN STUDIES

David A. Wolfe, Ph.D., *Department of Psychology, University of Western Ontario, London ON N A SC2, Canada*

SUMMARY:

Canadian research on the treatment of child physical and sexual abuse will be reviewed, focusing on the last five years. Emphasis across the country has turned toward prevention and early intervention, which will be the focus of this presentation. The following four areas of prevention/intervention work will be discussed:
(1) home visitations for high-risk parents and young children, especially aimed at physical abuse and neglect;
(2) court preparation and short-term stress reduction intervention for sexually abused children testifying before the court.
(3) group intervention programs for children who witness domestic violence.
(4) intensive group programs for adolescents from violent families to prevent dating violence and relationship abuse.

Recent published and emerging data from these four areas will be the topic of this presentation.

No. 30D
UNITED STATES TREATMENT OUTCOME STUDIES

William M. Friedrich, Ph.D., *Department of Psychiatry, Mayo Clinic, 200 Firsts Street S.W., Rochester MN 55905*

SUMMARY:

The available treatment studies that have addressed the impact of physical abuse and sexual abuse in children will be examined. The studies reviewed satisfy a number of research criteria including the utilization of a comparison sample, validated at treatment outcome measures, the provision of a designated treatment intervention, etc. The multiproblem nature of these families, including the need to address a number of treatment foci, will be outlined as well as guidelines for future research and intervention.

No. 30E
FUNDING FOR THE FAMILY VIOLENCE SERVICE IN THE UNITED STATES: OFFICE FOR CRIME VICTIMS

Carolyn A. Hightower, *Victims of Crime, US Department of Justice, 633 Indiana Avenue, NW, Washington DC 20531;* Joye Whatley

SUMMARY:

This paper will present a summary of federal funding available to support victim assistance and compensation programs in the United States. The Office for Victims of Crime formula for discretionary

grants for victims service programs, training for professionals to work with victims, and programs for enhancing victims rights will be described.

The Crime Victims Fund distribution by the Office for Victims of Crime will also be discussed. Educational sponsorship by this office for mental health professionals will be summarized.

Finally, discretionary grants will be discussed, as will the functions of the Office for Victims of Crime Trainers Bureau and Resource Center.

No. 30F
FUNDING FOR THE VIOLENCE SERVICE IN CANADA: CAVEAT (CANADIANS AGAINST VIOLENCE EVERYWHERE ADVOCATING ITS TERMINATION)

Dr. Priscilla de Villiers, *President, CAVEAT, 3350 Fairview Street Ste 3164, Berlington ON L7N 3L5, Canada*

SUMMARY:

The president of CAVEAT (Canadians Against Violence Everywhere Advocating Its Termination) will present funding sources available in Canada for victims of family violence and their respective families. She will discuss the utilization of such funds for mental health services and program development. Canadian family violence training initiatives and funding mechanisms for such training will also be presented.

REFERENCES:

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2. Family Violence: A Clinical and Legal Guide. Edited by Kaplan SJ. Washington, D.C., American Psychiatric Press, Inc. 1996.
3. Krugman R: The Battered Child, 5th edition, Univ of Chicago Press, 1997.
4. Wolfe D, Repucci ND, Hart S: Child abuse prevention: knowledge and priorities. J. Clinical Child Psychology 24:(suppl), 1995.
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SYMPOSIUM 31—MODELS OF MANAGED CARE IN THE PUBLIC SECTOR
APA Consortium on Organized Service Systems

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium the participant will be familiar with and understand the advantages and drawbacks of various different models of managed care currently in use in the public sector.

No. 31A
MARYLAND'S PUBLIC MENTAL HEALTH SYSTEM

Billy E. Jones, M.D., *Maryland Health Partners, 7172 Columbia Gateway Drive, Columbia MD 21046;* Brian M. Hepburn, M.D., Karen A. Oliver, Ph.D., Marilyn L. Martin, M.D.

SUMMARY:

Maryland implemented the statewide Medicaid 1115 waiver program, HealthChoice, in June 1997. Mental health services will be delivered through "carve-out" as part of a new publicly managed mental health system. The Public Mental Health System (PMHS) goes beyond Medicaid to manage all public mental health funds under one unified system. The mental health carve-out does not include substance abuse services and is the only substantial services carve-out in HealthChoice.

The PMHS system was conceptualized and promoted by the leadership of the Mental Hygiene Administration (MHA) in conjunction with Maryland's regional mental health planning and monitoring organizations, the Core Service Agencies (CSA's). The CSA's will manage the system at the regional level with funds allocated from the MHA for service provision. The MHA has contracted with Maryland Health Partners, a partnership of Green Spring Health Services Inc. and CMG Health Inc., to provide administrative services. In contrast with many other state behavioral health company contracts, MHP will not provide or take on financial risk for services, and thus has no incentive to deny care. This fee-for-service publicly managed system is a unique model with less aggressive managed care techniques than other states have implemented through Medicaid 1115 waiver reform.

The presenters will describe the highlights of the implementation including: (1) coordination of mental health services with substance abuse and medical services; (2) coordination with social service agencies, particularly for children's services; (3) the roles and responsibilities of the MHA, the CSA's, MHP, and other stakeholders; and (4) the role of consumer and provider input. They will also present preliminary findings of the consumer satisfaction survey and a focused study on the dually diagnosed.

No. 31B
SALUD! A HYBRID MODEL OF MANAGED CARE FOR NEW MEXICO MENTAL HEALTH

James N. Jacobson, M.D., M.B.A. *Presbyterian Salud Behavioral Health Care, 2340 Alamo S.E., Suite 200, Albuquerque, NM 87106*

SUMMARY:

Many states have implemented Medicaid managed care programs. Mental health benefits and services are a special focus of policy and program implementation. Mental health service delivery systems have traditionally been separate, and the needs of the Medicaid eligible population present challenges in mental health services that go beyond the experience of many HMO's. In addition, organized advocates and consumers have been able to significantly influence the policy process.

"Carving out" mental health services has been a common response to these issues. However, this structure is contrary to broader trends in the development and implementation of integrated delivery/care systems. New Mexico developed a "hybrid" program called SALUD!, which was initiated in July 1997. In this model, mental health services are fiscally integrated and clinically carved out. This design was seen as an effective compromise between competing interests and concerns.

This paper will present the details of the New Mexico model and provide an interim report on implementation to date. Issues of access to mental health services, the interface between behavioral health and other medical and social services, and the integration of mental health treatment will be discussed.

No. 31C
CARVE-OUTS FOR BEHAVIORAL HEALTH CARE: TREND OR PASSE?

C. Richard Orndoff, M.Ed., *Green Spring Health Services, 222 2nd Ave W, Suite #220, Nashville TN 37201;* Henry T. Harbin, M.D.

SUMMARY:

This paper will explore the future of behavioral health carve-outs. The author will present various models of integrating behavioral health care within a managed care environment. Interfaces with primary care physicians, financing alternatives, and coordinated care management alternatives will be explored. In addition, services configuration will be examined to explore what ancillary services should or should not be "carved out."

No. 31D
PSYCHIATRISTS AS MANAGERS IN PUBLIC SECTOR PARTNERSHIPS

Ivan C.A. Walks, M.D., *Assoc. Medical Director, Options Health Care, 240 Corporate Boulevard, Norfolk VA 23502*

SUMMARY:

At issue in the privatization of public sector behavioral health care is the disconnect between the for-profit managed care company and the care provider. Managed care companies are often run by nonclinicians without experience managing or providing services for public sector populations. This presentation will examine two innovative models that remove the line between provider and manager. By forming true partnerships with shared governance, managed care companies and CMHC's can utilize their complimentary areas of expertise to develop best practices in both care management and care delivery.

This presentation will describe two CMHC partnership models as represented by Florida Health Partnership and Colorado Health Networks. The presentation will include how the model impacts:

(a) access to mental health services;

(b) the interface between mental health and medical care, mental health and substance abuse, and mental health and social service delivery; and

(c) integration of mental health treatment.

No. 31E
MODELS OF MANAGED CARE IN THE PUBLIC SECTOR

Kurt A. Patton, M.S., *N.Y. State Dept. of Men. Hlth, 44 Holland Avenue, Albany NY 12229;* John M. Oldham, M.D.

SUMMARY:

New York State has been approved by the Federal Health Care Financing Administration to implement a 1115 Medicaid waiver. The research and demonstration component of the waiver proposes to develop capitated special needs plans (SNP) for two populations: those with HIV infection and those with serious mental illness. Special needs plans for the seriously mentally ill would be an extended benefits, mental health plan designed to serve the unique needs of this population. Each enrollee in a special needs plan for mental health would be simultaneously enrolled in a basic managed care program for access to physical health care services.

The NYS Office of Mental Health undertook an extensive public planning process to design the SNP service system, admission criteria for the program, performance measurement requirements, and protocols for linking with the basic plan providers of health care services. More than 150 stakeholders from the existing not for profit provider industry, acute hospital providers, managed care providers, state hospital administrators, and clinicians, recipients, advocates, families, and others participated in the six-month long planning process. The authors will describe the planning process, key results, pilot analysis, and current directions for serving this population using managed systems of care.

REFERENCES:

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2. Oliver, KA: Maryland's publicly managed mental health system: integrating a Medicaid carve-out with other publicly funded mental health services. Psychiatric Services, State Health Policy Column, in press.
3. Busch S: Carving out mental health benefits to Medicaid beneficiaries: a shift towards managed care. Adm Policy Ment Health 24(4):301–21, 1997.
4. Cahn B, Orndoff CR: Three disease management models from Green Spring. Behavioral Health Management July/August; 11–13, 1997.
5. U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services, October 1994.

SYMPOSIUM 32—MULTIDIMENSIONAL ASSESSMENT OF HEALTH

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to identify key components of a comprehensive and multidimensional approach to the appraisal of health.

No. 32A
INTERNATIONAL PERSPECTIVES ON HEALTH ASSESSMENT

Juan E. Mezzich, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, 5th Ave & 100th Str, Box 1093, New York NY 10029*

SUMMARY:

Modern efforts to appraise the status of health across the world started 100 years ago when the International Statistical Institute and Congress developed the first edition of the International Classification of Causes of Death. Half a century later, the scope of this international classification was expanded to cover morbidity in addition to mortality, incorporating psychiatric illness for the first time. Further expansion continued through the decenal revisions of the classification, leading to the coverage of "diseases and health related problems" in the current ICD-10. More specifically, psychiatric diagnosis has had a distinctly international methodological evolution. The Stengel (WHO) international survey and the U.S.-U.K. diagnostic project in the 60's were influential in moving the field toward greater systematization. Horowitz and Marconi (1996) from Chile, Berner (1969) from Austria, and, later, Feighner el al in the U.S. pioneered the use of explicit diagnostic criteria. Multiaxial schemas were first published some decades ago by Essen-Möller in Sweden, Lecomte in France, Bilikiewicz in Poland, and Leme Lópes in Brazil. All these key developments have been incorporated in the current ICD-10 and DSM-IV diagnostic systems.

The increasingly recognized need to attend to local realities in the implementation of universalistic systems of diagnosis is illustrated by the emergence of the Chinese Classification of Mental Disorders, 2nd Ed., Revised, the 3rd Cuban Glossary of Psychiatry, and the Japanese Clinical Modification of ICD-10. Furthermore, pointed attention to the cultural framework of psychiatric diagnosis was one of the innovations of DSM-IV. Attention to cultural and idiographic (personalized) aspects is leading to the preparation of international guidelines for diagnostic assessment by the World Psychiatric Association.

The above-mentioned issues, along with a strong interest in the contributions of the neurosciences, in a more ecological epidemiology and in advancing the usefulness of diagnosis for clinical care, are informing initial discussions toward the future development of ICD-11.

No. 32B
COMPREHENSIVE NOSOLOGY AND HEALTH

Rachel Jenkins, M.D., *Health, Wellington House, 133-135 Waterloo Road, London S31 84G, United Kingdom*

SUMMARY:

Classification is one of the basic devices for bringing order out of chaos, both in the universe and in human thought processes (Menninger, 1967). Without a commonly accepted classificatory language, it is impossible to communicate about patients to establish reliable standards of care, to evaluate advances in treatment, or advances in systems of health care. We need a nosology that will reflect the conceptual framework of contextual factors, risk factors, precipitants, presentation, underlying disorder, and consequences of psychiatric disorders, and which will do justice to the multiaxial dimensions of disorders, namely the physical, psychological, social, and personality components.

We are also now at the stage where we urgently need a nosology that will allow us to capture the various dimensions of positive mental health, building on such concepts as life skills, coping strategies, locus of control, quality of life, etc.

It is vital that our nosologies are rooted in epidemiological studies and effectively capture the reality of presentation in general populations as well as those in health care settings. Furthermore, we need a nosology that can be used in multidisciplinary teams in primary and specialist care, and that is not just the preserve of the hospital specialist.

Research needs a good nosology and nosology needs good research. They tend to progress in a leap frog fashion. Research can only be as good as the nosological framework that is used within it and therefore we need to devote a major scientific effort to ensuring that we develop adequate and comprehensive nosologies with well tested validity, reliability, and applicability.

No. 32C
SYSTEMATIZING THE ASSESSMENT OF PSYCHOPATHOLOGY

Andrew E. Skodol II, M.D., *Department of Psychiatry, NYS Psychiatric Institute, 722 West 168th Street, New York NY 10032*

SUMMARY:

Cross-national studies of psychiatric diagnostic practice in the 1960's and 1970's demonstrated wide variability along national lines. These studies were influential in focusing attention on the problem of the unreliability of psychiatric diagnoses and in stimulating the development of methods for improving reliability, such as structured diagnostic interviews and diagnostic criteria, which reduce information and criterion variance, respectively. Despite these advances, the reliability of psychiatric diagnoses can be disappointingly low. This may be due in large part to the failure to address the remaining major source of error variance in the diagnostic process—interpretation variance. Interpretation variance refers to the different thresholds that clinicians have for perceiving a given symptom and for attaching clinical significance to it. In order to systematize the routine, clinical assessment of psychopathology, clinicians need a standardized framework for conducting a mental status examination and clear and consensual definitions of the elements of psychopathology. In this presentation, the results of a review of the international literature on aspects of the mental status exam will be presented, concluding with a consensus outline of mental status exam components. Available glossaries of definitions of psychopathological signs and symptoms, such as these provided in DSM-IV, ICD-10, and the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) will be compared and evaluated as guides for the interpretation of psychopathology in routine clinical practice.

No. 32D
ASSESSMENT OF FUNCTIONING AND THE INTERNATIONAL CLASSIFICATION OF IMPAIRMENTS, DISABILITIES AND HANDICAPS FRAMEWORK

T. Bedirhan Ustun, M.D., *Department of Mental Health, World Health Organization, Geneva 27, Switzerland CH1211*

SUMMARY:

There is a "paradigm shift" in the conception and assessment of health status. In the last three decades scientists have effectively dealt with the issue of "diagnosis" of mental disorders. A comprehensive and operational classification system (e.g. ICD-10 and DSM-IV) and congruent set of assessment instruments have been developed. While the construct of diagnosis of mental disorders needs to be refined and advanced, especially in terms of neuroscience and genetics, its use in health services research remains limited. Information on disorders alone cannot answer questions on service utilization, need for care, treatment matching and outcome evaluation. For example, disorder-based epidemiological studies to estimate the need for mental health care are yielding discrepant results. The disablement construct may provide an important complementary perspective and insight for services research. Disablement criteria may help explain the meaning of illness with regard to mental health treatment needs. They may also improve the reliability and the stability of diagnostic assessments. Furthermore, the disablement construct may bring a new dimension to assess the impact of mental disorders. For example, the Medical Outcomes Study (MOS) found that disability was more highly associated to depression than to common chronic physical conditions—such as arthritis, diabetes and hypertension. This finding has been shown to be consistent across 14 different cultures in a WHO Primary Care Study.

In summary, the former paradigm in health-related thinking emphasized only disease; the new one emphasizes both disease and functioning. Hence, WHO has developed a set of assessment instruments linked to the second version of the International Classification of Impairments, Disabilities and Handicaps (ICIDH), which includes operational definitions of the categories involved.

No. 32E
THE APPRAISAL OF SOCIAL CONTEXT

Marianne C. Kastrup, M.D., *Rehab Center for Torture Victims, Borgergade 13, Copenhagen K, 1014 Denmark*

SUMMARY:

Analyses of diagnostic classifications suggest that a multiaxial approach may be an effective way to obtain a comprehensive picture of the clinical condition. In discussions related to the domains of a multiaxial approach, it has appeared as important that axes should contain information about illness, functioning, and contextual factors. This presentation will focus on promising approaches to the assessment and formulation of environmental or contextual factors.

The two major elements of environmental factors are, on one hand, social network and social supports and, on the other, environmental stressors. In the assessment process, codification of supports may be integrated with or kept separated from codification of stressors.

Future classifications should assess and scale social context, taking into consideration cultural settings, from kinship to community services. Further research and discussions are needed on how to handle factors connected to the life-style and life-management of the patient, and his or her special assets and resources.

No. 32F
QUALITY OF LIFE IN HEALTH ASSESSMENT

Helen E. Herrman, M.D., *Department of Psychiatry, St. Vincent's Hospital, 41 Victoria Parade, Fitzroy, Melbourne 30651, Australia*

SUMMARY:

Quality-of-life assessment is part of a clinical examination, and can contribute to an epidemiological study. It is one of a number of relevant measures when treating a patient or planning a health service. To obtain a full view of a patient's condition in clinical and epidemiological work requires assessment of symptoms, disability, and quality of life.

Quality-of-life assessment is now widely understood to have several dimensions and to require a subjective report; and it may be carried out and recorded in a number of ways, for different purposes. This paper will describe briefly the various approaches to assessing quality of life, and how the application in psychiatry may assist the clinical process and the assessment of treatment outcomes.

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SYMPOSIUM 33—COMPLEXITY OF BIPOLAR DISORDER

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of this symposium the participants should be able to:
(1) recognize the difficulties in developing an animal model of this disorder,
(2) demonstrate an appreciation of the cultural issues involved in diagnosing this disorder, and
(3) understand the genetic foundations of this disorder.

No. 33A
TOWARD AN ANIMAL MODEL OF BIPOLAR DISORDER

Aimee R. Mayeda, M.D., *Department of Psychiatry, VA Med. Ctr.–Indiana Univ., 1481 West 10th Street, 116A, Indianapolis IN 46202;* John R. Hofstetter, Ph.D., John I. Nurnberger, Jr., M.D.

SUMMARY:

Patients with bipolar disorder often demonstrate circadian rhythm abnormalities, and a hypersensitive response to the effects of light on the circadian rhythm of melatonin. Lithium lengthens the period of circadian rhythm cycling, and it has been hypothesized that lithium's effect in bipolar disorder may be attributable in part to its actions on the circadian system.

Genetically different strains of mice differ in the circadian period of locomotor activity and response to light. We found differences between C57BL/6J (B6) and DBA/2J (D2) inbred mice in effects of lithium on the circadian system. Mice received lithium in food pellets, and had blood levels comparable to the therapeutic range in humans. Baseline circadian period was determined in constant dark. The effect of lithium plus light was tested in two conditions: constant low level light and phase shift of the circadian rhythm in response to a pulse of light.

Lithium lengthened baseline period in both strains, with greater effect in B6 than D2 mice. In constant light lithium significantly increased the period in D2 mice, while significantly decreasing the period of B6 mice. This result was unexpected because most studies show both constant light and lithium lengthening period, and each of these factors alone increased the period of B6 mice. In studies to date on phase response, lithium significantly reduces phase advance in the B6 but not the D2 mice. There is no significant effect on phase delay.

Further studies are planned to identify genetic loci responsible for the circadian rhythm differences and the differing effects of lithium on these mice.

No. 33B
RECENT GENETIC FINDINGS IN BIPOLAR DISORDER

John I. Nurnberger, Jr., M.D., *Department of Psychiatry, Indiana University, 791 Union Drive, Indianapolis IN 46202;* J. Raymond DePaulo, Jr., M.D., Mary C. Blehar, Ph.D., Elliott S. Gershon, M.D., Theodore Reich, M.D.

SUMMARY:

Bipolar affective disorder (BP) clearly aggregates within families. The genetics of BP is complex, however, and not consistent with single major locus inheritance; no specific genes have yet been located and confirmed. A collaborative study involving four sites was supported as part of the NIMH Genetics Initiative. A structured interview (DIGS) was developed to provide a comprehensive phenotypic assessment of patients and relatives. Families included were required to have at least two affected subjects with bipolar I (BPI) disorder or one with BPI and a second with schizoaffective disorder, bipolar type (SA/BP). Probands and relatives were interviewed and provided a blood sample for transformation and storage at a national data bank. We present results from 540 subjects selected from 97 families. This group included 282 affected sibling pairs, (BP & UP), as well as 412 affected relative pairs. A survey was completed with 319 markers. Analysis was carried out using SIBPAL and other methods. Areas of interest were noted on chromosomes 1, 7, 10, and 16. Positive findings on chromosome 21 and X tended to support previous linkage claims, and areas on 22 and 6 are also regarded as promising. Follow-up is presently being carried out with a second sample.

No. 33C
ETHNIC ISSUES IN BIPOLAR DISORDER

William B. Lawson, M.D., *Department of Psychiatry, Veterans Affairs Medical Cntr., 1482 West 10th Street (116A), Indianapolis IN 46202*

SUMMARY:

Bipolar disorder was thought to be rare in racial and ethnic minorities. Subsequent research showed that it was being misdiagnosed. This paper will review cultural syndromes that may contribute to misdiagnosis. Under-recognition of the diverse subtypes of bipolar disorder further contributes to misdiagnosis. Misdiagnosis often led to inappropriate pharmacotherapy. Consequently neuroleptics may have been used excessively and in excessive doses. Recent findings of excessive neuroleptic-induced abnormal movement disorders among African Americans may be a consequence of inappropriate treatment. Issues of poor compliance in ethnic minorities may be a consequence of inappropriate pharmacotherapy. African Americans may have more side effects with lithium, which would indicate the usefulness of a variety of treatment choices. Novel antipsychotic agents seem to have fewer side effects and less racial disparity in movement-related side effects, which would make these agents more useful for ethnic minorities. However, issues of treatment availability may affect the access of novel treatments for minorities.

No. 33D
THE NEW USES FOR VALPROIC ACID

Samuel O. Okpaku, M.D., *Department of Psychiatry, Vanderbilt University, 1916 Patterson Street, Ste 504, Nashville TN 37211;* Elizabeth Spivey, R.N.

SUMMARY:

The prescription of any medication is dependent on a variety of factors. These include its approval by the regulatory agencies, its availability, the prescribing habits of the physicians, its efficacy, and its side effects profile. Equally important in prescribing are the economic costs of the drug. Furthermore, with managed care, the ability for psychiatrists to observe a patient prior to initiating medications is now severely restricted. The challenge to psychiatrists is made more difficult by the fact that pure psychiatric syndromes are the exception. At different stages in the natural history of a psychiatric disorder, the clinical picture may vary. Against this background, there is evidence that valproic acid, an anticonvulsant first introduced in psychiatry as an antimanic medication, is gaining reputation as an anti-aggressive drug. Recently, it is being used as an adjunct in the treatment of psychoses. This presentation will explore the current and expanding uses of valproic acid in various psychiatric disorders.

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SYMPOSIUM 34—AFFECTIVE DYSFUNCTIONS IN SCHIZOPHRENIA
Joint Session With the World Psychiatric Association and the German Society of Psychiatry, Psychotherapy and Nervous Diseases

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To understand concepts, possible brain mechanisms, and treatment strategies for affective dysfunctions in schizophrenia within a context of a symptom-oriented approach to psychopathology.

No. 34A
AFFECTIVE DYSFUNCTIONS: CONCEPTS AND ASSESSMENT

Wolfgang Woelwer, Ph.D., *Department of Psychiatry, University of Duesseldorf, Bergische Landstrasse 2, Duesseldorf D-40629, Germany;* Prof. Dr. Wolfgang Gaebel

SUMMARY:

The psychopathology of schizophrenia relies on signs and symptoms. According to DSM-IV affective dysfunctions are defined in terms of nonverbal characteristics (signs) that are indicators of subjective feeling states. Usually those dysfunctions are recorded by means of rating scales relying on more or less systematic observation. To overcome potential rating biases (e.g., rating tendencies, Halo-effects), the scientific approach to affective deficits should make use of more systematic and objective behavioral assessment methods. Because of the superior data quality, those data are more suitable as psychopathological starting points for studying brain-behavior relationships. In addition assessment conditions should be experimentally controlled to identify underlying psychological dysfunctions, e.g., receptive and expressive components of affective behavior.

Results from our own studies using this kind of approach demonstrate that, despite broad overlap in clinical rating scales, distinct behavioral patterns comprising facial activity, gestures, voice pitch, and speech activity, can be identified in schizophrenia and depression. In contrast, rating scale data proved to be less reliable, more unidimensional, and of less predictive value for the clinical course. The nosological specificity of findings can be improved by including the subjective and physiological level of emotional processes in addition to behavioral reactions in studying affective dysfunctions.

No. 34B
AFFECTIVE AND NEUROMOTOR DEFICITS IN SCHIZOPHRENIA: WHAT'S WHAT?

Robert H. Dworkin, Ph.D., *622 168th Street, New York NY 10032;* Xavier F. Amador, Ph.D., Scott C. Clark, M.D., Jack M. Gorman, M.D.

SUMMARY:

The results of recent studies indicate that it is important to include assessments of affective flattening in research on the psychopathology and pathogenesis of schizophrenia. Unfortunately, the results of these studies also suggest that assessments of affective flattening in schizophrenia may not reflect affective deficits. Although it has been assumed that the behaviors assessed in existing measures of affective flattening—for example, diminished facial expressivity and speaking in a monotone—reflect affective deficits, it has recently been proposed that these measures may instead reflect the social and neuromo-

tor abnormalities that are prevalent in schizophrenia. Individuals with schizophrenia may therefore manifest affective flattening because the expression of their emotions is compromised and not because their experience of emotions is decreased. To examine the nature of the deficits reflected by existing measures of affective flattening in schizophrenia, a series of studies was conducted in inpatients receiving neuroleptic medication and after withdrawal from all neuroleptics. The following results will be discussed: (1) There were significant associations between affective expression and affective experience in patients with schizophrenia and in control subjects, but this "affective congruence" was significantly reduced in the patients with schizophrenia. (2) As predicted, measures of affective flattening in patients with schizophrenia were significantly associated with neuromotor abnormalities as well as with a measure of affective deficit that does not involve the expression of affect. (3) The relationships among measures of pain insensitivity, anhedonia, and affective flattening in patients with schizophrenia provided support for the hypothesis that insensitivity to physical pain may provide an approach to examining affective deficits that is not confounded by neuromotor and social abnormalities. The results of these studies suggest that the interpretation of existing measures of affective deficits in schizophrenia is ambiguous, and that measures of diminished affective *experience*—for example, anhedonia and analgesia—may have greater validity in research on affective deficits than measures of flat or blunted affective *expression.*

No. 34C
BRAIN MECHANISMS OF AFFECTIVE AND SOCIAL BEHAVIORS

John F.W. Deakin, *Department of Psychiatry, Medical School, Oxford Road, Room G907, Manchester M139PT, United Kingdom*

SUMMARY:

Schizophrenia and mood disorders are profoundly influenced by social factors such as critical family environment and interpersonal loss. Furthermore, many symptoms such as paranoia and low self-esteem can be seen as mis- or false perceptions of social signals and contexts. Understanding brain mechanisms that transduce social signals is clearly important to elucidating pathogenesis.

Human brains have the developmental predisposition to form hard-wired circuits, which (a) detect social signals, and (b) organize social motor responses. There are well-known structural correlates of language function such as the planum temporale and Broca's area. In the visual system there are modules that detect facial expression and eye-gaze direction in inferotemporal cortex. Humans have the high-level ability to use such information to infer the intentions and mental states of others and how these are neurally represented is beginning to yield to scientific enquiry.

Damage to ventral frontal and cingulate cortex is associated with character change and social disinhibition. Ventral frontal and anterior temporal cortex connect with each other and with amygdala through the uncinate fasciculus. This is the basolateral circuit. There is evidence that the basolateral circuit is structurally and functionally abnormal in schizophrenia and in depression.

No. 34D
BRAIN MECHANISMS OF AFFECTIVE DISORDER IN SCHIZOPHRENIA

Peter F. Liddle, M.D., *Department of Psychiatry, University of British Columbia, 2255 Wessbrook Mall, Vancouver, BC V6T 2A1, Canada*

SUMMARY:

In schizophrenia, affective disturbances take various forms. The classic affective disturbances characteristic of schizophrenia are inappropriate affect and blunting of affect. However, other affective disturbances including depression and excitation are also common in schizophrenia. The brain mechanisms underlying these disturbances have not yet been fully delineated. Some pointers toward the nature of the underlying pathophysiological processes can be obtained by examining the other symptoms and neuropsychological impairments that tend to be associated with affective disturbances. These associations indicate that the affective disturbances arise from dysfunction of the neural circuits involved in the selection and initiation of mental activity. Functional brain imaging techniques such as positron emission tomography (PET) provide information about the cerebral location of the underlying neuronal malfunction associated with these symptoms (Liddle et al, 1992). For example, underactivity of lateral prefrontal cortex is associated with blunting of affect, while some evidence indicates that psychomotor excitation is associated with lateral prefrontal overactivity. Inappropriate affect appears to involve disorder in areas of the orbital and medial frontal cortex involved in the selection of mental activity. Depression in schizophrenia appears to arise by several mechanisms, possibly involving both limbic and lateral frontal underactivity.

No. 34E
AFFECTIVE DYSFUNCTIONS IN SCHIZOPHRENIA: TREATMENT STRATEGIES

Prof. Dr. Hans D. Brenner, Psychiatric Services, *University of Bern, Laupenstrasse 49, Bern BE Ch-3010, Switzerland;* Bettina Hodel, Ph.D.

SUMMARY:

Substantial research on deficient experience and the perception of emotion in schizophrenia has been performed in recent years. Data suggest that schizophrenic patients are impaired on several levels of emotional processing. Ensuing impairments include the characteristic deficits in social and instrumental role functioning, which in their turn influence the course and outcome of the illness. Several empirically validated approaches are aimed at the treatment of the relevant dysfunctions, but unfortunately they often comprise comprehensive intervention packages, which are not specifically designed for this purpose and have only secondary effects on emotional processing. Examples are social and independent living skills by Liberman and co-workers, or integrated psychological therapy by Brenner and co-workers. Relatively few systematic treatment programs are directly aimed at the remediation of maladaptive emotional processing and the corresponding affective dysfunctions in schizophrenic patients. Varying intervention approaches and the relevant empirical data are elucidated and discussed. Our group developed emotional management therapy (EMT), which is designed to help patients acquire and refine specific strategies for coping with distress, anxiety, and fear. This therapy combines techniques for remediating maladaptive syles of emotional processing in conjunction with imparting preventive strategies that operate as protective mechanisms. In a current study, the efficacy of EMT is compared with that of a cognitive treatment approach. EMT appears to be the more effective of the two approaches as measured during treatment and 12 months after the end of therapy. Results will also be discussed in relation to the actual findings on affective dysfunctions in schizophrenia.

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SYMPOSIUM 35—DEALING WITH PSYCHOPATHY: THE UNITED STATES SUPREME COURT'S HENDRICKS VS. KANSAS DECISION AND BEYOND

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) distinguish psychopathy from traditional mental illness, (2) understand the limits of both risk-assessment and treatment of psychopathy, and (3) identify potentially effective ways of adapting psychiatric systems to accomodate psychopaths.

No. 35A
DON JUAN: MYTHS, MILESTONES AND MANAGEMENT OF THE PARAPHILIAS

John M.W. Bradford, M.B., *Forensic Psychiatry, Royal Ottawa Hospital, 1145 Carling Avenue, Ottawa, ONT K1Z 7K4, Canada*

SUMMARY:

Paraphilias may be obsessive-compulsive spectrum disorders (OCD spectrum disorders). The concept is based on similarities in the phenomenology and natural history of OCD and the paraphilias, and the treatment success of serotonin reuptake inhibitors (SRI's) in both conditions. Although systematic studies of the efficacy of serotonergic agents are lacking, there are a number of case reports and some clinical studies that look promising. A 12-week, open-label, dose-titration pilot study of sertraline in the treatment of outpatients with pedophilia was conducted. Summary data from 21 patients showed that 18 completed the study. Marked improvement was observed on almost all aspects of sexuality. Statistically significant measures included improvements in the sexual preference for sex with young girls ($p < 0.05$) and decrease in sexual activity ($p < 0.05$), decrease in penile tumescence responses to audiotape description of pedophilia ($p < 0.05$), and decrease in obsessions on the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS), as well as significant reductions in sexual fantasies.

Peripheral neurobiological markers completed in parallel to this study will be briefly discussed as well as two other studies using SSRI's in the treatment of the paraphilias. The role of hypersexuality in the treatment of the paraphilias will be discussed. In addition a review of other pharmacological options in the treatment of the paraphilias will be completed, including antiandrogens (cyproterone acetate, medroxyprogesterone acetate, and other pharmacological option). A review of the research of the pharmacological treatment of the paraphilias will be covered as well as directions for future research in the pharmacological treatment of the paraphilias.

No. 35B
PSYCHOPATHY AS A RISK FACTOR FOR VIOLENCE

Robert D. Hare, Ph.D., *Department of Psychology, Univ. of British Columbia, 2136 West Mall, Vancouver, BC V6T1Z4, Canada*

SUMMARY:

Psychopaths are social predators: egocentric, grandiose, shallow, callous, remorseless, and impulsive individuals who use charm, manipulation, intimidation, and violence to control others and to satisfy their own selfish needs. Not surprisingly, they violate social and legal norms and expectations with little or no concern for the rights, feelings, or well-being of their victims. Although psychopaths are to be found in all walks of life, it is their capacity for cold-blooded and instrumental violence that typically captures public attention. The clinical features of psychopathy have long been known, but it is only recently that the disorder has emerged as an important construct in the mental health and criminal justice systems. As measured by the Psychopathy Checklist-Revised (PCL-R), a 20-item clinical rating scale scored on the basis of a semi-structured interview, and review of collateral information, psychopathy has proven to be a particularly robust predictor of treatment suitability, and for assessing risk for recidivism and violence in a variety of populations, including adult and adolescent offenders, forensic and civil psychiatric patients, and sex offenders. This paper reviews the relevant research on these topics, with emphasis on the extreme dangerousness of psychopaths who are sexually aroused by violence.

No. 35C
THE AGGRESSIVE PATIENT: BEYOND DENIAL

Gary J. Maier, M.D., *Mendota Mental Hlth Institute, 301 Troy Drive, Madison WI 53704-1521*

SUMMARY:

In 1996, Wisconsin passed a fifth standard for civil commitment, which allows clinicians to take the history of a patient's mental illness and its response to treatment into account at the time of commitment. The *Hendricks* decision affirmed that parole-eligible inmates identified as sexual predators may be committed and "treated" in correctional facilities. Both decisions herald change. Yet there are among mentally ill and dangerous civilly committed patients a sub-set that exhibit low frequency, high intensity, aggressive behavior. Central planners still deny the special management and treatment needs of this group, which include: (1) clarification of Axis I diagnoses including intermittent explosive disorder, impulse control disorder, alcohol and substance abuse disorders, and the presence of Axis II disorders; (2) documentation of a pattern of low frequency, high intensity aggression; (3) development of environments that will contain their aggressive impulses; (4) redefinition of their rights, such as withdrawing the right to the least restrictive environment; (5) anger management therapy and the use of pain compliance as an aggression management technique to control the patient and protect the staff; and (6) criminal prosecution for willful assault. Policymakers in the mental health and criminal justice system must be prepared not only to implement sexual predator laws, they must also address the needs of the chronic mentally ill who repetitively assault others and who require special legal and management approaches.

No. 35D
MAD VERSUS BAD REVISITED: MANAGING PREDATORY BEHAVIOR

William M. Tucker, M.D., *NYS Office of Mental Health, 44 Holland Avenue, 8th Floor, Albany NY 12229*

SUMMARY:

In response to a more conservative political environment and to a well-publicized murder in January 1995 by an eloped mental patient, New York's mental health authority began to restrict patients' community access. New legislation mandated inquiry of criminal

justice system records on all state hospital patients. Then the state moved from criminalizing the mentally ill to psychologizing criminal behavior: sexual and other repeatedly violent predators, near the completion of their prison terms, were given psychiatric diagnoses whenever possible and involuntarily committed to state mental hospitals. Numbers of such patients accelerated after *Hendricks*. Psychiatrists were exposed to considerable liability, both in daily management and, especially, at the point of discharge. Traditional risk assessment and knowledge of the usual relationship of mental illness and violence, developed for those with severe mental illness and/or substance abuse, did not apply to predators.

The mental health authority has begun to formulate a plan addressing the following: (1) segregation of these patients from traditional civil and forensic populations; (2) more specific evaluation measures to identify those potentially treatable; (3) provision of greater security to ensure safety in view of the ability of these patients to plan and organize others against staff; and (4) coordination with parole for discharge planning.

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SYMPOSIUM 36—RECENT FINDINGS IN SOCIAL PHOBIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation the participant should be able to describe the substantial recent developments in social phobia, such as diagnosing, its both prevalent and disabling, psychobiological abnormalities.

No. 36A
DIAGNOSTIC AND ASSESSMENT ISSUES

Richard G. Heimberg, Ph.D., *Department of Psychology, Temple University, Weiss Hall, 1701 N. 13th St., Philadelphia PA 19122*

SUMMARY:

Reliability and validity of measures for diagnosis and assessment are critically important in the evaluation of new treatments for social phobia. A number of self-rated and clinician-administered measures have been developed for the assessment of social phobia, but these measures differ dramatically in the support for their psychometric adequacy. Basic tenets of psychometric theory are reviewed. The psychometric data for the major self-report measures for social phobia (Social Interaction Anxiety Scale, Social Phobia Scale, Social Phobia and Anxiety Inventory) are reviewed and compared. The major focus of this presentation will be on the psychometric evaluation of the clinician-administered Liebowitz Social Anxiety Scale (LSAS) in a sample of 382 patients with social phobia who participated in several clinical trials. The presentation will include the following: internal consistency of the LSAS and its subscales, correlations among the subscales, correlations with other measures of social anxiety and avoidance that suggest both convergent and discriminant validity, the adequacy of the subscale structure of the LSAS, and the sensitivity of the LSAS to the effects of treatment with phenelzine versus placebo.

No. 36B
EPIDEMIOLOGY, MORBIDITY, COMORBIDITY AND DISABILITY

Murray B. Stein, M.D., *Department of Psychiatry, Univ. of California, San Diego, 9500 Gilman Drive, #0985, La Jolla CA 92093-0985*

SUMMARY:

Whereas earlier reports had placed the rate of social phobia (SP) in the range of 2% to 3%, more recent epidemiologic surveys provide estimates of SP in the range of 7% to 8% point prevalence and 13% to 14% lifetime prevalence (National Comorbidity Survey [NCS]; Magee et al., 1996). If these estimates are correct, this would make SP one of the most common mental disorders. A question that arises when reviewing these data, however, is what proportion of patients with SP in the community suffer from a unifocal form of SP (e.g., public speaking only) and what proportion suffer from a more pervasive, multifocal disorder (e.g., generalized SP). Findings from a reanalysis of the NCS (Kessler et al., in press) suggest that one in three social phobics suffer from a "speaking-only" type of SP, whereas the remainder suffer from a more "complex" form of SP, which typically involves speaking in addition to other social situations. The complex type of SP carries with it a greater burden of comorbidity (with mood disorders and with other anxiety disorders) and is more likely to be chronic. The extent and nature of the disability in patients with SP will also be reviewed in this presentation.

No. 36C
RECENT PSYCHOLOGICAL FINDINGS IN SOCIAL PHOBIA

Franklin R. Schneier, M.D., *Dept. of Therapeutics, NY State Psychiatric Institute, 722 West 168th Street, Unit 13, New York NY 10032*

SUMMARY:

Social phobia is increasingly being recognized as having important and measurable psychobiological characteristics. Recent studies have applied novel techniques of brain imaging, assessment of autonomic nervous system activity patterns, and measurement of gene marker frequencies to study the neurobiology of social phobia and related constructs, such as public speaking anxiety, introversion, behavioral inhibition, and avoidant personality disorder. This presentation will review and integrate recent findings.

Results: Recent findings related to the brain dopamine system in social phobia and related constructs include decreased dopamine transporter density in social phobia, higher blood flow in the basal ganglia of introverts, and association of D_2 receptor polymorphisms with avoidant personality traits. New data from ongoing studies of central nervous system dopamine regulation and of autonomic nervous system activity will also be presented. Convergent findings using different techniques and diagnostic classification schemes may help better define the central and peripheral nervous system correlates of this area of psychopathology.

No. 36D
FAMILIAL AND TEMPERAMENTAL FACTORS IN SOCIAL PHOBIA

Abby J. Fyer, M.D., *NYS Psychiatric Institute, Unit 82, 722 West 168th Street Box 82, New York NY 10032-2603*

SUMMARY:

This presentation will review (1) data supporting a heritable contribution to the development of social phobia, and (2) recent research strategies to attempt to identify possible genetic mechanisms of transmission.

Data supporting a heritable contribution to social phobia are drawn from three lines of research: studies of childhood and adult temperament, family and twin studies of social anxiety/phobia, and animal models. Findings to date indicate a definite but moderate genetic contribution to social anxiety (heritability .3 – .4) with a "complex" (i.e., nonMendelian) mode of inheritance.

Current research into possible genetic mechanisms is focused in two areas: (1) phenotype refinement (i.e., identification of more etiologically homogenous subtypes within social phobia), and (2) identification of candidate genes using data from studies of pharmacologic response, fearful temperament, and animal models. Examples of each of these strategies will be described.

No. 36E
TREATMENT OF SOCIAL PHOBIA

Michael R. Liebowitz, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 722 West 168th Street/MB #120, New York NY 10032-2603;* Richard G. Heimberg, Ph.D., Franklin R. Schneier, M.D.

SUMMARY:

Both pharmacological and cognitive behavioral treatments are being found effective in the treatment of social phobia, and these two modalities may have complementary strengths.

Pharmacological treatments have shown modest to marked acute efficacy. The standard MAOI, phenelzine, has the best demonstrated ability in the treatment of social phobia with three studies showing marked acute benefits, even in the hard to treat generalized subtype of social phobia. Clonazepam also appeared very effective in one trial. SSRI's also show substantial acute efficacy, but the reversible selective MAOI's have produced more variable results. All pharmacotherapies appear to be associated with substantial relapse after discontinuation, even following prolonged treatment. Cognitive-behavior therapy, on the other hand, is not associated with relapse following discontinuation. However, its acute efficacy, while substantiated, is less than that seen with the standard MAOI phenelzine. This provides a rationale for combined medication-CBT treatment, which is currently under investigation.

No. 36F
THE OFFENSIVE TYPE OF SOCIAL PHOBIA: CROSS-CULTURAL PERSPECTIVES

Si-Hyung Lee, M.D., *Department of Psychiatry, Kangbuk Samsung Hospital, 108 Pyung-Dong Jong No-Ku, 110 Seoul 100634, Korea;* Kang-Seob Oh

SUMMARY:

Since 1983, the authors have treated about 1,400 social phobic patients in the clinic. About 40% of our patients have a firm belief that they are harming others in interpersonal situations with their imagined physical defects. The nature of that belief is very similar with that of taijin kyofu in Japan. This offensive type of social phobia has been reported in East-Asian countries (Korea, Japan, and China). This could be explained by the sociocultural backgrounds where "regards for others" are emphasized. For this reason, the offensive type of social phobia can be seen in any part of the world where the same virtue is emphasized. The cognitive-behavioral group treatment (CBGT) along with paradoxical intention was very effective. Attendees will be asked to consider the differences in the nature of social phobia between Korea and Western countries. We will also discuss the associated features, clinical courses of illness, therapeutic outcomes of our cohort, and social phobic tendencies in Korean patients.

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SYMPOSIUM 37—PSYCHOTHERAPEUTIC ISSUES IN PSYCHIATRIC CARE
Joint Session With the American Psychoanalytic Association

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To recognize the need and usefulness of integrating psychodynamic psychotherapeutic modalities in the treatment of a spectrum of DSM-IV conditions: major depression, panic disorder, and PTSD. In addition, to recognize that psychotherapeutic modalities are an important adjunct in the care of the medically ill and in psychopharmacological patient management.

No. 37A
PSYCHOTHERAPEUTIC ISSUES IN MEDICATION MANAGEMENT

Allan Tasman, M.D., *Dept of Psych & Behav Sci, Univ of Louisville Sch. of Med, Louisville KY 40292-0001*

SUMMARY:

Emerging research evidence suggests that response to medications is influenced by the context of the doctor-patient relationship, which exists during drug treatment. A positive relationship appears to have a beneficial effect on response to medication. This presentation will discuss several aspects of this issue. Even when the primary therapeutic intervention is psychopharmacologic, the psychiatrist must be aware of a number of factors within the process of treatment. Not the least of these involve 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. 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 relationships will maximize treatment effectiveness. Practical ap-

proaches to addressing this matter will make up the second half of this presentation.

No. 37B
PSYCHODYNAMIC PSYCHOTHERAPY OF PANIC DISORDER

Barbara L. Milrod, M.D., *Mount Sinai Med Ctr Box 1, 1 Gustave Levy Place, New York NY 10029;* Fredric N. Busch, M.D.

SUMMARY:

This presentation will cover a specific adaptation of psychodynamic psychotherapy for a specific and serious DSM-IV Axis I disorder: panic disorder. Particular aspects of the clinical picture of panic disorder will be reviewed, with a focus on clinical psychodynamic methods in handling these phenomena. An overview of panic-focused psychodynamic psychotherapy (PFPP) will be presented, which is a manualized form of psychodynamic psychotherapy specifically designed for the treatment of panic patients. The presentation will highlight typical psychodynamic conflicts that we commonly see in panic patients, common transferential situations that occur in treatments with these patients, as well as delineations of techniques of psychodynamic psychotherapy as they apply to panic patients, and psychodynamic approaches to common problems as they arise in this type of psychotherapy for these patients. Brief clinical examples will be given to demonstrate our points, and a short videotape segment will be presented.

No. 37C
PSYCHOTHERAPY IN MANAGING THE MEDICALLY ILL

David Spiegel, M.D., *Department of Psychiatry, Stanford Medical School, 401 Quarry Road, Room 2325, Stanford CA 94305-5544*

SUMMARY:

There has been a substantial growth in the use of various models of group support for the medically ill. For example, many oncology programs in the United States now offer support group services. Numerous studies now demonstrate the efficacy of support groups in improving quality of life, patient adjustment, and reducing symptoms such as pain. Several models have been put forward, emphasizing various aspects of coping with cancer. They range from purely educational groups, which adopt a lecture format and emphasize information transfer, to psycho-educational and cognitive-behavioral models that focus on encouraging changes in coping style based on information transfer and practicing new coping roles, to supportive-expressive models that emphasize intensive bonds of social support, expressing emotion, and improving relationships, in addition to facilitating more active coping. One study (Kelly, et al) has compared cognitive-behavioral and supportive-expressive group approaches among patients with HIV infection and found an advantage for the supportive-expressive model. Evidence of efficacy of group approaches and research comparing different approaches, as well as essential therapeutic features of successful interventions, will be reviewed. This research on efficacy of specific aspects of group intervention is an important step in developing supportive group intervention techniques that are widely applicable in the routine medical setting. Related issues such as the need for specificity of patient referral on the basis of anxiety, depression, or other problems will also be reviewed.

Three randomized prospective trials of psychotherapeutic interventions among cancer patients have shown a surprising positive effect on survival time as well. These findings taken together suggest that group psychotherapy is feasible in the clinical setting, and has positive effects on patient adjustment and may affect disease course. These results provide a rationale for a more active role for psychotherapy in the treatment of the medically ill.

No. 37D
PSYCHOTHERAPEUTIC MODALITIES IN THE TREATMENT OF PTSD

Melvin R. Lansky, M.D., *1100 Glendon Avenue, 11527, Los Angeles CA 90024*

SUMMARY:

A psychotherapeutic approach to PTSD is described, which is informed by a lengthy study of post-traumatic nightmares. That study demonstrated that conflict in the PTSD patient included, but went beyond, the impact of trauma shown in the nightmare. The dreams screened childhood, coexisting, and contemporary trauma in many PTSD patients. Shame and fragmentation in the day preceding the dream integrated the nightmare. Exploration of these opened up exploration of processes of disorganization and repair, which are essential to the understanding and treatment of PTSD sufferers.

No. 37E
DYNAMIC THERAPY IN THE TREATMENT OF DEPRESSION

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

SUMMARY:

Depression is best understood as involving a genetic vulnerability that alters the sensitivity of the individual to stressors from the environment. A psychodynamic therapist assesses the meaning of stressors and helps the patient to understand what factors contribute to a particular episode of depression. In addition, the dynamic therapist looks at the psychodynamic themes in depression that run parallel with the biological factors. Empirical studies will be reviewed suggesting that psychodynamic therapy has been proven effective with patients who suffer from unipolar depression. Clinical examples will illustrate technical and theoretical points.

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SYMPOSIUM 38—PSYCHOSOCIAL INTERVENTIONS FOR DRUG ABUSE
Collaborative Session With the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation the participant should be able to describe the ways to reduce costs of treating addiction. Interventions in the treatment of substance abuse will be reviewed,

as well as practical guidelines for identifying patients best for these interventions.

No. 38A
CONTINGENCY-MANAGEMENT THERAPY WITH DRUG ABUSERS

Stephen T. Higgins, Ph.D., *Department of Psychiatry, Univ. of Vt/ Ira Allen School, 38 Fletcher Place, Burlington VT 05401*

SUMMARY:

Contingency-management interventions arrange for the systematic application of environmental consequences that are ethical, humane, and effective for motivating abstinence and other therapeutic change among illicit drug abusers. For example, no consensus yet exists on how to effectively treat cocaine abuse, but contingency-management interventions are one of the few treatments shown to be reliably efficacious with this disorder in controlled trials. Effective pharmacotherapies exist for heroin abuse, but they must be combined with psychosocial treatment for maximal efficacy. Contingency-management interventions are compatible with pharmacotherapies and reliably efficacious in opioid abusers. Special populations like pregnant, homeless, schizophrenic, HIV-infected, and otherwise chronically ill drug abusers offer unique treatment challenges, and contingency-management interventions are being developed to effectively meet those challenges. Contemporary research efforts on the use of contingency-management interventions across each of these settings and populations will be reviewed.

Learning Objective: Participants will learn about the varied strategies for using contingency management to motivate behavior change in illicit-drug abusers.

No. 38B
THERAPY FOR BORDERLINE PERSONALITY AND DRUG ABUSE

Marsha M. Linehan, Ph.D., *Department of Psychiatry, University of Washington, PO Box 351525, Seattle WA 98195-1525*

SUMMARY:

Background: A randomized clinical trial was conducted to evaluate whether dialectical behavior therapy (DBT), a psychosocial treatment shown to be effective for suicidal patients with borderline personality disorder (BPD), would be effective for drug-dependent women with BPD.

Methods: Eighteen women meeting criteria for both BPD and substance dependence were randomly assigned either to one year of DBT—a cognitive behavioral therapy that combines individual psychotherapy with group behavioral skills training—or to treatment-as-usual (TAU). Drug abuse outcomes were measured both by structured interviews using the time-line follow-back method and urinalyses. Other outcomes measured included parasuicidal behavior, amount of medical treatments, anger, social adjustment, and global functioning. Assessments were at four, eight, and 12 months, and at a 16-month follow-up.

Results: DBT was superior to TAU in reducing use of illicit drugs and alcohol as measured both by structured interviews and urinalyses throughout the treatment year and at follow-up. DBT was also superior to TAU in maintaining subjects in treatment and in improving global and social adjustment at follow-up. The data also indicate that adherence to the DBT treatment manual may be an important factor in treatment efficacy. No other differences emerged.

Conclusions: DBT was more efficacious than treatment-as-usual in reducing drug abuse in this study, providing more support for DBT as an efficacious treatment for severely dysfunctional BPD patients across different presenting problems.

Learning Objective: Participants will learn about empirically-validated steps involved in treating substance abusers with borderline personality disorder.

No. 38C
EFFICACY OF PSYCHOSOCIAL SERVICES FOR DRUG ABUSE

Thomas McLellan, Ph.D., *Pennsylvania/VA Center, Building 7, University Avenue, Philadelphia PA 19104*

SUMMARY:

While substance abuse continues to be a major health care problem facing this country, there are many who wonder whether treatment for these disorders can be effective and whether treatment is "worth" the costs. Even proponents of substance abuse treatment wonder which types of treatment are most cost effective.

This presentation will review the results of controlled clinical trials and large field studies of current forms of treatment for alcohol, cocaine, and opiate dependence as they are practiced in public and privately financed programs and in inpatient and outpatient settings. Results show that in general, substance abuse treatment can be effective in reducing substance use, increasing employment, decreasing crime, reducing health care utilization, and increasing family and psychological stabilization. The presentation will present evidence from multiple outcome studies showing that substance abuse treatment effectiveness is a joint function of the severity of problems presented by the patients and the number, quality, and "fit" of psychosocial services provided by the programs.

The presentation will conclude with guidelines for a cost-effective and practical method to provide treatment directors, third-party payers, and government agencies information regarding the comparative effectiveness and value of substance abuse treatment systems and programs.

Learning Objectives: Participants will learn about outcomes relative to the nature and extent of inpatient and outpatient services for substance abuse.

No. 38D
BEHAVIORAL COUPLES THERAPY FOR SUBSTANCE ABUSE

Timothy J. O'Farrell, Ph.D., *Department of Psychiatry, Harvard Medical School, 9401 Belmont Street, Brockton MA 02401*

SUMMARY:

Behavioral couples therapy (BCT) sees the alcoholic or drug abusing patient together with the spouse to build support for abstinence, increase relationship cohesion, and improve communication skills, because these relationship factors are conducive to substance abuse recovery. Research on BCT shows that BCT for alcoholics and drug abusers produces better abstinence rates and fewer marital separations over a two-year follow-up period than individually based treatment. Outcomes after BCT show substantial and significant reductions in domestic violence and very favorable cost-benefit and cost-effectiveness results. This presentation will describe the clinical interventions used in BCT, the results of studies showing clinical outcomes of better abstinence rates and improved relationship adjustment, and our most recent work showing reduced domestic violence and favorable cost outcomes.

Learning Objectives: Participants will learn about the therapeutic and cost benefits of including couples therapy in substance abuse treatment.

No. 38E
STRUCTURED PSYCHOTHERAPIES FOR DRUG ABUSE

Bruce J. Rounsaville, M.D., *Department of Psychiatry, Yale University, 34 Park Street, New Haven CT 06519*

SUMMARY:

A major advance in psychotherapy research methodology has been the use of detailed training manuals to guide treatments being evaluated in clinical trials. Such manuals are now almost universally used in psychotherapy research. However, clinicians in non-research settings have been slow to embrace manual-guided treatment, even when they have been shown to be effective. The factors related to effective psychotherapy for drug abusers will be presented using findings from a meta-analytic review of controlled clinical trials. Overall psychotherapies for drug abusers have been demonstrated to have efficacy comparable to psychosocial treatments for other mental disorders. Steps needed to obtain more widespread use of empirically validated treatments will be presented.

Learning Objective: Participants will learn to identify empirically-based factors related to effective psychotherapy for drug abuse.

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SYMPOSIUM 39—HARVARD PSYCHOPHARMACOLOGY EXPERT SYSTEMS PROJECT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: identify the medical "treatment(s) of choice" for a variety of patients with mood, anxiety, and psychotic disorders.

No. 39A
INVENTING AN INFORMATION SUPPORT SYSTEM

Robert D. Patterson, M.D., *Mental Health Center, 21 Blossom Street, Lexington MA 02173-8103*

SUMMARY:

Like carpenters, physicians are expected to bring their own tools to work. The primary tool of a psychiatrist is information. Keeping an up-to-date inventory of technical information is a daunting task each psychiatrist has to face essentially alone. The human ability to store, retrieve, and weigh information has limitations. This project aims to create information tools that are much easier to use and update than heretofore possible.

The goals are to develop techniques to organize the traditional inputs for clinical decisions such as research results, consensus guidelines, algorithms published by recognized experts, and clinical experience, and to present critical information to the clinician at the time that it is needed. Collaborations have evolved in which an expert works with another psychiatrist who has experience in computerizing algorithms. Their dialog often uncovers places where additions are needed or reasoning needs to be tightened.

We are only beginning to understand the form these new tools should take. For some clinicians, a paper format may still be preferred.

Information support systems will affect the dynamics of the relationship between psychiatrist and patient. Patient advocacy groups are eager to see psychiatry adopt more powerful information support systems.

No. 39B
PSYCHOPHARMACOLOGY OF DEPRESSION EXPERT SYSTEM

David N. Osser, M.D., *Department of Psychiatry, Harvard Medical School, 150 Winding River Road, Needham MA 02192*

SUMMARY:

The flow chart of the pharmacotherapy algorithms for major depression (non-psychotic and psychotic), dysthymia, and bipolar depression variants will be highlighted. A paper copy will be provided. Also, portions of the algorithms for managing non-pharmacologic factors contributing to poor outcome and frequent relapse (e.g., noncompliance) will be presented.

Most patients with dysthymia and non-psychotic major depression may receive an SSRI as first-line treatment. After adequate trials (defined) of the initial medication, nonresponders may receive another SSRI, switch to other antidepressants, or get augmentation. Tricyclics are suggested as first line for certain melancholic patients. Patients with atypical features who failed on SSRI's may try a MAOI. Psychotic depressed patients may initially be offered ECT or tricyclic/neuroleptic combination.

Depressed bipolar I and mixed rapid cycling patients (with depression predominating) receive lithium first, unless they are currently on valproate or carbamazepine. Otherwise, an SSRI or bupropion may be added. Bipolar II patients may start with an antidepressant, mood stabilizer, or both.

Treatment-resistant patients who failed at least two adequate medication trials are reassessed for comorbidity on Axis I/II/III. Specific recommendations are given for the various situations.

For all decision points, reasonable alternatives are presented with an analysis of their comparative merits.

No. 39C
PSYCHOPHARMACOLOGY OF PSYCHOSIS EXPERT SYSTEM

Carlos A. Zarate, Jr., M.D., *McLean Hospital, 115 Mill Street, Belmont MA 02178*

SUMMARY:

Introduction: Novel antipsychotic drugs are rapidly being introduced into psychiatric practice. These newer drugs appear to have some advantages over traditional antipsychotic agents in terms of efficacy and side-effect profile. However, the exact role of these newer agents (i.e., olanzapine, risperidone, sertindole, seroquel, ziprasidone) in decision trees for the treatment of psychosis remains unclear.

Objective: This presentation will present computerized algorithms developed for the treatment of psychosis and offer suggestions for where these newer antipsychotic agents may have a role.

Methods: Clinical experience of the author and existing literature on the pharmacological treatment of psychosis (MEDLINE 1966-1997) was reviewed, rated, and incorporated into decision trees for treatment.

Results: A series of computerized algorithms was developed for the treatment of psychosis. Some of the information presented will include: What are the first-line pharmacological treatments for psychosis? How does one choose one (i.e., typical/novel/atypical) antipsychotic drug over another one? When should clozapine be prescribed especially since other atypical antipsychotic drugs are now available? What are the steps to take if one fails to respond to a drug or develops treatment limiting side effects? How does one manage comorbid psychiatric syndromes?

Conclusions: The ongoing development and utilization of such algorithms are important to provide an orderly way in treatment, thus possibly avoiding unnecessary lengthy somatic treatments and minimizing the risk of adverse events.

No. 39D
ANXIETY IN PATIENTS WITH CHEMICAL ABUSE AND/OR DEPENDENCE

Rogelio D. Bayog, M.D., *Department of Psychiatry, Harvard Medical School, 25 Swing Drive, Berkley MA 02779*

SUMMARY:

Flow charts of pharmacotherapy algorithms for treating anxiety disorders in the addictions will be highlighted. A paper copy will be provided. Patients who are abstinent from their substances for at least one week are addressed in this presentation.

Algorithms for the psychopharmacological management of panic disorder, social phobia, OCD, and PTSD are covered. For patients with panic disorder, SSRI's are the first-line pharmacotherapy with consideration of nefazodone. Second line is a tricyclic. Subsequent choices are discussed.

For patients with social phobia generalized type, SSRI's are also the first-line choice. Buspirone augmentation may be helpful next. MAOI's should also be considered.

For PTSD, trazodone for insomnia may be the first and sufficient choice. SSRI's are first line for core PTSD symptoms with consideration of nefazodone. Second line are sedating tricyclics. Further recommendations are discussed.

For OCD, SSRI's are first-line treatment. Second-line recommendations are different augmentations depending on OCD subtype. Also consider clomipramine. When there are differences in relation to the type of addiction, these are addressed.

For all decision points, reasonable alternatives are presented with an analysis of their comparative merits. Benzodiazepines are generally accorded low priority for anxiety disorders in patients with chemical dependence.

No. 39E
PSYCHOPHARMACOLOGICAL ALGORITHMS: MENTAL RETARDATION

Edwin J. Mikkelsen, M.D., *Mentor Clinical Care, 313 Congress Street, 5th Floor, Boston MA 02210;* Leo McKenna, R.P.H.

SUMMARY:

Psychopharmacological algorithms can be diagnosis based for those individuals with mental retardation who present with behavioral disorders that clearly fit into existing nosological categories. Treatment algorithms for those who do not present with this degree of diagnostic clarity can be constructed by using a symptom-based approach that takes into account the existence of ancillary symptoms that may provide clues to an underlying etiology, the severity of the behavioral disorder, the probability of success from a particular agent, the side-effect profile of different medication options, and potential behavioral or organic contributions. The most common maladaptive behaviors that require this approach are severe self-injurious and/or aggressive behavior.

This process will be illustrated via a review of the published literature concerning the use of tricyclic and serotonin-reuptake inhibitor antidepressants for individuals with mental retardation who present with self-injurious and/or aggressive behavior. This exercise allows one to compute an approximate probability of success, which is the most difficult component of the equation to establish. Utilizing this methodology with other classes of psychotropic medication can lead to the construction of empirically based pharmacological algorithms for specific severe maladaptive behaviors as they occur in difficult-to-diagnose individuals.

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SYMPOSIUM 40—MEDICAL MARIJUANA: OPTIONS AND PROBLEMS
Joint Session With the American Academy of Addiction Psychiatry

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The participant will be able to define (1) specific medical indications for marijuana relative to other treatments, (2) historical and policy issues impinging on relevant legislative activities, and (3) specific cognitive and adverse effects of the drug.

No. 40A
THE PHARMACOLOGY AND CLINICAL PHARMACOLOGY OF MARIJUANA

Claudio A. Naranjo, M.D., *Depts. Pharma. Psych. Med., Sunnybrook Health Science Ctr., 2075 Bayview Avenue Room F327, Toronto, ONT M4N 3M5, Canada*

SUMMARY:

Interest in marijuana has been renewed because of its potential medical uses. Cannabis, obtained from the flowering tops of hemp plants, is a very ancient drug. The hemp plant synthesizes at least 400

chemicals, of which more than 60 are cannabinoids (i.e., psychoactive substances). The three most abundant include cannabinol, cannabidiol, and several isomers of tetrahydrocannabinol. The isomer responsible for most of the characteristic psychopharmacological effects is Δ^9-THC. Cannabinoid receptors have been described in various regions of the brain with the greatest abundance in the basal ganglia, hippocampus, and cerebellum. There are at least two subtypes of receptors: CB1 and CB2. The function of these receptors and the specific antagonists are still under investigation. Endogenous ligands (e.g., anandamide) have been identified but their role is still not fully elucidated. THC acts in the brain reward system and interacts with the ascending dopaminergic pathways. This action may explain its reinforcing effects. Cannabinoids also have other pharmacological effects (e.g., analgesic, hormonal, etc.). Time course of these effects may vary. Peak effects after inhalation and i.v. administration occur after 60 to 90 minutes. Δ^9-THC is lipophilic and thus is extensively distributed in fatty tissues and the brain. Redistribution may modulate drug concentrations. Plasma half-life is 50 to 60 hours after one-hour inhalation. The drug is extensively metabolized and induction of metabolism is possible. Δ^9-THC crosses the placental barrier. Because of interactions with many bodily systems various beneficial and side effects are possible.

No. 40B
MEDICAL MARIJUANA AND DRUG POLICY REFORM

Ethan A. Nadelmann, Ph.D.,J.D., *The Lindesmith Center, 888 Seventh Avenue, New York NY 10016*

SUMMARY:

The issue of medical marijuana has been highly politicized in the United States, and to a lesser extent, in other countries as well. The success of Proposition 215, the Medical Marijuana Ballot Initiative in California, has stimulated a national debate with important implications for broader drug policy reform. The issue is now under consideration in state legislatures and new ballot initiatives as well as the subject of fairly extensive litigation. Questions have been raised about the relationship between medical marijuana reform and other aspects of the drug policy reform agenda.

No. 40C
MARIJUANA: STILL A SIGNAL OF MISUNDERSTANDING

J. Thomas Ungerleider, M.D., *Department of Psychiatry, UCLA Med Ctr NPI, 760 Westwood Plaza, Los Angeles CA 90024*

SUMMARY:

This brief presentation will begin with events shortly after the isolation and identification of THC as the principal psychoactive ingredient in marijuana, namely the submission of the findings of the National Commission of Marijuana and Drug Abuse to President Nixon in 1972. It will review the history of marijuana policy and the research emanating (and not emanating) therefrom. It will conclude with this presenter's view of a truly incredible phenomenon: a retired general, serving as the most recent "drug czar," is repeatedly threatening to criminally prosecute physicians, not for prescribing marijuana, but for talking to their patients (including terminally ill patients), and suggesting that marijuana might be medically helpful. Loss of DEA license and all HMO contracts would also result from such a conversation. Beyond threats, federal legislation has been introduced stating that the physician must serve not less than eight years in the penitentiary if the patient was even one day under 21 years old when the medical marijuana suggestion was given (SB 40; Helms, Faircloth). How has this assault on one of the most sacred parts of our medical tradition, the patient-physician relationship, evolved? Examples and anecdotes will be presented.

No. 40D
COMPASSION OR CONTRADICTION? MARIJUANA AS A MEDICINE

John Mendelson, M.D., *Department of Psychiatry, University of Calif. at S.F., 401 Parnassus Ave. BX CPR0984, San Francisco CA 94143;* Debra S. Harris, M.D., Reese T. Jones, M.D.

SUMMARY:

Marijuana has been used as a medicine for at least 2,000 years. In the last 30 years, marijuana has been used to relieve nausea and vomiting in cancer patients undergoing chemotherapy; to lower intraocular pressure in glaucoma patients; to decrease spasticity in neurologic conditions including multiple sclerosis, stroke, cerebral palsy, and spinal cord injury; for relief of acute and chronic pain; to treat depression, bronchospasm, epilepsy, alcoholism, alcohol and opiate withdrawal, and bacterial infections; and for suppression of tumor growth. Marijuana has been used to stimulate appetite in cancer and AIDS and to treat numerous other conditions. Efficacy and safety have yet to be established for the treatment of most of these conditions. Despite a lack of enthusiasm by the medical establishment, the people of California and Arizona in 1996 voted to permit marijuana to be used for the treatment of medical illnesses. Marijuana is now being dispensed through a variety of outlets in California. The evidence supporting and refuting the effectiveness of "medical marijuana" in the treatment of medical diseases will be presented. The patterns of use and the illnesses treated in current users of marijuana as a medicine in the San Francisco area will be described.

No. 40E
ADVERSE EFFECTS OF MARIJUANA: DO THESE LIMIT MEDICAL USE?

Robert B. Millman, M.D., *Department of Psychiatry, Cornell Univ. Medical Center, 411 East 69th Street, New York NY 10021-5603;* Ann Beeder, M.D.

SUMMARY:

The effects of cannabis are quite variable and depend on the route of administration, the personality, psychopathology, and expectations of the user and the setting. Given these complex interacting factors, it is often difficult for the most experienced clinicians to predict whether the drug might be useful or whether use might be associated with adverse consequences. Physicians attempting to prescribe this medication or recommending the use of this medication to patients must be aware of the possible indications for the drug, and what the adverse effects might be. The potential medical indications must be better characterized if the drug is to prove medically useful. The influence of the various factors noted on adverse effects and the prevalence, nature, and severity of the adverse effects will be discussed. Despite the intensity of the belief systems fueling much of this controversy, the prevalence, nature, and severity of adverse effects are reasonably well understood. Since the indications for the drug, the route, and the dose are not based on reliable experimental data or consensually developed empirical observations, some of this discussion will be based upon conjecture.

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SYMPOSIUM 41—PRACTICING EVIDENCE-BASED PSYCHIATRY: MDD

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To integrate practice guidelines, assessment tools, and clinical data for the treatment of major depressive disorder. At the conclusion of this presentation, participants will be able to apply principles of evidence-based medicine to the treatment of patients with major depressive disorder.

No. 41A
MAJOR DEPRESSIVE DISORDER: USING PSYCHIATRIC MEASURES IN CLINICAL CARE

Kimberly A. Yonkers, M.D., *Department of Psychiatry, UT Southwestern Medical Center, 5959 Harry Hines Blvd., #520, Dallas TX 75235-9070;* Jacqueline Samson, Ph.D., Laurie McQueen, M.S.W.

SUMMARY:

The *Handbook of Psychiatric Measures,* being developed by the APA, is an evidence-based guide to educate clinicians in evaluating, interpreting, and using measures. Envisioned as a "toolbox" with instructions for psychiatric measures, it will cover various domains of assessment including symptoms, function, and outcomes. The *Handbook's* purpose is to provide clinicians in mental health settings with a guide to available measures that are useful in the clinical care of patients or for the interpretation of treatment and services research.

This project responds to challenges and opportunities presented by health care reform, managed care, and patient care needs. Public and private entities are developing new methods for measuring and reviewing psychiatric care that may not reflect good research or the perspective of clinicians. Mental health providers and patients are being held to "criteria" for the determination of access to services or for inclusion in care networks. Many clinical and policy issues are affected by the selection and application of measures: eligibility determinations, outcomes assessment, risk adjustment, quality assurance, utilization review, and practice guideline-related activities.

How to choose, use, and interpret measures for clinical use with major depressive disorder is the presentation's focus. Topics include goals of assessment, implementation issues, interpreting psychometric data, and the selection of measures of severity and screening for MDD.

No. 41B
CLINICAL PRACTICE GUIDELINES FOR TREATMENT

T. Byram Karasu, M.D., *Department of Psychiatry, Albert Einstein College of Med., 1300 Morris Pk Ave, Belfer 202, Bronx NY 10461;* Deborah A. Zarin, M.D., Leslie Seigle

SUMMARY:

The American Psychiatric Association's practice guideline project is committed to the promotion of evidence-based psychiatry to improve patient care. APA practice guidelines are designed to result in documents that are both scientifically sound and clinically useful to psychiatrists by adhering to a development process that ensures clinical consensus, using standards from the Institute of Medicine and the American Medical Association. Well-constructed guidelines offer a critical review and synthesis of a rapidly expanding treatment literature; a framework for clinical decision making and, within it, recommendations for treating a "typical" patient with a given diagnosis; and consideration, in light of research data, of the implications of specific clinical features for treatment recommendations.

The major depressive disorder practice guideline was published in 1993. The guideline, which is currently being updated, covers various treatment principles and alternatives. More specifically, psychotherapeutic management and psychodynamic psychotherapy and psychoanalysis are reviewed. Also covered is the use of antidepressant and other psychotropic medications, ECT therapy, and considerations for concurrent medical disorders and other patient variables. The revised guideline will update the recommendations made in 1993 based on the current available literature.

No. 41C
WHAT'S REALLY GOING ON IN THE TREATMENT OF MDD?

Mark Olfson, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York NY 10032;* Harold Alan Pincus, M.D., Deborah A. Zarin, M.D., Julie L. Johnson, M.A.

SUMMARY:

Practice-based data collected through the APA's Practice Research Network (PRN) regarding the treatment of major depressive disorder will be presented. The APA PRN consists of 500 psychiatrists nationwide practicing in routine clinical practice settings who collaborate to conduct clinical and services research.

Detailed information regarding the sociodemographic and clinical characteristics (e.g., co-occurring disorders, level of functioning) of patients with major depressive disorder seen by psychiatrists will be presented. Treatment practice patterns including history, services provided, medication usage (dosage and type), and future treatment plans will be highlighted. Factors that may impact the provision of care, such as health care financing issues (e.g., payment source, type of health plan, utilization management techniques) psychiatrist characteristics, and clinical decision making will be examined. Comparisons of current psychiatric practice patterns for the treatment of major depressive disorder with external measures of quality, such as the APA practice guidelines, will be made.

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SYMPOSIUM 42—NEW INSIGHTS ON BIPOLAR DISORDER

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be better able to diagnose and treat patients with bipolar disorder.

No. 42A BIPOLAR MOOD DISORDER: OVERVIEW OF ILLNESS AND MANAGEMENT

Gary S. Sachs, M.D., *Bipolar Clinic, Massachusetts General Hospital, 15 Parkman Street, WACC-815, Boston MA 02114*

SUMMARY:

Bipolar mood disorders are common, deadly, and treatable. Although the DSM-IV criteria for mania are highly reliable, patients often go undiagnosed. Assessment is hampered by unrealistic expectations concerning the presentation and course of mania. The often imagined presentation of "full blown mania" with infectious euphoria, continuous motoric activity, and pressured speech is, in fact, rare. Reliance on the distorted self-report of manic patients to assess current signs and symptoms often misleads the clinician to diagnosis depression or euthymia. Collateral informants and emphasis on longitudinal factors improve diagnostic accuracy.

Unlike DSM-IV, Kraepelin's conceptualization of manic depressive insanity stressed the diagnostic significance of age of onset and course of illness. Understanding the natural course of illness greatly aids management as well as diagnosis of bipolar patients.

Polypharmacy is almost always necessary in approaching the treatment of bipolar patients. Skillful polypharmacy utilizes a systematic iterative approach to treatment and requires accurate clinical assessment. This presentation reviews guidelines for management of acutely manic patients through the maintenance phase of treatment and will provide instruction on the use of systematic assessment techniques developed at the Massachusetts General Hospital Bipolar Mood Disorder Program, including clinical monitoring at follow-up visits and simple mood charting.

No. 42B NOVEL TREATMENT STRATEGIES FOR REFRACTORY BIPOLAR DISORDER

Andrew L. Stoll, M.D., *Department of Psychiatry, Harvard Medical School, 221 Longwood Avenue, Boston MA 02115*

SUMMARY:

This presentation will review the pharmacology and clinical usage of traditional, as well as novel drug treatments for bipolar disorder. The safety and efficacy of various combinations of mood stabilizer drugs will also be reviewed. Recent work regarding possible mechanisms of action of mood stabilizing compounds suggests that inhibition of post-synaptic signal transduction pathways may be a feature common to all agents with acute and prophylactic efficacy in bipolar disorder. The implications of elucidating the mechanism of action for mood stabilizers are far reaching. First, safer and more rational combinations of mood stabilizing agents can be devised. Second, new mood stabilizing drugs can be formulated through an understanding of the mechanism of action of currently used mood stabilizing agents. One example is the omega-3 fatty acid group of compounds. High concentrations of omega-3 fatty acids in plasma membranes reduce signal transduction through inhibition of the hydrolysis of the membrane phospholipids, which serve as precursors to second messenger molecules. A recently completed double-blind, placebo-controlled trial of omega-3 fatty acids demonstrated that the omega-3 fatty acids did have mood stabilizing efficacy in unstable bipolar disorder. The next decade of bipolar research should produce major advances in our understanding and treatment of bipolar disorder.

No. 42C CHILD AND ADOLESCENT BIPOLAR DISORDER: A REVIEW

Ronald J. Steingard, M.D., *Department of Psychiatry, Cambridge Hospital, 1493 Cambridge Street, Cambridge MA 02139*

SUMMARY:

While bipolar disorder typically has an onset in early adulthood, the lifetime prevalence of bipolar disorder in adolescents is approximately 0.6%. Additionally 20% to 40% of adults with bipolar disorder report an onset of symptoms in childhood. While the adult onset of bipolar disorder is often associated with significant morbidity in all social domains, high suicide rates, and chronic disability, the early onset of bipolar disorder appears to be characterized by an even more pernicious course, which includes a poorer response to pharmacological interventions and is associated with high rates of familial loading. Furthermore, prepubertal onset bipolar disorder appears to be a nonepisodic, rapid cycling, mixed state disorder that is characterized by having a chronic course and high rates of comorbid psychopathology. The seriousness of the disorder and the consequences of early onset argue for greater recognition and understanding of childhood presentations of bipolar disorder. This presentation will review the epidemiology, natural course, comorbidity, and treatment of child and adolescent bipolar disorder.

No. 42D MRS STUDIES OF BRAIN CHEMISTRY IN BIPOLAR DISORDER

Perry F. Renshaw, M.D., *Brain Imaging, McLean Hospital, 115 Mill Street, Belmont MA 02178;* Deborah Yurgelun-Todd, Ph.D., Constance M. Moore, Ph.D., Suzann Babb, m.s., Bruce M. Cohen, M.D.

SUMMARY:

The recent development of magnetic resonance spectroscopy (MRS) methods for the noninvasive assessment of brain chemistry is providing new insights into the pathophysiology of bipolar disorder. The first MRS studies of bipolar disorder made use of lithium MRS to measure human brain lithium levels. This body of work has suggested that brain lithium levels are lower than those in serum and that elimination of lithium from the brain is much slower than elimination from muscle or blood pools. This may, in part, explain why the neurological complications of lithium toxicity persist following a decline in serum lithium levels. Also, steady state brain:serum lithium ratios appear to increase with age, thus providing a rationale for the clinical observation that some younger patients require higher serum lithium doses. Studies of brain chemistry using both phosphorus (31P) and hydrogen (1H) MRS are providing evidence for brain

region and mood state dependent alterations in membrane phospholipid metabolism. In particular, manic subjects appear to have decreased cortical levels of cytosolic choline, a precursor for phospholipid synthesis. Lithium is known to potently and specifically inhibit transmembrane choline transport and this effect may mediate some aspects of lithium's therapeutic efficacy. These observations also suggest that clinical trials of agents that modify membrane function or metabolism for the treatment of bipolar disorder may be warranted.

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SYMPOSIUM 43—ETIOLOGY OF EATING DISORDERS: HIGH-RISK GROUPS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To understand the etiology of eating disorders based on an examination of high-risk groups. The participant should be able to understand the risk factors for eating disorders and thereby to identify etiological factors that may be amenable to prevention and treatment.

No. 43A
EPIDEMIOLOGIC STUDIES OF EATING DISORDERS

Paul E. Garfinkel, M.D., *University of Toronto, 250 College Street, #835, Toronto, ONT M5P 1R8, Canada*

SUMMARY:

Whether the eating disorders have increased in frequency is open to debate. Several studies have now shown a cohort effect with an increased frequency of bulimia nervosa in individuals born after 1960, and a younger age of onset in this time period. Data from the Ontario Health Supplement will be used to describe this. Changes in the frequency of anorexia nervosa are less clear but are also suggestive of an increase. Again, there is evidence for a decrease in age of onset in conjunction with changing cultural forces. There has been a change with regard to the syndromal features, with a shift toward an increase in bulimic forms.

Risk factors will be described using data from the Ontario Health Supplement and the literature. These risks include: pressures to be thin and to perform (e.g., medical students, ballet students, and dancers), some familial states (e.g., depression, alcoholism, eating disorders, and impaired autonomy) and individual characteristics (e.g., depression, low self-esteem, obesity, diabetes mellitus, and earlier sexual abuse).

The eating disorders are multifactorial syndromes, which are the products of an interplay of various forces. Epidemiologic studies can help determine mechanisms of etiology.

No. 43B
EATING DISORDERS AND SEXUAL ABUSE: WHAT IS THE LINK?

Janet M. deGroot, M.D., *Department of Psychiatry, Toronto Hospital-Western Div., 399 Bathurst Street, Toronto, ONT M5T 2S8, Canada*

SUMMARY:

The number of research studies investigating the role of a history of sexual abuse among women with eating disorders has burgeoned in the past decade but they reveal highly conflictual findings. The prevalence of reported childhood sexual abuse among those with eating disorders is variously reported as equal to the general female population, or increased to the same extent as in women with other psychiatric disorders, or as present among all women with eating disorders. The balance of evidence suggests that childhood sexual abuse acts as a nonspecific risk factor that may contribute to the development of an eating disorder. Further, history of childhood sexual abuse may affect the nature and severity of the eating disorder, the level of psychological disturbances or frequency of serious personality disorders, and the response to treatment. Potential mediators contributing to these associations with childhood sexual abuse may include impaired family functioning and self-denigratory beliefs. This literature will be reviewed and the role of the therapeutic environment in clarifying important "links of meaning" between such memories and eating disorder symptomatology will be discussed.

No. 43C
COMPULSIVE EXERCISING AS A RISK FOR EATING DISORDERS

Caroline A. Davis, Ph.D., *Department of Psychology, The Toronto Hospital, 200 Elizabeth Street, Toronto, ONT M5G 2C4, Canada*

SUMMARY:

Compulsive exercise may increase the risk for eating disorders. Not only is the prevalence of excessive exercise among eating disordered patients very high, but high-level exercisers are more weight preoccupied and have a greater drive for thinness than moderate exercisers. Cultural influences, individual vulnerabilities, and biological factors all help to explain the link between eating disorders and exercise. Focus on body and appearance is common among high exercising females, particularly those who are perfectionistic and who compare themselves negatively with underweight fashion figures. Elite athletes and ballet dancers may experience even more pressure of this kind in their subcultures. An animal model—relevant for those who are highly athletic, have a low body weight, but are not strictly anorexic—suggests that the risk of their condition becoming unstable and degenerating is very high. We know that food-restricted rodents will increase their physical activity. However, with moderate restriction they tend to stabilize their body weight at about 75% of freely fed rats while maintaining a high level of running. Eventually, however, this highly perturbed system becomes unstable, the animals increase activity, eat less, and soon die. Whereas exercise is health-promoting in humans, compulsive exercise may be a risk factor for dietary restriction and chronic serious eating pathology.

No. 43D
THE RELATIONSHIP BETWEEN OBESITY AND EATING DISORDERS

Allan S. Kaplan, M.D., *Department of Psychiatry, The Toronto Hospital, EN8-231, 200 Elizabeth Street, Toronto, ONT M5G 2C4, Canada;* Donna Ciliska, Ph.D.

SUMMARY:

This presentation will examine the relationship between obesity and eating disorders, focusing on obesity as a risk factor for an eating disorder and on treatment outcome of obese eating-disordered individuals. Obesity, whether in childhood or in adulthood, has been well established as a significant risk factor for the development of an eating disorder. A biopsychosocial risk factor paradigm will be presented to postulate mechanisms through which the overweight state predisposes an individual to an eating disorder. Factors such as the genetics of weight control, comorbidity, the effects of dieting and caloric restriction, as well as the psychosocial consequences of obesity will be reviewed in detail in this regard. The presentation will examine epidemiologic data supporting the increased prevalence of eating disorders, specifically bulimia nervosa and binge eating disorder, in clinical and nonclinical populations of obese subjects. In addition, outcome studies of obese eating-disordered patients treated at the Eating Disorder Day Hospital Program of the Toronto Hospital will be presented. These data demonstrate that in subjects with bulimia nervosa, the presence of obesity, whether current or historic, is associated with a poorer outcome ($p < .05$), defined as the frequency of bingeing and purging post-treatment, compared with normal weight, never obese bulimic subjects. The presentation will conclude with a discussion of the specialized interventions developed at the Toronto Hospital specifically for obese subjects with dysregulated eating. Data will be presented related to the effect of these interventions on the obese eating-disordered individual.

No. 43E
EATING DISORDERS IN GAY MALES: DOUBLE STIGMA

Arnold E. Andersen, M.D., *Department of Psychiatry, University of Iowa, 200 Hawkins Drive, Iowa City IA 52242*

SUMMARY:

Eating disorders are more common in gay males than in the general population. Gay males account for 20% of eating disorders vs 5% for the general population. Increased risk for eating disorders in gay males may be mediated by weight and shape norms within the gay community. Gay men demonstrate more body dissatisfaction and greater desire for thinness than heterosexual males, while lesbian females score lower on body dissatisfaction than heterosexual females. Sociocultural, rather than biomedical factors, better explain sexual orientation differences in prevalence of eating disorders. Gay sexual orientation is more likely in adolescent and young adult eating-disordered males rather than in pre-pubertal males or eating-disordered males >25. Bulimic gay males are at increased risk for being HIV positive or to have AIDS. Personal stigma and perception of stigma from others for eating disorders add to the still present stigma from gay orientation. Gay eating-disordered males often consider their eating disorder more of a burden than being HIV positive. Treatment of gay males must integrate psychosexual and gender identity issues along with weight restoration, normalization of bulimic behavior, and treatment of psychiatric and medical comorbidity. Future research should include preventative work in the gay community to decrease eating disorder risk.

No. 43F
EATING DISORDERS AND DIABETES: IATROGENIC?

Gary M. Rodin, M.D., *Department of Psychiatry, The Toronto Hospital, 200 Elizabeth Street, Toronto, ONT M5G 2C4, Canada;* Marion P. Olmsted, Ph.D., Anne Rydall, M.S.C., Shari I. Maharaj, M.A., Patricia Colton, M.D., Jennifer M. Jones, B.A., Denis Daneman, M.B.

SUMMARY:

Insulin-dependent diabetes mellitus is a metabolic disorder that is common in adolescence and associated with insulin deficiency and elevated blood sugars. Prevalence studies of eating disorders in young women with diabetes have been contradictory and inconclusive due to small sample sizes in the age of risk and variable assessment tools. However, it has been established that one third of adolescent females with diabetes deliberately omit insulin to prevent weight gain and up to 25% suffer from clinical or subclinical eating disorders. Normal dietary self-regulation is disturbed by the restrictive dietary requirements of diabetes treatment, particularly in young women who are already weight preoccupied. Further, body dissatisfaction and the drive for thinness may be heightened by the weight gain associated with insulin treatment. These factors may lead to a cycle of dietary restriction, binge eating, and deliberate omission of prescribed insulin to prevent weight gain. The consequences of this cycle are significant since young women with diabetes and eating disorders have elevated blood sugars and a three-fold increase in the incidence of diabetic eye disease. Preliminary evidence suggests that interventions such as psychoeducation help to alleviate these eating disturbances.

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SYMPOSIUM 44—DEVASTATING EFFECTS OF CHILDHOOD ABUSE ON MIND AND BRAIN

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of the symposium the participant will be able to identify the range of psychiatric outcomes associated with exposure to childhood abuse, and will have an understanding of emerging work identifying correlates in the brain and physiology of abuse.

No. 44A
CLINICAL PRESENTATION OF DISSOCIATIVE DISORDERS RELATED TO ABUSE

Dorothy O. Lewis, M.D., *550 First Avenue/NB 21S25, New York NY 10016*

SUMMARY:

Exposure to severe childhood physical and sexual abuse is associated with a wide range of adverse psychiatric outcomes. This presentation will focus on the relationship of extreme, ongoing physical and/or sexual abuse to the development of dissociative identity disorder (DID) in children. The phenomena associated with DID in children will be illustrated in a videotape.

No. 44B
EFFECTS OF CHILDHOOD ABUSE ON PSYCHOPATHOLOGY AND BRAIN ANATOMY

J. Douglas Bremner, M.D., *Department of Psychiatry, Yale University, P.O. Box 208038 Yale Station, New Haven CT 06520*

SUMMARY:

There is an increasing appreciation for the long-term effects of childhood physical and sexual abuse, through increased psychopathology, as well as biological and anatomical changes in the brain. We have studied survivors of extreme childhood physical and sexual abuse using psychometric evaluation, neuropsychological testing, and neuroimaging. Patients were evaluated with the Early Trauma Inventory (ETI), a reliable and valid instrument for assessment of a wide range of childhood traumas. Scores on the physical, emotional, and sexual abuse subscales were highly correlated, suggesting that these events tend to occur together. Surprisingly, exposure to emotional abuse events was associated with an equally high relative risk for the development of PTSD in adulthood as sexual and physical abuse events. Severity of abuse exposure as measured with the ETI was correlated with deficits in verbal declarative memory in the abuse patients ($r = -0.46$; $p < .05$). Patients with childhood abuse-related PTSD showed a 12% reduction in left hippocampal volume as measured with magnetic resonance imaging (MRI) in comparison subjects ($p < .01$), as well as marked deficits in verbal declarative memory. Data from 24-hour measurement of plasma cortisol is currently being analyzed. These findings indicate that a wide range of abuse events in childhood can have long-term consequences on mental health as well as the brain.

No. 44C
THE NEURO-ARCHEOLOGY OF CHILD ABUSE AND NEGLECT: USE AND DISUSE OF DEPENDENT NEURODEVELOPMENT

Bruce D. Perry, M.D., *Department of Psychiatry, Baylor College, One Baylor Plaza, Houston TX 77030*

SUMMARY:

Deprivation of sensory stimuli during critical periods of development result in altered brain organization and functioning. Over the last five years, we have been systematically examining a variety of abuse-related factors in maltreated children. This work has demonstrated various patterns of neurodevelopment associated with abuse and neglect, supporting a neuro-archeological view of trauma.

Children (n = 450; ages 8 mo-17y) experiencing abuse, neglect, or both were evaluated using clinical and psychophysiological measures, CT or MRI imaging, and continuous heart rate (CHR) monitoring. Superimposing videotaped interactions of these children (n = 50) with their CHR allowed a comparison of "free-play" (FP) vs structured interviews (SI).

All children demonstrated "trauma-specific" significant changes in mean HR during SI relative to FP. Children (80% female) with predominant dissociative symptoms had mean decreases in HR, while those (80% male) with predominant hyperarousal symptoms had increases in HR during SI. A total of 13 of 23 CT/MRI scans in children with severe neglect demonstrated either "cortical atrophy" or "enlarged ventricles."

We conclude that the impact of experience (or lack thereof) during childhood alters brain development and functioning. These findings support a "neuro-archeological" conceptual framework for studying brain development and functioning following abuse and neglect.

No. 44D
STRESSOR REACTIVITY IN ABUSED AND NONABUSED GIRLS

Frank W. Putnam, Jr., M.D., *Devp Psychopath Bldg 15K, NIMH, 9000 Rockville Pike, Bethesda MD 20892;* Penelope Trickett, Ph.D., Jennie Noll, Ph.D.

SUMMARY:

Clinical research has established that traumatized individuals often show heightened physiological reactions to stressors, particularly if they are reminiscent of the trauma. This study investigated HPA axis reactivity and heart period variability in sexually abused (N = 31) and matched comparison girls (N = 51) to a neutral stressor (mental rotation task) and a traumatic stressor ("most traumatic event" narrative). There was a significant group x time ($p = .006$) effect for serial salivary cortisols during the neutral stressor and a group by condition trend ($p = .07$) for vagal tone during the traumatic stressor. Grouping subjects by high or low dissociative status yielded significant group x time ($p = .0002$) and group by condition ($p = .05$) effects, respectively. This study extends research on differential reactivity to abused children under neutral and traumatic stressor conditions.

No. 44E
CHILDHOOD AND OTHER TRAUMAS IN THE ETIOLOGY OF DEPRESSION

Carolyn M. Mazure, Ph.D., *Psychiatry, Yale University Med Sch, Yale New Haven Hosp 10-507 EP, New Haven CT 06504;* J. Douglas Bremner, M.D.

SUMMARY:

Purpose: The role of childhood trauma in the etiology of adult depression has long been a subject of interest. We examined the relationship between childhood abuse and other traumas in 30 patients with major depression and 30 comparison subjects without psychiatric disorders.

Methods: Trauma history was assessed with the Early Trauma Inventory (ETI), a 56-item standardized instrument that assesses physical, sexual, and emotional abuse, and a range of other traumatic events, occurring before the age of 18. Relative risk for depression following exposure to individual abuse/trauma events was examined using odds ratios.

Results: There was a significant increase in relative risk for depression in individuals who had been exposed to death of a sibling (OR = 16.2; $p = .01$), natural disaster (OR = 15.2; $p = .001$), and assault (OR = 10.5; $p = .01$). There was also a significantly increased risk for depression in individuals who had received severe physical punishment in childhood (OR = 10.5; $p = .01$). Although events from the emotional or sexual abuse domains did not confer a significantly increased risk for adult depression, there was a pattern of increased adult depression for several abuse events.

Discussion: The findings provide empirical support for theories indicating that various types of traumatic stress in childhood are risk factors for depression in adulthood.

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SYMPOSIUM 45—NEUROANATOMY OF NORMAL AND PATHOLOGICAL EMOTION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

Describe what recent empirical findings in humans reveal about the neural substrates of: (1) certain normal emotions (e.g., happiness and sadness); (2) familial mood disorders, including the effects of treatment; (3) OCD; and (4) PTSD.

Describe current understanding of the relationship between normal and pathological emotional states.

No. 45A NEURAL CORRELATES OF NORMAL HUMAN EMOTION

Richard D. Lane, M.D., *Department of Psychiatry, University of Arizona, P.O. Box 245002, Tuscon AZ 85721;* Eric M. Reiman, M.D., Margaret M. Bradley, Ph.D., Peter J. Lang, Ph.D., Raymond J. Dolan, M.D.

SUMMARY:

To investigate the neural substrates of pleasant and unpleasant emotion, 12 healthy women viewed emotion-evoking picture sets while positron emission tomographic (PET) measurements of regional cerebral blood flow (CBF) were obtained. Pleasant and unpleasant emotion were each distinguished from neutral by significantly increased CBF in the vicinity of medial prefrontal cortex (BA 9), thalamus, hypothalamus, and midbrain, areas previously activated in a study of happiness, sadness, and disgust. Unpleasant emotion was also associated with activation of bilateral occipitotemporal cortex and cerebellum and left parahippocampal gyrus, hippocampus, and amygdala, while pleasant emotion was also associated with activation of the head of the left caudate nucleus.

We next studied ten normal men in a selective attention paradigm designed to examine the neural correlates of subjective emotional responses during viewing of emotional picture sets. When subjects attended to their subjective emotional responses highly significant increased neural activity was elicited in rostral anterior cingulate cortex (BA32) and medial prefrontal cortex. In contrast, under the same stimulus conditions when subjects attended to spatial aspects of the picture sets, activation was observed in parieto-occipital cortex bilaterally. The findings indicate a specific role for the anterior cingulate cortex in representing subjective emotional responses.

No. 45B MOOD LATERALIZATION: TRANSCRANIAL MAGNETIC STIMULATION

Mark S. George, M.D., *Department of Radiology, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425;* Ziad H. Nahas, M.D., Wendel Williams, M.D., Andrew M. Speer, M.D., Benjamin D. Greenberg, M.D., Robert M. Post, M.D.

SUMMARY:

Introduction: Brain lesion and tachistoscopic display studies support the role of the right hemisphere in producing and evaluating negative affect and the left, positive. However, these findings are controversial. We have been testing the role of the different hemispheres in emotion regulation with functional imaging (015 PET, echoplanar BOLD fMRI) and transcranial magnetic stimulation (TMS).

Methods: Using 015 PET, we imaged 11 healthy adult women while they were in three self-induced mood states (sad, happy, and neutral). In two other studies, we applied TMS over the left or right prefrontal cortex and examined self-rated mood.

Results: Self-induced sadness was associated with bilateral increased activity in prefrontal and lateral temporal cortex. In contrast, TMS studies have found lateralized effects on mood, with right-sided stimulation associated with increases in self-rated happiness and left-sided, sadness.

Conclusions: Thus, TMS studies appear to determine more lateralization of mood, while imaging studies reveal bilateral activity. These studies in mood are similar to imaging studies during movement, which commonly show bilateral activation (especially during complex tasks with the non-dominant hand), while TMS has only one hemisphere that can be stimulated to produce movement. TMS may be able to identify the necessary regions of a distributed network, while imaging studies often reveal the entire network. TMS is a useful additional tool for exploring questions of hemispheric lateralization and emotion.

No. 45C ANATOMICAL CORRELATES OF FAMILIAL MOOD DISORDERS

Wayne C. Drevets, M.D., *Department of Psychiatry, University of Pittsburgh, 200 Lothrop Str, PET Fac. B938, Pittsburgh PA 15213*

SUMMARY:

PET measures of blood flow and glucose metabolism were acquired to investigate the anatomical correlates of depressive episodes, the neurophysiological effects of antidepressant treatments, and the trait-like abnormalities that persist into remission in familial mood disorders. In the depressed versus the non-depressed states, flow and metabolism are increased in parts of the orbital and pregenual anterior cingulate cortex that appear similar to areas activated during experimentally induced emotional states in non-depressed humans. Flow and metabolism are also abnormally elevated in the amygdala and medial thalamus, and reduced in the dorsolateral and dorsomedial prefrontal cortex (PFC), the anterior cingulate gyrus ventral to the genu of the corpus callosum (subgenual PFC), and—in unipolar depressives—the caudate. Successful treatment alters metabolic activity toward normal in orbital cortex, dorsolateral PFC, medial thalamus, and amygdala.

During depressive episodes amygdala metabolism correlates positively with depression severity and plasma cortisol. Between episodes amygdala activity remains abnormally elevated in the unmedicated,

asymptomatic phase, and during treatment the failure to reduce amygdala metabolism is associated with an increased risk of relapse. Another trait-like abnormality exists in the subgenual PFC where MRI-based measures of grey matter volume are abnormally decreased in bipolar and unipolar samples.

No. 45D
FUNCTIONAL NEUROIMAGING STUDIES IN ANXIETY DISORDERS

Scott L. Rauch, M.D., *Department of Psychiatry, Mass. General Hospital, 149 13th Street, Charlestown MA 02129;* Paul J. Whalen, Ph.D., Lisa M. Shin, Ph.D.

SUMMARY:

Recent neuroimaging findings in anxiety disorders will be reviewed. Symptom provocation studies suggest that a core neural system, comprising anterior paralimbic and limbic structures, plays a role in mediating anxiety generally. However, specific anxiety disorders may be characterized by unique activation profiles, distinguishing them from other disorders or physiological anxiety states. For instance, cortico-striatal dysfunction has been implicated in obsessive-compulsive disorder (OCD) and involvement of the amygdala has been suggested in post-traumatic stress disorder (PTSD), whereas rostral anterior cingulate activation appears to be a nonspecific correlate of emotional information processing. We have assembled a battery of cognitive activation tasks that recruit these neural systems in an effort to develop improved tools for testing their functional integrity. Using PET and functional MRI, we have validated probes of (A) cortico-striato-thalamic circuits, (B) anterior cingulate sub-territories, and (C) the amygdala. Emerging findings using this strategy will be presented. For example, a study of patients with OCD demonstrated their failure to normally recruit the striatum while performing an implicit learning task; aberrant activations in medial temporal regions were observed instead. Functional neuroimaging techniques, including the complementary approaches of symptom provocation and cognitive activation paradigms, promise to advance neurobiological models of anxiety disorders.

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SYMPOSIUM 46—RECOGNITION, MANAGEMENT AND REPORTING OF DRUG-INDUCED DISEASE: A CLINICAL PHARMACOLOGIC APPROACH FOR PSYCHIATRISTS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

(1) Understand the diagnostic/management process utilized in the case of a patient with possible drug-induced psychiatric or non-psychiatric disease; (2) Describe how FDA reviews individual medication clinical investigational databases for adverse drug events (ADE's) and their impact on drug approval and labeling; (3) Explain clinical pharmacologic considerations (pharmacokinetic/pharmacodynamic) that underlie new drug approval and ADE management.

No. 46A
PREMARKETING DRUG SAFETY EVALUATION

Thomas P. Laughren, M.D., *HFD-120, Food & Drug Admin, 5600 Fishers Ln Rm 10B-45, Rockville MD 20857-0001*

SUMMARY:

Demonstrating that a drug is reasonably safe under the conditions of its proposed use is one of the requirements for drug approval and also the basis for safety information included in the drug's initial approved labeling. Evaluating the safety of a new drug on the basis of premarketing studies is a challenge since this database is generally relatively small and premarketing studies are focused mostly on showing effectiveness rather than safety. In fact, the approach to analyzing for safety is more a process of estimation and exploration rather than the hypothesis testing that characterizes the analysis of effectiveness data.

This presentation will focus on the approach used at FDA to evaluating the premarketing safety database for a new drug, beginning with a characterization of that database. The general goals of this process are to (1) identify causally related adverse events, (2) estimate the risk for those events, and (3) identify risk factors for those events, including patient factors such as age and gender, and drug factors, such as dose and duration of use. If successful, this process will reveal the more common adverse events associated with a drug's use, but will likely not identify the rare events that often emerge only after marketing.

No. 46B
DRUG-INDUCED DISEASE: PHARMACOKINETIC AND PHARMACODYNAMIC CONSIDERATION

John D. Balian, M.D., *Clinical Pharmacology, Food and Drug Administration, 1451 Rockville Pike HFD 850, Rockville MD 20852*

SUMMARY:

Significant morbidity may occur if benzodiazepines are overdosed, especially in the elderly. Three of the most commonly prescribed benzodiazepines, alprazolam, midazolam, and triazolam, have been shown to be substrates of cytochrome P450 3A (CYP3A). Since these benzodiazepines undergo significant first-pass metabolism, it is clear that metabolic inhibitors could cause clinically important changes in their clearance. Prolongation of the effects of short-acting benzodiazepines is known to result in significant morbidity including prolonged sedation, impairment of driving ability, and falls leading to hip fractures in the elderly. The importance of drug interactions with triazolam and alprazolam prompted recent changes to the clinical pharmacology labeling of these drugs. Clinical pharmacology incorporates the study of mechanism of action, pharmacodynamics (PD), pharmacokinetics (PK), PK/PD relationships, drug-drug interactions, special populations, and disease states. It optimizes drug dosing and individualization of therapy and evaluates drug safety and effectiveness. To make the labeling of a product more informative, now, it is routine to expect information on the metabolism, PK/PD characteristics, and properly designed drug interaction studies of a compound. Clinically significant drug-induced disease may be avoidable by the thorough study and analysis of drug metabolism in the drug development phase. Current state of knowledge of *in vitro* technologies and *in vitro-in vivo* correlations provides for such assessments.

No. 46C
CLINICAL ASSESSMENT, WORK-UP AND REPORTING OF ADVERSE DRUG EVENTS

Stephen A. Goldman, M.D., *Medwatch, Food and Drug Administration, 5600 Fishers Ln/HF-2/Rm 9-57, Rockville MD 20857*

SUMMARY:

The clinical assessment of adverse drug events (ADE's) is an important and complex task for psychiatrists and other health professionals to master. ADE recognition is impacted by its acknowledged subjectivity. Distinguishing between an ADE and normal disease can be difficult and sometimes impossible, as both may act through the same physiological and pathological pathways. As a result, it is often hard to reach a firm conclusion that a particular adverse event's occurrence is linked to drug exposure.

These considerations emphasize the need for a systematic approach to diagnosing drug-induced disease. Various structured strategies, and understanding such concepts as dechallenge and rechallenge, can be of great utility in ADE assessment. Of tantamount importance is the use of clinical experience and judgment, and knowing how to augment one's pharmacological knowledge base.

A drug's safety profile is an evolving, ongoing process deriving from post-marketing clinical experience. Including a possible ADE or drug-drug interaction in the differential diagnosis of a patient's disease or clinical symptoms should become part of the regular evaluative thought process. Further, by reporting serious adverse events/product problems to FDA's MEDWATCH program, psychiatrists and other health professionals can play a major role in improving the public health.

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SYMPOSIUM 47—SCHIZOPHRENIA: A NEURODEVELOPMENTAL PERSPECTIVE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand recent findings on the potential role of neurodevelopmental disruptions in the pathogenesis of schizophrenia.

No. 47A
PRENATAL RUBELLA AND ADULT SCHIZOPHRENIA

Alan S. Brown, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 2, New York NY 10032*

SUMMARY:

Objective: We sought to extend our findings on the relation between prenatal rubella and schizophrenia in a birth cohort clinically and serologically documented with gestational rubella exposure and followed up in young adulthood.

Method: In the present study, we compared: (1) the risk of schizophrenia between the rubella-exposed (N=70) and a larger unexposed cohort (N=1,346), (2) the respective proportions of cases and non-cases exposed in each month of gestation, and (3) the risk of affective disorders (unipolar and bipolar) between the exposed and unexposed cohorts.

Results: The rubella-exposed, versus the unexposed, demonstrated substantially increased and significant risks for schizophrenia [relative risk (RR) (95% CI)=6.6 (2.4–18.2), p=.002]. Maternal infection during gestational month 3 was observed in 62% of those meeting symptom criteria for schizophrenia, versus 36% of those not meeting criteria [RR (95% CI)=1.7 (.98–3.0), Fisher p=.09]. The risk for affective disorder was similar between the cohorts [RR (95% CI)= 1.1 (0.65–1.9), p=0.66].

Conclusions: Exposure to rubella in the third month of gestation may confer an especially increased risk of schizophrenia symptoms, and prenatal rubella appears to be a specific risk factor for schizophrenia among major psychiatric disorders. Ongoing studies of this cohort will also be discussed.

No. 47B
NEUROHORMONAL AND BEHAVIORAL CHANGE IN SCHIZOTYPAL ADOLESCENTS

Elaine F. Walker, Ph.D., *Department of Psychology, Emory University, Kilgo Circle, Atlanta GA 30322*

SUMMARY:

Stress and pubertal development have been viewed as playing important roles in triggering the expression of latent vulnerabilities to psychotic disorders. It has been suggested that the effect of stress on the behavioral expression of the neural substrate for schizophrenia is principally mediated by activation of the hypothalamic-pituitary-adrenal (HPA) axis. During puberty, normal neuromaturational changes stimulate increased activity of the HPA axis, as indexed by a rise in salivary cortisol. The research reported here is intended to identify the predictors of the progression of schizotypal personality disorder in adolescent subjects. We find that adolescents with SPD show elevated cortisol levels and more dysmorphic features (minor physical and dermatoglyphic abnormalities) when compared with normal and psychiatric controls. Further, cortisol levels, as measured at baseline, are linked with measures of clinical outcome one year later. The findings will be discussed in light of their implications for etiologic models of schizophrenia. Specifically, given evidence from experimental animal research that exposure to prenatal insult can result in both HPA dysregulation and dysmorphic signs, neural mechanism mediating the effects of prenatal and postnatal stressors on the expression of schizophrenia are explored.

No. 47C
GENES, PRENATAL FACTORS AND IQ OF OFFSPRING AT HIGH RISK FOR PSYCHOSIS

Jill M. Goldstein, Ph.D., *Department of Psychiatry, Harvard Medical School, 74 Fenwood Road, Boston MA 02115;* Stephen L. Buka, S.C.D., Larry J. Seidman, Ph.D., Hang Lee, Ph.D., Gwen L. Zornberg, M.D., Lisa Denny, B.A., Ming T. Tsuang, M.D.

SUMMARY:

The impact of genetics and obstetric complications (OCs: e.g., viral and chronic hypoxia [CH], on psychiatric and cognitive status

from birth to age 37 are being assessed in offspring of 200 psychotic parents individually matched to 200 normal controls from two cohorts of the National Collaborative Perinatal Project. They have been prospectively followed from maternal events during gestation to their birth through age 7, and are being assessed to age 37, regarding mental, motor, sensory, and physical development. To date, logistic regression of correlated binary outcomes of matched pairs over time was used to predict the cognitive status of high- versus low-risk male and female offspring up to age 7. Results on IQ showed that high-risk offspring were significantly more likely to fall in the lowest IQ decile and remain there through age 7, potentially suggesting a genetic influence on IQ deficits. This presentation will discuss the impact of the independent and interactive effects of OCs (viral and CH) with genetic vulnerability to psychosis on IQ up to age 7 in offspring at high risk for psychosis.

No. 47D
A RAT MODEL OF SCHIZOPHRENIA: NEONATAL HIPPOCAMPAL DAMAGE

Barbara K. Lipska, Ph.D., *CBDB, NIMH Neuroscience Center, 2700 Martin Luther King Ave SE, Washington DC 20032*

SUMMARY:

Traditional models of schizophrenia have greatly enhanced our understanding of the mechanisms of action of antipsychotic drugs and the mechanisms underlying certain behavioral phenomena. It seems, however, that this purpose is too narrow. Neuroleptics, even the atypical ones, do not cure schizophrenia. Animal models that have helped to develop them are limited in exploring novel therapeutic strategies that are not based on the traditional dopamine foundation. We have witnessed recently an explosion of interest in new animal models of schizophrenia based on the neurodevelopmental hypothesis. Their common feature is that they use an early developmental insult to indirectly disrupt certain brain functions in an animal's adult life. Our own studies have focused on perinatal damage induced by infusion of an excitotoxin into hippocampus in rats. This early hippocampal disruption has behavioral consequences different from those seen after similar damage produced in adulthood, and indirectly affects function of the dopamine system. This model mimics some of the key neurobiological features of schizophrenia; it also reproduces functional pathology in presumably critical brain regions interconnected with the hippocampus and targeted by the antipsychotic drugs-nucleus accumbens and medial prefrontal cortex. This model with its multiple aspects of the human disease in terms of phenomenology as well as its temporal characteristics, may prove useful in testing new therapies that would reverse or prevent the emergence of behavioral disturbances.

No. 47E
LOW SPECIFICITY FOR DEVELOPMENTAL PRECURSORS OF PSYCHOSIS

Peter B. Jones, Ph.D., *Department of Psychiatry, University of Nottingham, Porchester Road, Nottingham NG3 6AA, United Kingdom*

SUMMARY:

Developmental precursors of schizophrenia are important because they suggest models of causes, mechanisms, and preventive strategies. Specificity to subgroups of patients, or to schizophrenia itself among the psychoses, is fundamental to such models. Developmental precursors of a range of adult psychiatric patients were studied in two longitudinal samples: the British 1946 (n=5,362), and the North Finland 1966 (n=12,058) birth cohorts. In both, motor and speech milestones occurred later in children (n=30 and 89, respectively) who developed DSM-III-R schizophrenia as adults. In the former, IQ at 8, 11, and 15 years was lower in these children by some 33% of a standard deviation. In the British cohort, these findings were also evident in 195 cases of childhood affective disturbance; most effects were more modest than in schizophrenia but the pattern was similar. The effects for IQ occurred across the whole population—the lower the IQ, the higher the subsequent risk of both disorders. In the Finnish cohort, motor effects were also seen in other DSM-III-R psychoses. They also were not confined to subgroups. These overt effects are crude manifestations of *underlying* neural mechanisms, which *may* differ in different disorders. Unknown factors, and/or gender, may determine outcome. Low specificity is an advantage for prevention.

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SYMPOSIUM 48—MANAGEMENT OF SCHIZOPHRENIA WITH COMORBID DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation participants should be able to recognize clinically significant comorbid psychiatric conditions in schizophrenia. This symposium will familiarize participants with the new approaches in assessment and treatment of this often complex and refractory group of schizophrenics.

No. 48A
MANAGEMENT OF COMORBID DEPRESSION IN SCHIZOPHRENIA

Samuel G. Siris, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks NY 11004*

SUMMARY:

This presentation reviews the differential diagnosis of a depression-like syndrome in the course of schizophrenia, and the implication of each diagnosis for management and treatment. Differential diagnoses include comorbid medical conditions and side effects of treatment agents; acute or chronic use or discontinuation of substances, including nicotine and caffeine; acute disappointment reactions; demoralization syndrome; depression as an intrinsic component of decompensation, either on a biological or psychological basis; the "negative symptom" syndrome; a component of EPS secondary to neuroleptic use, including akinesia and akathisia; the possibility of other dysphoric reactions to neuroleptic medications; schizoaffective disorder; and a "true" affective syndrome occuring in the course of schizophrenia. Treatment strategies considered in relationship to these various situations include reducing or otherwise adjusting neuroleptic dosage; changing neuroleptic agents, including the possible use of so-called atypical neuroleptics; the rational use of adjunctive antidepressant medications such as tricyclics, SSRI's, or MAOI's; the potential role of other adjunctive agents such as benzodiazepines, lithium, antiseizure medications, or ECT; and the impor-

tance of psychosocial approaches. An orderly path for considering diagnosis and treatment will be presented.

No. 48B
MANAGEMENT OF OBSESSIVE-COMPULSIVE PATIENTS WITH SCHIZOPHRENIA

Michael Y. Hwang, M.D., *Department of Psychiatry, East Orange VAMC, 6 Boulder Trail, Chappaqua NY 10514;* Miklos F. Losonczy, M.D., Edward Steinberg, M.D.

SUMMARY:

While obsessive-compulsive (OC) phenomena in schizophrenia have been described for many years, their clinical and pathophysiological significance have remained obscure. Previously, OC phenomena among schizophrenics had been thought to occur only rarely and to have a relatively benign clinical course. Furthermore, the precluding of the simultaneous diagnosis of schizophrenia and obsessive-compulsive disorder (OCD) until the publication of DSM-III-R, resulted in significant clinical dilemmas in the management of these patients. However, recent studies have demonstrated greater prevalence and worse outcome among these OC schizophrenics. Also, a common neurobiological basis for OCD and a wide range of OC-related neuropsychiatric disorders (e.g., Tourette's syndrome, Sydenham's chorea, autism, eating and somatoform disorders) have been suggested in recent years. In our study of OC schizophrenics, the preliminary findings indicate a significantly worse clinical course and lower levels of functioning among the OC subgroup compared with non-OC schizophrenics. In addition, open treatment trials with adjunctive anti-OCD medication have demonstrated marked symptom relief and functional improvement in previously refractory OC schizophrenics. In this symposium presentation, we will examine the current clinical and neurobiological evidence in proposing a new treatment strategy for schizoprenics with OC features.

No. 48C
VIOLENCE IN SCHIZOPHRENIA

Leslie L. Citrome, M.D., *Clinical Research, Nathan Kline Institute, 140 Old Orangeburg Road, Orangeburg NY 10962;* Jan Volavka, M.D.

SUMMARY:

Violent or threatening behavior is a frequent reason for the admission to a psychiatric inpatient facility, and that behavior may continue after the admission. For patients with schizophrenia the association between pre-admission threats and post-admission violence is impressive. The distinction between transient and recidivistic assaultiveness is important: a small group of recidivistic patients may cause the majority of violent incidents.

Patients with schizophrenia and aggressive behavior must first be assessed for the possibility of comorbid conditions. Medical conditions need to be ruled out. A risk assessment that includes past history and access to weapons is vital.

Short-term sedation with lorazepam is a safe and effective choice for the acute episode. Longer-term management may include the use of a specialized hospital unit, if available. Pharmacotherapy remains the mainstay of treatment. Clozapine, and perhaps risperidone, appear to be more effective than typical neuroleptics in reducing aggressivity in patients with schizophrenia. Beta-blockers may also be helpful as an adjunctive agent to neuroleptics for aggression and schizophrenia. Carbamazepine and valproate are also used with neuroleptics to decrease the intensity and frequency of agitation and poor impulse control, but they have not been extensively studied under double-blind, placebo-controlled conditions. A new class of selective serotonin agonists, dubbed "serenics," holds hope that a specific anti-aggressive agent may be available in the future.

No. 48D
MANAGEMENT OF COGNITIVE IMPAIRMENT IN SCHIZOPHRENIA

Dilip V. Jeste, M.D., *Department of Psychiatry, Veterans Affairs Medical Ctr., 3350 La Jolla Village Drive, San Diego CA 92161-0001;* Barton W. Palmer, Ph.D., Jovier D. Evans, Ph.D., Julie A. Gladsjo, Ph.D., M. Jackuelyn Harris, M.D., Robert K. Heaton, Ph.D.

SUMMARY:

Cognitive impairment is an almost integral feature of schizophrenia. We have studied over 150 middle-aged and elderly patients with schizophrenia using a comprehensive neuropsychological test battery. The cognitive impairment is primarily in the areas of attention, learning, psychomotor and motor skills, and abstraction/cognitive flexibility. The severity of cognitive deficits in schizophrenia patients predicts worse functioning capacity, poorer prognosis, and greater cost of care. Clinically diagnosable dementia is uncommon among outpatients with schizophrenia. Presence of such dementia warrants search for known causes of dementia including physical comorbidity, medications, substance abuse, sensory impairment, etc. These causes, if detected, should be treated appropriately. The management of cognitive impairment requires a multipronged strategy that includes judicious use of antipsychotic medications, cognitive-behavioral interventions, and education of caregivers. There is growing evidence that the newer atypical antipsychotics are generally superior to the conventional ones in their beneficial effects on cognition in schizophrenia patients, although long-term studies with these agents are so far lacking.

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3. Volavka J: Neurbiology of violence. Washington, D.C., American Psychiatric Press, Inc., 1995.
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SYMPOSIUM 49—SINGLE PAYER OR COMPETITION? CANADIAN AND UNITED STATES VIEWS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: understand more clearly pros and cons of financing psychiatric care in Canada and/or the United States through a government system, with decision making more centralized, or a market-based system with more decisions entrusted to the periphery.

No. 49A
CANADA'S SINGLE PAYER SYSTEM

Arthur L. Lesser, M.D., *62 Thorndales Cres, Hamilton, ONT L8S 3K2, Canada*

SUMMARY:

Canada's health care system (Medicare) has been in place for 25 years. It is publicly financed by taxation, and is a system based on inclusion and need rather than exclusion and profit. It offers socialized insurance, not socialized Medicare. The federal government sets the standards; the provinces administer.

The Canadian system offers universality, comprehensiveness, access to care, and portability. There is limited or no interference in patient care, administrative costs are low, and technology resources are pooled. The results are improved health and high consumer satisfaction.

However, significant federal and provincial debts resulting in continued efforts at cost containment have adversely affected the system. Hospitals have been closed. Physicians' incomes have been capped. Nurses in particular have been affected by cutbacks. Hospitals have waiting lists for beds, for certain types of surgery, and access to sophisticated technology is rationed.

The system is gradually being transformed into being community based, rather than hospital based. The major cutbacks appear to be over. The system is at a crossroads, but the Canadian public has made it eminently clear that the system must be maintained at all costs. The coming few years will tell the tale.

No. 49B
WHY A PRIVATE ALTERNATIVE IS ESSENTIAL

Joseph Berger, M.D., *4430 Bathurst Street Suite 501, Downsview, ONT M3H 3S3, Canada*

SUMMARY:

The challenge is to provide the best medical services to the largest number of people at the most reasonable cost. Does the Canadian experience have something to offer? Twenty-five years ago there existed a mixed private and universally accessible public system. Today, Canada is restricted to government-controlled monolithic systems. I maintain that any reading of history and of economics demonstrates just one conclusion: that government-controlled monopolies are a disaster for the wider public. Data from the former Soviet Union have shown horrendously low life-expectancy rates. Data from hospitals in New York City in the early 1990's when government funding was reduced showed increased morbidity and mortality. A public system will always be vulnerable to political pressures.

Competition from a private alternative is essential to maintain high standards. The democratic concept of personal choice obligates the acceptance of a parallel private alternative.

If a two-tier system discriminates against the poor, then a one-tier system is just as discriminatory against those who choose to make health care a higher priority. The Canadian system that worked faded away ten years ago. Don't confuse that memory from the past with the system that is breaking down today.

No. 49C
ADVANTAGES OF SINGLE PAYER SYSTEM

Captane P. Thompson, M.D., *44 College Park, Davis CA 95616-3644*

SUMMARY:

Canada is ahead of us in many ways. Health care is a right, not a privilege. Everyone is covered whether rich or poor, employed or unemployed, citizen or recent immigrant. Doctors know their fee schedule and can gang bill for all patients seen each week and receive a single check. There are no copays or deductibles. Payment is not denied because an emergency visit was not pre-authorized. There are no arbitrary limits on the number of hospital days or outpatient visits per year.

Unlike Canada, the U.S. is rapidly retreating from government run health insurance. Medicare and Medicaid are being contracted out often to for-profit managed care organizations, to control costs. We are moving toward a single system with multiple payers. Behavioral health carve outs are consolidating. Legislation is being introduced to protect patients from some of the most egregious managed care policies.

However, even with truly beneficent managed care, there will be many seriously mentally ill persons who are too disorganized to continue treatment in the private system without a case manager to expedite their access to medical, social, financial, legal, and vocational rehabilitation services. We will need a publicly funded safety net that is well integrated with the acute care system, however it is funded.

No. 49D
MANAGED CARE VERSUS MEDICAL SAVINGS ACCOUNTS: FACT AND FICTION

Frederick K. Goodwin, M.D., *Department of Psychiatry, George Washington University, 2300 I Street, NW, Room 514, Washington DC 20037*

SUMMARY:

Managed care represents a profound challenge to our core values as professionals. Efforts to deal with it fall into two broad categories: (1) the development of alternatives that return economic control to individual patients and doctors; (2) expanded regulation of managed care through legislation or litigation. The problem with regulatory solutions is that, by increasing the role of government, they may actually further compromise the freedom of individual professionals and patients. This presentation will review the historical factors that have shaped (i.e., distorted) the financing of health care in the U.S. during the second half of this century—principally the imposition of wage freezes, which fueled the development of "wage equivalents," principally health benefits designed to circumvent wage freezes. The resultant "blank check" era of comprehensive insurance reimbursement set in motion the ever-enlarging cycle of overutilization-oversupply, which in turn eventually stimulated the top-down controls we call managed care. Medical Savings Account (MSA) legislation corrects an inbalance in the tax code, which created a tax penalty for those assuming financial responsibility for their own routine health care. This presentation will describe how MSA's (combined with catastrophic insurance) can work, review the data on the health status of MSA participants and their use of preventive services, and the evidence for and against adverse selection.

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SYMPOSIUM 50—PHARMACOLOGICAL TREATMENTS IN SCHIZOPHRENIA AND THEIR EFFECT ON COGNITIVE FUNCTION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To understand that cognitive treatment in patients with schizophrenia is necessary to improve patients' quality of life. The audience will be informed about the current data regarding the cognitive effect of the antipsychotic drugs and other novel agents.

No. 50A
COGNITION AND ATYPICAL ANTIPSYCHOTICS IN SCHIZOPHRENIA

Richard S.E. Keefe, Ph.D., *Psychiatry, Duke University, Box 3270, Durham NC 27710;* Susan G. Silva, Ph.D., Diana Perkins, M.D., Jeffrey A. Lieberman, M.D.

SUMMARY:

Cognitive deficits are a fundamental feature of the psychopathology of schizophrenia. Yet it is unclear to what extent treatment is effective against this dimension of the illness. Atypical antipsychotic medications have been reported to enhance neurocognitive abilities. However, studies of the pattern and degree of cognitive improvement with these compounds have been methodologically limited and produced variable results. Few findings have been replicated. To clarify the state of our understanding in this area, this presentation will describe the results of a meta-analysis of all published and abstracted studies of the effects of atypical antipsychotic drugs on neurocognitive deficits in schizophrenic patients, and describe the profile of therapeutic and adverse effects on neurocognition resulting from these pharmacologic treatments. This meta-analysis suggests that few cognitive functions consistently respond to atypical neuroleptic treatment. The most consistent finding is that atypical neuroleptics minimize the adverse effects of extrapyramidal symptoms, and thus allow better performance on tests of motor skills. The implications of these data for the treatment of neurocognitive deficits with atypical neuroleptics will be discussed, as will the potential cognitive effects of newer atypical neuroleptics currently under investigation.

No. 50B
EFFECTS OF CLOZAPINE ON COGNITION IN SCHIZOPHRENIA

Larry J. Seidman, Ph.D., *Mass Mental Health Center, 74 Fenwood Road, Boston MA 021115;* William S. Stone, Ph.D., Anthony Kalinowski, Ph.D., Win Sachs, Ph.D., Joseph J. Schildkraut, M.D., Alan I. Green, M.D.

SUMMARY:

Despite incomplete effects, treatments for schizophrenia reduce clinical symptoms and improve functioning. The growing recognition that residual deficits in schizophrenia are at least partly mediated by cognitive problems, however, underscores recent attempts to develop treatment strategies that target both clinical and cognitive symptoms. This issue is being addressed in an ongoing study of the neuropsychological effects of clozapine in treatment-refractory schizophrenia. We report here on within-group comparisons, initially after patients received "standard" neuroleptics, and subsequently after they received treatment with clozapine. All subjects have chronic schizophrenia and marked cognitive impairment when tested on standard neuroleptics (≈ 1 standard deviation below that expected in schizophrenia). Results from neuropsychological tests thus far support these main conclusions: (1) Clozapine improves cognitive functions in schizophrenia, despite the severity of the sample. (2) The extent of improvement is largest in tests of memory, smallest in tests of executive function, and intermediate in most other measures. (3) Clozapine's positive effects on neuropsychological function may be most apparent in subgroups of subjects. Moreover, as neuropsychological functions do not return completely to normal levels after treatment, either the administration of clozapine to a less chronic sample, and/or its use in conjunction with novel pharmacotherapies, may improve selected cognitive abilities further.

No. 50C
EFFECT OF RISPERIDONE ON COGNITIVE FUNCTION IN SCHIZOPHRENIA

Ileana Berman, M.D., *Department of Psychiatry, Taunton State Hosp/Harvard Med, 60 Hodges Avenue, Taunton MA 02780;* Demetra Pappas, B.S., Charu Patel, M.D., Howard Chang, M.D., Donald Goff, M.D.

SUMMARY:

There has been an increased interest in studying the effect of novel neuroleptics on cognitive function in chronically psychotic patients. Some studies have shown that clozapine may be superior to typical neuroleptics in improving cognitive function. We are going to present our results about the effect of risperidone on cognitive performance. Approximately 60 patients with a clinical diagnosis of schizophrenia or schizoaffective disorder were assessed psychiatrically and cognitively before and six weeks after risperidone initiation. The patients' assessments included the Positive and Negative Syndrome Scale for schizophrenia (PANSS) and a cognitive battery that included the Mini-Mental Status Examination (MMSE), as well as tests of verbal fluency, attention, and memory. On risperidone, the patients improved in all the PANSS scores, in the MMSE, and other cognitive assessments. The present data support the hypothesis that risperidone, in addition to improving the clinical schizophrenic symptoms, may have an effect on cognitive function as well. Based on this trial, we cannot determine whether this improvement in cognitive function is a specific cognitive effect of risperidone, or whether it is the result of the overall improvement of these patients who also showed amelioration in their psychiatric symptoms. In a small double-blind comparison study with haloperidol, risperidone continued to show an improvement of the global cognitive function as measured by the MMSE, even though other cognitive scores did not suggest significant changes. The importance of finding agents (e.g., ginkgo biloba extract and glutametergic drugs) that target specifically cognitive deficits in patients with schizophrenia will be discussed.

No. 50D
EFFECTS OF GLUTAMATERGIC AGENTS ON COGNITIVE FUNCTION

Donald C. Goff, M.D., *Psychiatry, Freedom Trail Clinic, 25 Stanford Street, Boston MA 02114;* Ileana Berman, M.D., Thomas Posever, M.D.

SUMMARY:

As the primary excitatory neurotransmitter in the brain, glutamate is believed to play a major role in cognitive functions. Antagonism of the glutamatergic NMDA receptor complex by phencyclidine (PCP) and ketamine produces impairment on tests of working memory and disrupts patterns of perfusion of the prefrontal cortex. D-cycloserine, a partial agonist of the glycine recognition site of the NMDA receptor, improves memory function in animal models, and improved performance on a test of working memory when added to conventional neuroleptic in a preliminary study of ten patients with

schizophrenia. More recently, the "ampakines," which positively modulate activity of the glutamatergic AMPA receptor, have been shown to facilitate memory in animal models. Data will be presented from a placebo-controlled, dose-finding trial of an ampakine, CX516, added to clozapine in patients with schizophrenia, evaluating performance on a neuropsychological battery.

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SYMPOSIUM 51—EARLY DETECTION AND THE TREATMENT OF FIRST PSYCHOSIS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The symposium will demonstrate the importance of focusing on the early course of psychosis, the promise of early treatment, and a new study designed to test these issues.

No. 51A
THE TIPS PROJECT: AN INTERNATIONAL MULTICENTER SITE FOR EARLY DETECTION

Per Vaglum, M.D., *Behavioral Sciences, University of Oslo, PO Box 1111 Blindern, Oslo N-0317, Norway;* Thomas H. McGlashan, M.D., Erik Simonsen, M.D., Jan Olav Johannessen, M.D., Stein Opjordsmoen, M.D., Svein Friis, M.D.

SUMMARY:

Several recent studies indicate that a reduction of the duration of untreated psychosis (DUP) may improve the prognosis of first-onset schizophrenia. However, these studies have so far not been able to rule out that the poor prognosis after a long DUP may be due to a systematic sampling bias. To find out whether a reduction in DUP really makes a difference, the TIPS project, using a quasi-experimental design, compares the outcome of first-onset schizophrenic patients from a catchment area with a specific early detection program for reducing DUP (Rogaland County, Norway, N = 320,000) with such patients from two catchment areas with "detection as usual" (Ullevaal Sector, Oslo, N = 185,000 and Roskilde Sector, Denmark, N = 95,000). There will be between 200 to 300 patients included in the study. All sites have the same core two-year treatment protocol including medication, multi-family group intervention, and individual, supportive psychotherapy. We are studying the course and outcome by using identical assessment methods (including a neuropsychological battery) at all sites: at entry and after three, 12, 24, and 60 months. The early detection program in Rogaland consists of mass media campaigns, education of professionals and the public, and special, easily available detection teams. All patients coming to these teams are evaluated, and particularly those who possibly are in a prodromal phase, are followed-up to identify predictors of psychosis. Details of the design, methods, and organization will be outlined.

No. 51B
EARLY DETECTION IN THE EXPERIMENTAL SECTOR

Jan Olav Johannessen, M.D., *P.O. Box 1163, Rogaland Psychiatric Hospital, Armauer Hansensvei 20, Stavanger 4004, Norway;* Marthe Horneland, M.D., Gerd Ragna Bloch-Thorsen, M.D., Tor Kjetl Larsen, M.D., Cato A. Guldberg, M.D., Sigurd Mardal, Ph.D.

SUMMARY:

Studies of untreated psychosis in first-episode cases have revealed that patients are often psychotic for a long period before they get help. Bringing treatment more rapidly to a person who has become psychotic is therefore a major challenge for our psychiatric health care systems. A strategy for early detection of psychosis in the experimental sector of the TIPS project is described. This includes an early detection system and team with education programs targeted toward primary health care systems, psychiatric treatment centers, and the public through radio and newspaper advertisements.

Before starting the information campaign, we did an opinion poll at baseline in Rogaland County (320,000 inhabitants), Telemark County (200,000 inhabitants), and the Ullevaal Sector of Oslo County (185,000 inhabitants), regarding attitudes toward psychiatric disorders and help-seeking behavior. Results of the poll showed a relatively positive attitude toward psychiatric patients, but relatively low knowledge regarding psychotic disorders and their symptoms. This opinion poll will be repeated bianually to see if the level of knowledge changes over time, i.e., whether the massive information campaign has an impact. Key aspects of the poll will be described.

The information toward schools will be described and includes lectures for high school teachers regarding early signs and ways of referral, brochures, and videos for teachers and pupils. The GP's and other health professionals in the catchment area will be trained in the PANSS psychosis rating scale and the early signs of psychosis through a program consisting of videos, lectures, and training in symptom evaluation (the TIPS manual). The information used with the public will be outlined, and examples of brochures given to all households nationwide will be demonstrated, as well as newspaper advertisements and other elements of the two-year information package.

Preliminary results from the first half year indicate that we are able to change the help-seeking behaviors of the public and reduce duration of untreated psychosis (DUP). Early data about recruitment include the following: referrals to the Early Detection Team 01/01/97-03/06/97: 374; assessed (PANSS/GAF): 81; included: 35; observation group ("at risk mental states"): 26. Sources of referral: mother: 17%, father: 4%, sibling: 6%, child: 4%, patient: 18%, spouse: 5%, psych. clinic: 15%, school: 10%, GP: 8%, other: 13%.

We will present data from the first 15 months.

No. 51C
TIPS: THE NORWEGIAN COMPARISON SITE, ULLEVAAL HOSPITAL

Ingrid Melle, M.D., *Department of Psychiatry, Ullevaal Hospital, Kirkeveien 166, Oslo N0407, Norway;* Svein Friis, M.D., Eva Sortland, M.D., Stein Opjordsmoen, M.D., Emly Ellefsen, M.D., Kjersti S. Tvedt

SUMMARY:

Ullevaal Sector is the largest catchment area in Oslo, covering 46% of Oslo's acreage and 39% of the inhabitants in the city. Out

of 185,500 inhabitants in this sector, 120,000 are 15 to 65 years of age. The greatest variance in living conditions in Norway is found in the capital, and the variability in social structure in our sector is representative for Oslo as a whole.

Based on an earlier study and on admission data for the last few years, we expected 25 to 30 patients to be included in the TIPS study during the first year. By August 1997 a total of 39 first-episode patients were eligible for diagnostic screening. Seven patients (two with a possible diagnosis of schizophrenia) refused to participate in the screening. Thirty-two patients have been screened. Sixteen patients met the inclusion criteria, but five of these refused to give informed consent to further participation (four with a probable diagnosis of schizophrenia). The diagnostic distribution for the 11 included patients is: schizophrenia or preliminary diagnosis of schizophreniform disorder (5), schizoaffective disorder (1), mood disorder with mood-incongruent delusions (2), delusional disorder (1), brief psychotic disorder (1), and psychosis NOS (1). The mean age (SD) for the patients is 33 years (10), GAF symptoms 29 (8), GAF function 33 (6), PANSS positive 21 (7), PANSS negative 15 (8), and PANSS general 35 (8). Duration of untreated psychosis ranged from one to 260 weeks for the patients with schizophrenia (median 40 weeks) and from one to 87 weeks for the patients with other psychotic disorders (median one week). None of the patients met the criteria for a deficit syndrome. The patients with schizophrenia that did not give informed consent to further participation had a duration of untreated psychosis that ranged from 26 to 52 weeks (median 52).

We will present findings for the first 15 months. We will discuss the results with emphasis on psychopathology, duration of untreated psychosis, and motivation for treatment.

No. 51D
TIPS: THE DANISH COMPARISON SITE, ROSKILDE COUNTY, DENMARK

Erik Simonsen, M.D., *Fjorden, Amtssygehuset, Smedegade 10-16, Roskilde DK-4000, Norway;* Ulrik Haahr, M.D., Anne Dahl, M.D., Lis Olsen, M.D.

SUMMARY:

The Middle Sector in Roskilde County, Denmark, is one of the two comparison sites of the TIPS project. It has a population of 95,000 inhabitants. We have 12 to 15 first episodes of psychosis a year. Premorbid, clinical, functional, and psychosocial characteristics of 18 to 20 patients included in the project will be presented.

To date, 18 patients have been evaluated with PANSS and SCID; 11 patients fulfilled the criteria for entering the study; seven have entered the study, while four are considering it now. No one has refused to participate. Seven patients did not meet the inclusion criteria, one was mentally retarded and had suffered severe abuse, two were not psychotic but showed prodromal symptoms. Four were diagnosed as various personality disorders; one of these was anorectic.

Preliminary data on the seven patients included in the study are as follows: four male and three female patients, age 20 to 41, median age 25. Diagnosis: paranoid schizophrenia, five; schizo-affective disorder, two. Alcohol and substance abuse was a major problem in four of the patients. These patients had a long duration of untreated psychosis, the abuse presumably masking the severe symptoms. Only one patient had a history of conduct disorder in childhood. Deficit syndrome was present in one patient.

Duration of untreated psychosis was from 16 to 186 weeks, median 53 weeks. Prodromal phase: 0 to 296 weeks, median 143 weeks. Initial GAF ratings: symptoms 23 to 38, median 35; functional level: 28 to 45, median 35. Initial PANSS ratings positive subscale: 14 to 25, median 16; negative subscale: 7 to 30, median 12,5.

Updated data will be presented.

No. 51E
DURATION OF UNTREATED PSYCHOSIS: CAN IT BE REDUCED?

Tor Kjetl Larsen, M.D., *Rogaland Psychiatric Hospital, Armauerhansensy 20, Stavanger 4011, Norway;* Cato A. Guldberg, M.D., Kjetil Hustoft, M.D., Svein Aspoy, R.N., Marthe Horneland, M.D., Knut Gabrielsen, R.N., Jan Olav Johannessen, M.D.

SUMMARY:

At Rogaland Psychiatric Hospital in Stavanger, Norway, a first-episode pilot study of consecutively admitted non-affective psychoses was carried out during 1993 and 1994. Duration of untreated psychosis (DUP) was long (mean 2.1 years; median 26 weeks). We established a service for early treatment and intervention in psychosis (the TIPS project) on January 1, 1997. The experimental sector is Rogaland County, with a program for early detection of psychosis. This program includes educational initiatives, medical/social detection networks, and early detection teams of clinicians.

This study has two principal aims: (1) to test if a program designed to reduce DUP in the Rogaland geographical area actually reduces DUP in a current sample; and (2) to test if a reduction in DUP actually improves the outcome of the current sample compared with the pilot sample.

Results as of August 1, 1997. Sixteen patients have been included in the new project. Compared with the pilot sample, we find a marked reduction in DUP (114 vs. 21 weeks mean, 26 vs. 12 weeks median, $p < 0.001$). Age at hospitalization was 28.4 in the pilot sample and 25.4 in the current study. There are no statistically significant differences between the two samples regarding gender, premorbid functioning, age at onset of psychosis, GAF at hospitalization, or PANSS scores at hospitalization. The only exception was "unusual thought content": in the current sample, patients have much fewer bizarre delusions ($p < 0.001$).

Significance. Early results suggest that DUP can be reduced. DUP data will be presented on at least twice the sample size and will include early longitudinal data on prognosis and outcome.

No. 51F
FAMILY INTERVENTION IN PRODROMAL AND EARLY PSYCHOSIS

William R. McFarlane, M.D., *Department of Psychiatry, Maine Medical Center, 22 Bramhall Street, Portland ME 04102*

SUMMARY:

Objective: The presentation will describe the specific aspects facing the family during the early phases of psychotic disorders and the therapeutic interventions that have been designed to address them. These interventions are in use in treatment trials in Norway and Maine.

Methods: The approach being used is an adaptation of psychoeducational multiple family groups, which have been demonstrated to be a highly cost-effective means of preventing relapse and fostering functional recovery. The adaptation focuses on the atypical components of early psychosis, especially ambiguities of diagnosis; overlap of psychosis-driven behavioral aberration and adolescent misbehavior; cognitive impairments and normal neuropsychological immaturity; and family response to incipient psychosis and instability commonly associated with developmental milestones and events in late adolescence, among others. The intervention includes empathic engagement of patient and family, education about the psychobiology of the common psychotic disorders, the benefits and mechanisms of action of antipsychotic drugs, and strategies for family management of symptoms and relapse prevention, and ongoing multiple-family groups with a focus on problem-solving, individualized illness management, and communication skills.

Results: While research outcomes are not yet available, effects observed clinically to date include a high rate of participation in family educational workshops, increases in acceptance of illness and in medication compliance, and reductions in family conflict burden and patient-family schism. We will report on early empirical results in relapse, medication and therapy compliance, vocational status, family perceptions of burden and conflict, and degree of family cohesion.

Conclusion: Family intervention that addresses the particularities of early-phase psychosis shows promise to significantly alter the course and prognosis of these illnesses, when undertaken in concert with advanced drug therapy and psychosocial management and rehabilitation.

All mental health disciplines, medical generalists, family advocacy group members.

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SYMPOSIUM 52—A WORLDWIDE CHALLENGE: WORLD PSYCHIATRIC ASSOCIATION'S RESPONSES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation the participant should be able to describe the World Psychiatric Association's programs on education, schizophrenia, diagnostic assessment, and review of the ICD-10 for psychiatrists.

No. 52A
WORLD PSYCHIATRIC ASSOCIATION EDUCATIONAL PROGRAMS IN THE CZECH REPUBLIC: A MODEL

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

SUMMARY:

The Czech Psychiatric Association is a society of about 1,000 members. It meets regularly 10 times a year in the capital, Prague, where about 200 psychiatrists attend. One of the main activities of the society is the participation in postgraduate and continuing psychiatric training. WPA educational programs are also valuable tools for this purpose. We have translated into the Czech programs on dysthymia, schizophrenia, social phobia, and OCD. The schizophrenia program was lectured in three modules. About 40 psychiatrists participated in all of them. Social phobia was the most successful program, prepared in three steps including weekend training in CBT methods. About 50 psychiatrists received certificates and another 20 will get receive them in the near future. The OCD program was presented several times during the various psychiatric conferences and weekend training of CBT is being prepared. We are now ready to present the newly prepared depression program. Our society was asked to prepare a special program regarding panic disorder. WPA educational programs are popular in the Czech Republic and are useful teaching aids in training of psychiatrists as well as in the education of medical students. About one third of our psychiatrists have taken part in them and one-tenth of them received certificates stating that they fulfilled the criteria.

No. 52B
WORLD PSYCHIATRIC ASSOCIATION EDUCATIONAL PROGRAMS ON TEACHING AND LEARNING ABOUT SCHIZOPHRENIA

Driss Moussaoui, M.D., *Centre Psych Universitaire, IBN Rochd Rue Tarik IBN Ziad, Casablanca 00210, Morocco*

SUMMARY:

Research in the fields of psychiatry and mental health witnessed a tremendous growth during the two last decades. Dissemination of this new knowledge is essential to the progress of the daily practice. That is why education became a very important part of the work of the World Psychiatric Association.

Contrary to what happened for depression, schizophrenia was almost forgotten from the educational point of view. As a result a WPA Program on Schizophrenia, supported by a grant from Janssen, was initiated in 1994, "Teaching and Learning about Schizophrenia."

The committee that developed this document was chaired by N. Andreasen, and included J.A. Costa e Silva, T. Crow, J.J. Lopez Ibor, and D. Moussaoui. Fourteen other contributors from various parts of the world helped in this program.

The whole kit includes text and slides and is divided into four modules (clinical presentation, pathophysiological mechanisms, treatment, and case vignettes). This program was translated into several languages (particularly Spanish, Japanese, Korean, and Czech) and has been widely distributed.

No. 52C
A WORLDWIDE CHALLENGE: EDUCATION EFFORTS BY THE WORLD PSYCHIATRIC ASSOCIATION

Pedro Ruiz, M.D., *Department of Psychiatry, University of Texas, 1300 Moursund Street, Houston TX 77030*

SUMMARY:

The use of in-training examinations within medical specialities has expanded greatly in the last two to three decades. Multiple-choice in-training examinations have been used since the mid 1960's. The internal consistency or reliability of multiple-choice questions in exams with more than 100 questions has been well established. This type of exam method is very useful when one intends to test knowledge across a wide range of topics. However, new methods of testing knowledge have evolved in recent years, for instance, the written patient management problem format in which a complex clinical scenario is presented and the examinee is tested based on

his clinical decisions and actions resulting from previously acquired knowledge. This type of exam format can also be used via computers. The use of "simulated patients" has also been tried in exams focusing on the assessment of clinical performance. With respect to continuing education programs, a good method of evaluation is the subjective grading of the didactic methodology used and the knowledge conveyed in the educational program. In this presentation, the pros and cons of these methods of evaluation will be addressed thoroughly.

No. 52D
INTERNATIONAL GUIDELINES FOR DIAGNOSTIC ASSESSMENT

Juan E. Mezzich, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, 5th Ave & 100th Str, Box 1093, New York NY 10029*

SUMMARY:

This presentation discusses a WPA educational program under development that is aimed at offering international recommendations for comprehensive and practical diagnostic evaluations. It covers the following components: (a) conceptual and historical bases, (b) interviewing the patient, (c) extended sources of information, (d) organizing the clinical chart, (e) symptom and mental status evaluation, (f) supplementary assessment instrument, (g) standardized multiaxial formulation, (h) Idiographic or personalized formulation (which includes consideration of cultural framework), and (i) linking diagnosis to treatment and prognosis.

One of the program's innovative features is the articulation of a comprehensive diagnostic model. This encompasses a standardized multiaxial diagnosis aimed at facilitating international communication on clinical patterns and therapeutic approaches as well as an idiographic formulation to pay attention to the uniqueness of each patient and thus engaging him or her in the process of clinical care.

No. 52E
ICD-10 FOR PSYCHIATRISTS AND PRIMARY CARE PHYSICIANS

Juan J. Lopez-Ibor, Jr., Ph.D., *Clinica Lopez Ibor, Nueva Zelanda, 44, Madrid 28035, Spain*

SUMMARY:

The World Psychiatric Association has developed educational tools to increase diagnostic skills of psychiatrists and other professionals, based on experiences in different countries. For instance, in Spain every psychiatrist and every resident in psychiatry has received a free copy of the different versions of the ICD-10 and about 80% have participated in one-day training seminars. General practitioners have been involved in the field trial of the primary health care version and subsequently all of them have received a copy of the primary health care version. About 15% of them have attended training seminars carried out by general practitioners with the support of psychiatrists. The training also includes diagnostic instruments such as the SCAN or the IPDE (International Personality Disorders Evaluation). Similar training has been carried out in other Spanish and non-Spanish-speaking countries. One year ago the World Psychiatric Association prepared a diskette including instructions for carrying out seminars, references, case vignettes, and a collection of slides, which can be printed for overhead projection or transferred to a program for making slides. This diskette, which was produced in conjunction with the Division of Mental Health of the World Health Organization, was distributed to the participants of the Xth World Congress of Psychiatry (Madrid, 1996). A second edition will be available in mid 1998.

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SYMPOSIUM 53—CULTURE AND ETHNICITY: AN ARAB PERSPECTIVE
Joint Session With the Arab-American Psychiatric Association

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize cultural factors in dealing with Arab patients.

No. 53A
ETHNIC AND CULTURAL INFLUENCE IN THE PSYCHIATRIC DIAGNOSIS

Ossama T. Osman, M.D., *Department of Psychiatry, Mercer University, 1508 College Street, Macon GA 31210*

SUMMARY:

A complete psychiatric evaluation includes assessment of an individual's ethnic and cultural values. Exploration of one's ethnic background, cultural views of their illness, cultural identity, and cultural support system is critical before being able to accurately formulate a diagnostic impression.

An increasing number of academic institutions and clinicians world-wide are using the structured diagnostic methodologies in the DSM manual. The DSM-IV prompts clinicians to take into account the individual's ethnic and cultural context in the evaluation of each of the DSM-IV axes.

This presentation will clarify how culture is important for diagnostic formulation. Cross-cultural comparisons of specific examples of psychiatric syndromes will be reviewed. Important culture-specific features of psychiatric disorders in patients of Arab origin will be outlined.

No. 53B
GROUP THERAPY: AN ISLAMIC APPROACH

Osama M. Al-Radi, M.D., *PO Box 1083, Taif 00270, Saudi Arabia*

SUMMARY:

An eclectic approach to group therapy based on Islamic worship practices, Holy Quran, sayings of the prophet Mohammad, and accepted techniques of contemporary schools of group therapy are applied to patients in a private polyclinic in Taif, Saudi Arabia. The goals of therapy were first the elimination of symptoms, then overcoming loneliness, alteration of behavior through mechanisms of conscious control, better adaptation, personal growth with increasing awareness and a continuous search for personal potential, and finally activation of Islamic values and standards as a central idea for the individual and group. Sixty-eight male outpatients of different diagnoses undertook group therapy over a period of 20 months. The majority were between 20 and 30 years old. A total of 41.1% had a college education, 29.4% had secondary school education, 47 percent had a diagnosis of social phobia, 35.4% reached the ultimate

goal of formation of the Islamic central idea, 29.4% had experienced symptom relief, 17.6% of patients did not show any improvement (eight of them are personality disorder patients and four are schizoprenics). The total improvement on various levels was 82.4%.

No. 53C
ETHNICITY AND PSYCHOPHARMACOLOGY

Ahmed M.F. Okasha, M.D., *Neuropsychiatry, Ain Shams University, 3, Shawarby Street/Kasr El Nil, Cairo 00094, Egypt*

SUMMARY:

There is a large individual variability in drug response and side-effect profiles, which can reach 40 fold or more. This variability can be determined by genetic disease, nutritional states, concurrent use of drugs, and demographic factors such as age, gender, and ethnicity. Associations have been identified between ethnicity and pharmacogenetics, which in turn can influence the patient's response to a particular drug. P450, which is a cytochrome responsible for the metabolism of the majority of chemotherapeutic agents, is genetically controlled and so the response of patients to drugs such as SSRI's and anticonvulsants will vary among individuals and ethnic populations. Also there is an ethnic difference in the frequency of poor and extensive metabolizers. Cultural and psychosocial factors will affect pharmacodynamics and pharmacokinetics and compliance to drug intake.

This presentation will discuss the effect of ethnicity on the psychopharmacology of tricyclic antidepressants, monoamine oxidase inhibitors, selective serotonin reuptake inhibitors, neuroleptics, and lithium with a highlight on its impact on the Arab world.

No. 53D
ETHNICITY AND TRANSCULTURAL ASPECTS OF ECT

Tarek A. Okasha, M.D., *48 Geziret El Arab Street, Mohandeseen Imbaba 12411, Giza 00094, Egypt*

SUMMARY:

The guidelines and indications of ECT in the United States and Europe cannot be the ideal method in developing countries. In Egypt ECT is considered to be the least expensive treatment and so its application in a variety of psychiatric disorders is a necessity. In addition, it is a treatment where compliance is better than drugs with our Egyptian or Arab mental patients.

The stigma of ECT is changing gradually through the mass media and by abandoning the term "electroconvulsive therapy" in favor of "brain synchronizing therapy" (BST) or "brain restoration treatment" (BRT).

The author will present his experience with 120 Egyptian patients, receiving about 1,000 ECT's, and will review the diagnoses, outcome, and complications with an evaluation of cognitive functions following ECT, using a battery of objective psychometric tests.

No. 53E
EDUCATING TRAINEES TO CARE FOR PERSONS OF OTHER CULTURES

Earl L. Loschen, M.D., *Department of Psychiatry, Southern Illinois University, SOM, P.O. Box 19230, Springfield, IL 62794*

SUMMARY:

Objective: As the cultural diversity of the United States continues to increase, it is ever more important to expand the experience of medical students and residents with different cultural groups during their training. However, it is often difficult to highlight cultural issues effectively within the usual clinical training setting where the trainee is often more engrossed with eliciting psychopathology and instituting treatment than with understanding the cultural milieu of the patient.

Method: To address this challenge, we have developed a set of activities and experiences for medical students and residents emphasizing cultural issues. In addition to the series of seminars, conferences, and other didactic work, we have established an elective experience for trainees in conjunction with a Native American reservation, which allows our trainees to experience first-hand an annual celebration involving tribal rituals and native healing ceremonies.

Results: To date our trainees who have elected this experience have been overwhelmingly enthusiastic. Likewise, this has been a positive experience for the reservation.

Conclusion: Development of a nonclinical experience for students utilizing a clearly defined cultural group can increase student awareness of cultural issues.

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SYMPOSIUM 54—THE CONNECTIONS BETWEEN GENDER AND VICTIMHOOD
APA Rhode Island Psychiatric Society's Committee on Women

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium the participants will be able to identify the factors that may lead a person to present as a victim or to be reacted to as a victim, both in society and in treatment.

No. 54A
THE EXPLORATION OF THE CONCEPT OF VICTIMHOOD IN A PATRIARCHAL CULTURE AND THE CONSEQUENCES FOR EACH GENDER

Alison M. Heru, M.D., *Department of Psychiatry, Brown Univ./ Butler Hospital, 345 Blackstone Boulevard, Providence RI 02906*

SUMMARY:

Victimhood is a state of having been subjected to trauma, often of an overwhelming nature, and is somewhat synonymous with a diagnosis of acute stress disorder or post-traumatic stress disorder. One can be a victim of a motor vehicle accident, hostage-taking, war, torture, childhood or adult sexual assault, or abuse, etc. The adoption of the role of victim is, however, different from these diagnoses. What factors contribute to the adoption of the role of victim? Do sociocultural influences play a part in reinforcing the

role of victim for women and not sanction this role for men except in special circumstances, e.g., war hero? Is victimhood associated with secondary gain, and what is the role of responsibility in those people who see themselves and are identified as victims? Clearly the aggressor is responsible for the traumatic event, but what is the responsibility of the victim toward preventing relapse, and toward his/her recovery? How does gender play a role in this recovery process?

No. 54B
INDO-PAKISTANI WOMEN: THE CAPTURED BEINGS

Neeta Jain, M.D., *Women and Infants Hospital, 101 Dudley Street, Providence RI 02905;* Uzma Ambareen, M.D.

SUMMARY:

Women's roles are heavily dictated by their cultural standards and influenced by the surrounding environmental forces. The authors present and discuss the paradox that exists among Indo-Pakistani women. This subcontinent is home to millions of illiterate and impoverished village women as well as women holding influential positions of power and prestige such as Benazir Bhutto and Indira Gandhi. It is hard to determine whether these women would have been as established in the political arena if their fathers were not prominent figures. Even so, it is harder to say whether these women would have arisen to their political status as single women. All these women share a commonality: they are held captive by the very institutions that attempt to safeguard and protect them, such as family, marriage, educational institutions, employment, and political infrastructure. How do women in a patriarchal society overcome roles that are gender specific? What are the factors that are common in women who strive and prevail in defining themselves as professional?

No. 54C
WOMEN, TOBACCO, BONDAGE AND FREEDOM

Terry Halbert, J.D., M.D., *School of Bus. & Mgmnt., Temple University, 111 Speakman Hall (0006-00), Philadelphia PA 19122*

SUMMARY:

There is, in the marketing of tobacco products to women, an ironic twist. While it often plays on the theme of breaking the bonds of sexism, it has the effect of reinforcing those bonds, adding to them the bonds of physical addiction. From the days of the flapper to the modern "You've come a long way, baby," women have been encouraged to think of cigarettes as torches of freedom, to think of smoking as self-expressive, rebellious. This emancipation is pure illusion, however. Because of another, repressive series of associations, women exist to be desirable to men. To be desirable to men women must be sultry and slender: smoking is seductive; smoking keeps weight down. In 1967, as cigarette manufacturers began pouring billions of dollars into the marketing of brands like Virginia Slims and Silva Thins, sales to teenaged girls spiked sharply upwards. We witness this enslavement to thinness—as synonymous with glamour and attractiveness—even as the actual dangers of smoking are more publicly known than ever.

The tobacco juggernaut is now poised to exploit this strategy in the developing world, where the vast majority of smokers are so far male, but where millions of women will soon learn to be "free."

No. 54D
GENDER AND THE MEDICAL RESPONSE

Henrietta L. Leonard, M.D., *Department of Psychiatry, Brown University/RI Hospital, 593 Eddy Street, Providence RI 02903*

SUMMARY:

This presentation will focus on how the medical community may respond to specific symptoms of individuals based upon biases and increasing constraints. The perception that complaints are taken less seriously from patients who are women will be examined. Obstacles to women accessing health care and being included in clinical trials will be reviewed.

No. 54E
VICTIMHOOD: THE ROLE OF LEGAL INTERVENTIONS

Patricia R. Recupero, M.D., J.D., *Department of Psychiatry, Brown Univ./Butler Hospital, 345 Blackstone Boulevard, Providence RI 02906*

SUMMARY:

The judicial system's traditional approach to issues relating to women has been paternalistic and protectionistic. In early legal theory married women were considered to be incompetent and unable to transact business on their own behalf. Gradually, during the industrial revolution, women began to take their place outside the home. This period resulted in the introduction of many legislative efforts to protect the "virtue" of women from the depraved influences of men. This process resulted in a number of protectionist legislative efforts that limited the ability of women to participate in economic life and to enforce their own autonomy.

With women's suffrage, women were seen as gaining more power. There was a backlash against some of the protectionist legislation, but most remained in force. It has only been after 1960 that a re-examination of the protectionist philosophy for the "weaker sex" has been addressed systematically.

This presentation will examine the consequences of legal attempts to disenfranchise women from the economic fear, protect women from the sexual depredations of men, and to protect women from presumed sexual violence. Special emphasis will be placed on laws regulating sexual conduct between men and women and the differing responses to issues such as pornography.

The role of legislation and judicial protection in furthering the perception of various groups as victims will be reviewed. Alternative strategies for addressing the legislature and seeking court action will be discussed.

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4. Swedo SE, Leonard HL: It's Not All in Your Head: Now Women Can Discover the Real Causes of Their Most Commonly Misdiagnosed Health Problems: New Breakthroughs. San Francisco: Harper Collins, 1996.
5. Sexual Harassment in the Workplace and Academia: Psychiatric Issues. Edited by Shrier DK. Washington, DC, American Psychiatric Press, Inc., 1996.

SYMPOSIUM 55—MILITARY MENTAL HEALTH

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to discuss current developments in military mental health practice,

including changing readiness roles, community prevention initiatives, confidentiality protections, and trends in military residency programs.

No. 55A
THE MILITARY PSYCHIATRIST IN DEPLOYMENT

Elspeth C. Ritchie, M.D., *Department of Psychiatry, Walter Reed Army Med. Ctr., Washington DC 20307;* James R. Rundell, M.D.

SUMMARY:

The military psychiatrist is increasingly called upon to deploy to disasters and conflicts throughout the world. Recent deployments have included the Gulf War, Haiti, Somalia, and Bosnia. Preparation for deployment includes advising commanders on preparing personnel for extended separations and on determining which personnel are not suitable for deployment. The psychiatrist must decide which psychiatric medications should be brought on the deployment and must undergo personal training for the deployment environment and its primitive conditions. During a deployment, the military psychiatrist uses well-established principles of military psychiatry, including the concepts of immediacy, proximity, expectancy, and simplicity. The doctrine of combat stress control is employed both preventively and therapeutically. Unique deployment stressors include exposure to dead bodies, limited contact with home, a potentially hostile populace, and the possibility of biological and chemical warfare. Military psychiatrists assist with critical incident debriefings during deployments. When psychiatric pathology occurs, the question of fitness for continued duty must be addressed. The psychiatrist must decide which personnel can be retained in the deployment theater and which must be returned home. He or she must also assist in redeployment and preparing military personnel to return home at the deployment's conclusion.

No. 55B
MENTAL HEALTH IN PRIMARY CARE: AN AIR FORCE PROTOTYPE PROJECT

Karl O. Moe, Ph.D., *Dept. of Mental Health, U.S. Air Force, 1050 West Perimeter Road, Andrews AFB MD 20762*

SUMMARY:

This paper will review progress of an Air Force prototype project designed to demonstrate the value of having mental health professionals work in a primary care clinic. The project assigns a psychiatrist, a psychologist, and a social worker to work in the primary care clinic of an Air Force hospital for 18 to 36 months. While this approach to treating the mental health problems that present in primary care has been demonstrated before, the current project will attempt to delineate the variables relevant to implementing this idea in an Air Force setting and in an integrated staff practice model. Metrics will be collected at the patient level, the primary care clinic level, and the medical treatment facility level. These will be used to evaluate performance of the prototype project. Whenever possible, outcome will be translated into cost in order to provide a commonly understood metric for comparisons. Additionally, patient and provider satisfaction as well as patients' quality of life will be assessed as important qualitative variables. Possible implications for re-engineering of mental health services to provide for primary, secondary, and tertiary prevention will be discussed.

No. 55C
CONFIDENTIALITY ISSUES IN MILITARY MEDICINE

Joseph A. Procaccino, Jr., J.D., *AFLSA/JACT, HQ USAF SGJ, 1501 Wilson Blve. Room 835, Arlington VA 22209*

SUMMARY:

The military has been re-examining the issue of confidentiality and privilege in the practice of health care. It is often difficult to balance the ethical traditions of privilege with the military mission, national security, and officership. This discussion will focus on the background of the privilege issue and the military's efforts to reach a balance of interests. It will also serve to complement the clinical discussions of this issue by fellow panel members by giving a legal perspective.

No. 55D
SUICIDE RISK REDUCTION IN THE AIR FORCE: A COMMUNITY PREVENTION

Karl O. Moe, Ph.D., *Dept. of Mental Health, U.S. Air Force, 1050 West Perimeter Road, Andrews AFB MD 20762*

SUMMARY:

During the early 1990's, the Air Force experienced a small but noticeable increase in the rate of active duty suicides. In May 1996, the Vice Chief of Staff directed that an integrated product team review the epidemiology of suicide in the Air Force as well as programs intended to reduce the risk of suicide. A cross-functional, multidisciplinary team reviewed available statistics and obtained expert consultation from outside experts. The results of this review will be presented as well as the wide-ranging recommendations presented to the Vice Chief of Staff. An update on the results to date will be provided. This approach to reducing the risk of suicide in the Air Force may offer ideas that are relevant to other organizational and community mental health prevention programs.

No. 55E
EVOLUTIONS IN MILITARY PSYCHIATRY RESIDENCY TRAINING

James R. Rundell, M.D., *Department of Psychiatry, USUHS, 4301 Jones Bridge Road, Bethesda MD 20814;* Scott W. Joslin, M.D., Robert J. Ursano, M.D., Timothy W. Lacy, M.D.

SUMMARY:

Since the end of the Cold War, the scope and nature of military operations have changed. The changes include overall downsizing, more frequent military medical deployments by psychiatrists, mental health care focused on maintaining the operational force, and expanded roles of psychiatrists as primary care consultants. These factors have placed new demands on the seven military psychiatry residency programs. For example, military psychiatry residencies rely increasingly on alliances with civilian training programs, provide realistic military-unique training for residents, and conduct an increasing amount of combined residency training. More than half of military psychiatry residents now train in programs that are integrated with other military psychiatry residency programs or with civilian psychiatric residencies. Military-unique training for psychiatry residents includes operational military exercises, courses in military psychiatry, and supervised experience in consultation with commanders and military organizations. There are five military combined residency training programs, three in psychiatry-family practice and two in psychiatry-internal medicine. These combined programs now train one-third of all military physicians with psychiatry training. Physicians with combined training have unique operational deployment advantages and place the military in the forefront of initiatives to integrate psychiatry into primary care medicine.

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3. Jones FD: Psychiatric principles of future warfare, in War Psychiatry. Edited by Jones FD, Sparacino LR, Wilcox VL, Rothberg JM, Stokes JW. Washington DC, TMM Publications. 1995, pp. 113-132.
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SYMPOSIUM 56—ADMINISTRATIVE PSYCHIATRY: HOW CLINICIAN EXECUTIVES CAN SURVIVE THESE TURBULENT TIMES!

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the changes psychiatric administrators must undergo to meet the challenges of the changing mental health scene—in financing, planning, staffing, in a multiplicity of settings.

No. 56A
AN OVERVIEW OF THE EVOLVING BEHAVIORAL HEALTH SYSTEM

Michael A. Freeman, M.D., *1110 Mar West Street, Suite E, Tiburon CA 94920*

SUMMARY:

This presentation will provide an overview of the evolving behavioral health systems within which administrative psychiatry will be required to function, and the "disruptive technologies" that are affecting the nature of psychiatric administration. The following evolutionary trends and their impact on evolving systems will be discussed:

- Value-based purchasing methods used by employers and public purchasers, and their impact on behavioral health systems;
- Disease management programs;
- Capitated, computerized, guideline-driven managed care delivery systems;
- Consolidation of managed care plans; and
- New models and systems of care.

No. 56B
CORE ADMINISTRATIVE CONCEPTS

Miles F. Shore, M.D., *Room 450-B, JFK School of Government, 79 John F. Kennedy Street, Cambridge MA 02138*

SUMMARY:

The evolution of the health care system has added a host of new core concepts to the lexicon of psychiatric administrators. These include the assumption of risk, population-based services, and the measurement of quality. The new health care environment includes intense competition in seeking market share, a customer orientation, the marketing of programs, integrating information technology, broader accountability for professionals, and close attention to the determination of costs among various program elements. The keys to the present administrative environment include: (1) the management of adaptive change, (2) providing vision to generate commitment to organizations that cannot ensure stability or long-term employment, (3) the adoption of new technology to support rather than interfere with clinical practice, (4) sustaining professional standards while adding organizational accountability for quality and the costs of care, (5) expanding the learning environment of organizations to integrate the new knowledge necessary to function in a radically altered, constantly changing environment, (6) assisting clinicians to function effectively in organizations, and (7) constant attention to the strategic position of the organization in the marketplace.

No. 56C
NEW ROLES FOR BEHAVIORAL HEALTH PLAYERS

Judith Browne, R.N., *Department of Administrat, FHC Health Systems, 240 Corporate Boulevard, Norfolk VA 23502*

SUMMARY:

The presentation will cover the changing roles of nonpsychiatric professionals. The impact of managed care, particularly its impact on the practice environment, its impact on demands for services, and the new opportunities in multidisciplinary group practices will be explored.

We will review how science and economics are shaping the change and the diverse career pathways that emerge.

We will discuss the primary role consumers are playing in the changes and the emerging roles consumers are playing in the care delivery system.

No. 56D
HOW SELECTED BEHAVIORAL HEALTH SYSTEMS ARE MOVING TOWARD INTEGRATION

Jose M. Santiago, M.D., *5112 N Via Condesa, Tucson AZ 85718-5714*

SUMMARY:

Across the nation, over the past five years, a trend has swept the health care field: the creation of integrated delivery systems. This movement developed as a structural and functional response by health care providers to the changing reimbursement and delivery of health care services: behavioral health systems have had to respond quickly and flexibly to this reconfiguration of service delivery and competitive forces. This presentation will review how selected behavioral health systems such as private hospitals, psychiatric group practices, managed behavioral health organizations, VA's, and others have responded to the movement to integrate. A cost-benefit analysis of integration will be presented. The experiences to date of integration will be reviewed.

No. 56E
LAW AND ETHICS

Donald H. Williams, M.D., *Department of Psychiatry, MI State University, Room A236, E. Fee Hall, East Lansing MI 48823*

SUMMARY:

As predicted by Starr and others, American health services are coming under the control of corporate enterprises. Health care is

becoming a market commodity and physicians are becoming corporate employees. There are concerns that as physicians lose their autonomy and control over their condition of work, medical care decisions will be determined by market forces rather than by professional judgments as to what are best for patients. Given the marginal status of psychiatric care for serious mentally ill persons, psychiatric administrators and practitioners will experience particular stress in reconciling the realities of managed care with the provision of quality psychiatric care.

This paper will review the legal and ethical issues that psychiatric administrators and practitioners must address in this new era of corporate health care. This review will summarize findings of the relevant manuscripts that will be published in the forthcoming edition of the APPI Textbook of Administrative Psychiatry.

No. 56F
FUTURE ISSUES FOR ADMINISTRATIVE PSYCHIATRY

John A. Talbott, M.D., *Department of Psychiatry, University of Maryland, 701 West Pratt Street, Ste 388, Baltimore MD 21201*

SUMMARY:

I will summarize and synthesize some of the trends in administrative psychiatry that have appeared in the past few years and in the prior presentations and their impact on the future of our specialty.

Patient trends that have most affected us include demographic, diagnostic, and economic ones as well as the location where patients are treated and their changing roles, from passive recipient to collaborator, advocate, and provider.

Treatments have also changed due to scientific, demographic-epidemiologic, organizational, and economic-administrative reasons.

Systems issues that strongly affect administrative psychiatry include integrated systems, primary care, the behavioral health carve-out, networks, and the privatization of the "public" system.

In a few years, we have switched from depending upon and talking about reimbursement to revenues, whether "private" managed care, contracts, or medicaid.

Technology has had a huge impact, including computers, telemedicine, outcome measurements/report cards, protocols/treatment guidelines/disease management, quality assurance, and quality improvement.

Finally, the language we use has changed; we now talk "business-speak" (e.g., bottom-line or one-stop shopping) and "computer-talk" (e.g., "user-friendly services"), and even use neologisms (e.g., gate-keeping).

REFERENCES:

1. Bower JL, Christensen CM: Disruptive technologies: catching the wave. Harvard Business Review, Jan-Feb. 1995
2. Shore MF: Introduction to section III. Core administrative psychiatry concepts, in The APPI textbook of Administrative Psychiatry: New Concepts for a Changing Behavioral Health System. Edited by Talbott JA, Browne J, Freeman M, Hales RE. Washington, D.C. American Psychiatric Press, Inc., 1998 in press.
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5. Starr P: The Social Transformation of American Medicine. New York, Basic Books, 1982.

SYMPOSIUM 57—ARTISTS AT MID LIFE: CONFRONTATIONS WITH DEATH

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to describe the changes seen in the lives and works of great artists during the midlife period and explain how confrontation with death plays a mediating role in bringing about these changes.

No. 57A
THE MID-LIFE CRISIS IN ARTISTS

Elliott Jaques, M.D., *George Washington University, 6 Raven Lane, Gloucester MA 01930*

SUMMARY:

The midlife period—roughly 33 to 37 years of age—comes as a true crisis in life and work of nearly all great artists. It compares with the crisis of adolescence, except that it is depressive rather than schizoid in nature. The depressive quality is expressed in a strong awareness of death, not as a general idea, but as an inevitable oncoming reality to be taken into account for oneself. The death rate of great artists is curiously high in the midlife period, suggesting that strong physiological changes are taking place. The nature of such changes remains unclear.

Artistic creativity pre-midlife tends to be spontaneous hot-from-the-fire, lyrical rather than tragic, and celebrating the joys of life. Post-midlife creativity tends to be much more reflective, worked over, with a tragic quality that takes personal death into account.

The careers of great artists reflect this midlife watershed. Many early careers end at midlife. Many careers, start at midlife. And careers that start in early adulthood and continue into late adulthood show a marked change from the pre-midlife to the post-midlife type of creativity.

Comprehensive examples will be cited.

No. 57B
REMBRANDT AT MID LIFE: ST. JEROME IN A DARK CHAMBER

Joseph J. Schildkraut, M.D., *Department of Psychiatry, Harvard Medical School, 74 Fenwood Road, Mass MH Ctr., Boston MA 02115*

SUMMARY:

In the early 1640's, while Rembrandt (1606–1669) was going through his midlife period, there were profound changes in his art, his style of life, and his sense of self. While many art historical issues have been raised by scholars attempting to understand these changes, of undoubted importance too were the deaths of his mother in 1640 and his wife in 1642. These changes are dramatically illustrated by comparing his etchings, "Self-Portrait Leaning on a Stone Sill" of 1639 and "Self-Portrait Drawing at a Window" of 1648. The former, a light-filled grandiose composition, shows the artist dressed in theatrical Renaissance finery, his eyes intense and piercing as he looks with confidence, possibly even arrogance, into the space ahead. The latter self-portrait, in contrast, reveals a much older looking artist dressed in everyday studio garb. His facial features have broadened and become heavier, his saddened eyes gaze out from darkened shadows. In 1642, the year of his wife's death, Rembrandt created one of his darkest and most impenetrable etchings, "St.

Jerome in a Dark Chamber." This presentation will consider the possibility that Rembrandt might have been depressed at the time he created this etching and will develop the hypothesis that "St. Jerome in a Dark Chamber" represents a spiritual and psychological self-portrait of Rembrandt at midlife. The relationship of this etching to Albrecht Dürer's great midlife engravings of the previous century, "Melencolia I" and "St. Jerome in His Study," will be discussed.

No. 57C
LORD BYRON: A FEVERED DYING

Kay R. Jamison, Ph.D., *Department of Psychiatry, Johns Hopkins University, 2745 Brandywine Street, NW, Washington DC 20008*

SUMMARY:

Lord Byron (1788–1824) was an extraordinary poet and an immensely charismatic, volatile man. His family history was riddled with severe melancholy, erratic behavior, and suicide; he himself was subject throughout most of his life to paralytic depressions, suicidal thoughts, and highly agitated moods and behaviors. But his life was, as well, filled with close friendships, poetry, laughter, and consuming passions. Not surprisingly, Byron's views on death, as on life, were complicated, inconsistent, deeply perceptive, sardonic, and impulsive.

This lecture will discuss Lord Byron's death in the context of his life and work.

No. 57D
ARSHILE GORKY: TERMINAL AGONIES AND ABSTRACT EXPRESSIONISM

Kareen Akiskal, B.A., *Department of Psychiatry, International Mood Center, 3350 LaJolla Village Drive, San Diego CA 92161-0603;* Hagop S. Akiskal, M.D.

SUMMARY:

Arshile Gorky, widely acclaimed as one of the pioneers of America's new abstract art, produced his most important work during the last years of his life. Although (and perhaps *because*) he was afflicted with colon cancer and a colostomy, between ages 42 and 44, he painted with a feverish pace, which culminated in some of the most poetic paintings in the history of modern art. While abstract, these paintings tell the agonizing story of his present life, woven with the colors and symbols of his past and those of his ancestors in historic Armenia. We develop the thesis that Gorky's melancholy, yet restless, temperament played a major role in how he gave birth to abstract expressionism, as he faced his own mortality. During this last period of his life, he confronted other tragedies such as a neck injury, which in part paralyzed his painting hand, a fire that burned his paintings, and desertion by his wife who walked away with his two young children. His suicide note before he hung himself read "Goodbye my 'Loveds,'' bequeathing his art to his children and family, as well as to the future of abstract art.

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SYMPOSIUM 58—WHEN SPORTS GOES OVER THE LINE
Joint Session With the International Society for Sport Psychiatry

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the etiological forces behind violence and aberrant behavior in the athletic arena, have a working definition of what constitutes verbal abuse in sports and its behavioral consequences, understand the legal aspects of sports violence and its ramifications to society, and be in a better position to educate parents, coaches, athletes, and local youth sports leagues in order to reduce and prevent the occurrence of violence on and off the field.

No. 58A
VIOLENCE ON AND OFF THE FIELD

Antonia L. Baum, M.D., *Department of Psychiatry, University of Rochester, 300 Crittenden Blvd, Rochester NY 14642*

SUMMARY:

Violence in the athletic arena and among spectators is explored, to further our understanding of this phenomenon. Physical aggression during an athletic contest is a culturally syntonic occurrence. The spillover of aggression after the clock stops is not an uncommon event.

Etiologic factors are discussed, including psychoanalytic theories of aggression, premorbid personality traits, permorbid Axis I diagnoses (such as attention deficit-hyperactivity disorder, substance abuse/dependence, and bipolar affective illness), steroid abuse, and the cultural condoning of violence.

The sequelae of violence in sports are reviewed. Some emphasis will be placed on off-the-field, "over the line" behavior by athletes and fans. Not only are there athletic injuries, interpersonal difficulties, and physical and sexual abuse or assault, but the image and ideals of athleticism are undermined by this violence.

Attention is focused on the prevention of violence related to athletics. This can be effected through education, mentoring, screening for steroid and substance abuse, and by making treatment for substance abuse and psychiatric treatment readily available.

No. 58B
THE EFFECTS OF VERBAL ABUSE IN SPORTS

Robert W. Burton, M.D., *Department of Psychiatry, Northwestern University, 625 N Michigan Ave Ste 1737, Chicago IL 60611*

SUMMARY:

One of the most common examples of when sports go over the line is in its tolerance of verbal abuse. Classically occurring between coach and athlete, it can take place anywhere and involve players, fans, parents, and even members of the media. While widely recognized and easily identified by observers, little attention has been paid to the effects on its victims in the sports context.

Consequences of verbal abuse can range from causing teams morale problems and decreasing players' motivation, to promoting excessive aggression or self-destructive acting out behaviors both on

and off the playing field. The cost can vary from impaired athletic performance to real human suffering and life-threatening clinical conditions.

Most alarming is an apparent belief on the part of some coaches and other authority figures in sport that verbal abuse is character building and positively motivating. Clearly there are little, if any, data to support this belief and much to document its deleterious effects.

Public awareness of the problem should be raised. Coaches, athletes, and parents should be educated in ways to encourage the healthy expression of anger, aggression, and competitiveness, in addition to the resolution of conflicts. Finally, guidance as to how to approach an abusive individual or situation should be offered.

No. 58C
ATHLETE TO ATHLETE VIOLENCE

Ronald L. Kamm, M.D., *257 Monmouth Road, #A-5, Oakhurst NJ 07755-1502*

SUMMARY:

Why does a competitive sports experience suddenly turn violent and how can such occurrences be curtailed or prevented?

Mike Tyson biting Evander Holyfield's ear in their championship fight, a violent act even for boxing, turned a spotlight on this phenomenon.

This paper discusses predisposing factors to athlete-athlete violence such as territoriality, weaponry, family background, and coaching influences, as well as the heightened state of physiological arousal that athletes bring to competition. Also explored are factors particular to the arena—heat, noise, and crowding.

A risk/benefit model is advanced as one way of understanding violent behavior on the athletic field, as is the role of perceived injustice, retaliation, frustration, fear, and insult.

The erosion of sports' bedrock values—fairness, sportspersonship, and respect and compassion for one's opponent—is discussed, as are suggestions for parents and youth sport coaches, who can use violent events in professional sports to re-teach and reinforce these values. Psycho-education can also be helpful in preventing parents and coaches from allowing their own aggressive instincts to be expressed vicariously by their athletes.

In professional sports, the attitudes and expectations of owners, coaches, and officials can greatly affect the incidence of athlete-athlete violence. Techniques such as role playing and the use of humor, empathy, and catharsis are discussed as ways of helping coaches and athletes deal differently with potentially explosive situations. Highly publicized acts of violence that have occurred on the athletic field are examined.

No. 58D
THE RELEVANCE OF THE SPORTS PSYCHE IN THE LEGAL ARENA

Thane Campbell, Esq., *390 Bay St., Suite 1615, Toronto, ON Canada M5B 2Y2*

SUMMARY:

The line between acceptable and unacceptable behavior in sport is often quite different than in society generally. While one's actions might appear to be "over the line" if conducted on a street corner or in an office setting, in the sports setting these actions might not only be acceptable, but the norm. For example, hockey fights are commonly called 'part of the game' whereas these same fights outside the arena may result in crominal charges or civil lawsuits.

This leads to inevitable conflict between the policing of sport and our justice system. Should the standard of acceptable behavior be any different in the sports arena? In law, the line is determined by the standards of acceptable behavior in the particular sport, at the level of competition in question.

What is clear is that at all levels of sport, the line is often dependent upon whether or not an injury or damage occurs. In hockey as well as in football and other physical sports, it seems acceptable to cause injury if it is a 'clean hit' which causes the injury. A 'dirty hit' will result in much more severe consequences if injury occurs. The same 'dirty hit' where no injury occurs, and which often results in only a minor penalty, would likely result in a suspension if injury occurs.

Also problematic is the fact that the standard or line changes naturally with time. In addition, in professional sports, as salaries increase, so does the tolerance by fans for a more physical game. In the context of million dollar salaries, a few hits and lost teeth don't seem so serious. In amateur sport, the prevalence of violence also shifts upward, both unintentionally, as a consequence of children emulating the play of professionals, and intentionally, as a result of the higher rewards for being successful at a sport, including professional careers and university scholarships. Athletes are willing to do more to succeed in sport, as are coaches and parents.

The legal consequences for an athlete can be severe if standards of acceptable conduct within the sports arena are not adhered to, as society is generally far less tolerant of unacceptable behavior in sport and the athletes may be scrutinized unfairly, that is, using a differnt line of acceptability. An exception to this rule would be sexual assault, which is considered as being equally as reprehensible in the sports and public arenas.

The presentation will deal with the interaction between sports, law and applicable rules and regulations. Examples of this often difficult relationship will be provided.

Expert Panel: Bobby Czyz, World Champion boxer; Stewart Gavin, professional hockey player with the National Hockey League; Jill Ross Woolley, track and field, Olympic silver medalist for Canada; and Daniel M. Begel, M.D., President of the International Society for Sport Psychiatry.

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SYMPOSIUM 59—OUTCOME MEASUREMENT IN PSYCHIATRY: A CRITICAL REVIEW

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The participants will acquire knowledge about the outcome measurement of different psychiatric disorders. They will recognize the importance of these measurements in general and in the managed care environment, in particular. They will also become familiar with standard tools used for this purpose and ways of applying them. They will be acquainted with the use of novel computerized technology in documentation and analysis of outcome data.

No. 59A
OUTCOME MEASUREMENT: DEFINITION, HISTORY AND REVIEW OF AVAILABLE TOOLS

Waguih W. Ishak, M.D., *Department of Psychiatry, NYU Medical Center, 564 First Ave #16-X, New York NY 10016;* Tal Burt, M.D.

SUMMARY:

The psychiatric field has experienced a paradigm shift in the last two decades. The shift was from a state in which the focus was on general aspects of personality and subjective sense of improvement, to a state in which clear diagnostic criteria are sought, and a goal-directed change in one or more objective parameters is expected. The primary incentive of clinicians is to receive feedback on the effectiveness and efficacy of the interventions they make. They are, however, driven by managed care agencies to consider and account for outcome variables that are often vague and incongruent with the concept of illness, as the medical model perceives it. There is no consensus on what is a standard and objective manifestation of improvement, recovery, and cure, and therefore no consensus on how to measure them. The furthest we got is in establishing practice guidelines for a wide variety of psychopathology. It is clear that professionals who deliver mental health care should arrive at the consensus on the nature of outcome measures in mental health. The evolution of graphs in the documentation of bipolar illness from Kraepelin to Post, will be given as an example.

This presentation will focus on:

(1) The historical perspective: the emergence of outcome measurements in psychiatry, trying to answer the question: "why now?" (2) Outcome measurements as means of providing the clinician with objective feedback on the effectiveness and efficacy of the therapeutic intervention, and (3) The issue of accountability and its requirement by managed care and regulatory agencies.

No. 59B
THE IDEAL OUTCOME MEASUREMENT TOOL

Susan Eisen, Ph.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont MA 02178*

SUMMARY:

This presentation will summarize: (1) factors to consider in choosing measurement strategies to be used for outcome assessment of psychiatric services, (2) features of a number of widely used outcome/performance measures, and (3) strengths and weaknesses of particular measures.

Important factors to consider in choosing measurement strategies include program goals, content and structure, target population, data sources, perspective, standardization, reliability and validity, sensitivity, costs and burden, practicality and utility for program planning, clinical care, and quality improvement. Demands of accrediting agencies and third-party payers must also be considered.

Outcome/performance measures may include data obtained from administrative databases, medical records, direct observation, patient interviews, and/or self-report questionnaires. Although more than 1,400 different outcome measures were used in 348 research studies reported in the literature between 1983 and 1988, a more recent volume reviews just 16 widely used outcome measures. Efforts to create mental health report cards will depend on narrowing the field of outcome measures so that results can be compared across providers, facilities, and systems of care using the same criteria.

Specific measures to be discussed in this presentation will include BASIS-32, SF-36, BSI, Quality of Life Inventory, Addiction Severity Index, Hamilton Rating Scale, BDI, GAF, BPRS, and Life Skills Profile.

No. 59C
CRITICAL APPRAISAL OF DIFFERENT OUTCOME MEASUREMENT TOOLS

Jean Endicott, Ph.D., *Department of Psychiatry, NY State Psych Institute, 722 W 168th Street Unit 123, New York NY 10032*

SUMMARY:

Clinicians have always had a need to assess the outcome of their therapeutic efforts and now there are increasing pressures upon them to do this in a systematic manner that is suitable for communication with other clinicians, third-party payers, administrators, and various agencies that are monitoring their activities.

Ideally, outcome measures would have good "face validity" and would be suitable for use in repeated evaluations, in a variety of clinical settings, with patients who have different disorders, and regardless of the treatment modalities in use. An overview of the advantages and disadvantages of a number of the procedures that have been proposed for use in outcome measurement of patients with mental disorders will be discussed. These will include the Global Assessment of Functioning Scale (GAF) and the Social and Occupational Functioning Scale (SOFAS), as well as other measures of clinical status and functioning.

No. 59D
IMPLEMENTING OUTCOME ASSESSMENT IN A CLINICAL FACILITY

Lloyd I. Sederer, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont MA 02178–1048*

SUMMARY:

The audience will learn how a system of outcomes assessment can be implemented in a clinical facility by using the example of how this was done at McLean Hospital. The four components of McLean's outcome system will be explained (clinical outcome, patient satisfaction, readmissions, harmful events). The audience will then learn how these four quality domains were chosen, what measurement instruments and indices were adopted, and how this was introduced into the standard operations of a clinical care system. Finally, the audience will learn how these quantitative measurements have been used for quality assurance, quality improvement (CQI), and toward the establishment of report cards (which are distributed to our professional staff, and to the professional, regulatory, and payer communities).

No. 59E
OUTCOME MEASURES: COMPUTERS, MANAGED CARE AND REHABILITATION

Zebulon C. Taintor, M.D., *Department of Psychiatry, NYU Medical Center, 550 First Avenue, NB20N11, New York NY 10016;* Russell F. Lim, M.D.

SUMMARY:

Outcomes tend to be measured as behaviors and functioning rather than effects and symptoms. Many factors can contribute to outcomes. These can be tracked in information systems that enable retrieval of the longitudinal dimension of patient care, e.g., what medications were tried for how long with what result, or whether there was a change in patterns of homelessness after a policy of intake multiservice shelters was initiated?

Psychiatric rehabilitation assumes that patient function can be increased even while symptoms exist. Its intake and assessment instruments often are ideal outcome measures. Improving skills increases competence and ability to play roles while reducing the need for support. The cost of all of these can be tracked via information

systems. Various outcome measures used in both academic and managed care environments will be discussed, as well as the rationale for choosing particular instruments in a given setting.

Computerized technology and the medium of graphic representation can aid in the rapid and efficacious processing of large amounts of raw information. The evolution of graphs in the documentation of bipolar illness from Kraepelin to Post, will be given as an example.

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SYMPOSIUM 60—CLINICAL SUBTYPING OF SCHIZOPHRENIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participants should be able to recognize various clinical subtypes of schizophrenia and recognize the function an effective subtyping system should perform.

No. 60A
ASSOCIATED SYNDROMES IN CHRONIC SCHIZOPHRENIA

Paul C. Bermanzohn, M.D., *Department of Psychiatry, Hillside Hospital, 87-80 Merrick Boulevard, Jamaica NY 11432;* Linda Porto, M.S.N., Samuel G. Siris, M.D.

SUMMARY:

Background: The enormous clinical heterogeneity found among patients with schizophrenia (scz) has created a need for meaningful subtypes. Associated psychiatric syndromes (APS) such as depressive, obsessive-compulsive, and panic disorders occur commonly in scz. These syndromes have often been hidden from clinical and scientific view by exclusion rules that prohibit their being diagnosed, so that little work has been done to establish their clinical validity. There is evidence that APS are stable over time and that they may (adversely) influence patients' prognosis, yet may be treatable. Hence, APS may be a useful basis on which to develop a clinical subtyping system for scz. We report here data from a prevalence study of APS in chronic scz.

Method: One hundred chronic scz patients enrolled in a day program were studied using the Structured Clinical Interview for Diagnosis for DSM-IV. Exclusion rules prohibiting the diagnosis of APS were bypassed. Clinical staff were consulted in all assessments.

Results: While data from all 100 patients will be presented, we have so far only analyzed data from the first 37. Nineteen patients (51.4%) had one or more APS, including 17 patients (45.9%) with depressive disorders, including major depression (N = 10; 27%), dysthymia (N = 5; 13.5%), and minor depression (N = 2; 5.4%). Fifteen (40.5%) had OC symptoms; 10 (27%) met full criteria for OCD, but two patients failed to meet OCD criteria because they were obsessed with a psychotic content. Four (10.8%) met criteria for panic disorder. Several patients whose diagnoses were hierarchically excluded showed responses to open trials of medications appropriate to their excluded diagnoses.

Conclusions: APS appear to exhibit several of the key features to be found in a useful diagnostic system; they appear to affect prognosis, offer possible treatment options, and they are temporally stable. Unfortunately, because of hierarchical assumptions built into the diagnostic system, APS have as yet been very little studied.

No. 60B
IS THERE ROOM FOR A SCHIZO-OBSESSIVE SUBTYPE?

Joseph Zohar, M.D., *Department of Psychiatry, Chaim Sheba Medical Center, Tel Hashomer 52621, Israel;* Yehuda Sasson, M.D.

SUMMARY:

As many as 15% of chronic schizophrenic patients also suffer from obsessive-compulsive disorder (OCD). This increased prevalence of OCD in schizophrenia compared with that in the general population (2%) has raised intriguing questions about association between OCD and schizophrenia. Many schizophrenic patients can differentiate the ego-dystonic, obsessive-compulsive (OC) symptoms they perceive as originating from within themselves from ego-syntonic delusions perceived as introduced from the outside. Long-term follow-up studies demonstrate the stability of the diagnosis over the years. The presence of OCD in schizophrenia predicts a poor prognosis, thus suggesting that a new approach is needed. Preliminary data regarding the role of atypical neuroleptics such as clozapine and olanzepine in treating this subset of patients will be presented, along with an open-study (ABA design) in which the anti-obsessive medication clomipramine (CMI), was added to ongoing antipsychotic medications in 18 schizophrenic patients with OCD. Twelve showed a marked decrease in OC symptoms; in nine, it was also associated with an improvement in psychosis (expressed by a decrease in BPRS). The different course of schizo-obsessive patients, the poor prognosis, and preliminary data regarding their response to combining antipsychotic and anti-obsessive medication, suggest that there is room for a schizo-obsessive subtype.

No. 60C
HOW VULNERABLE ARE SCHIZOPHRENIA PATIENTS TO DEPRESSION?

Martin Harrow, Ph.D., *Department of Psychiatry, University of Illinois, 912 South Wood Street, Chicago IL 60612;* James R. Sands, Ph.D., Joseph F. Goldberg, M.D., Rajiv P. Sharma, M.D., Robert Faull, B.A.

SUMMARY:

Objective and Method: Recent data suggest that a number of schizophrenia patients may be vulnerable to post-hospital depression.

To determine what percentage of schizophrenics are vulnerable on a longitudinal basis to post-hospital depression, and whether it interferes with functioning in schizophrenia, we assessed 133 patients, including 46 schizophrenia and 22 bipolar patients. Patients were studied at the acute phase and followed up at two years, again at 4.5 years, again at 7.5 years, and then at 10 years post-hospital, using standardized measures of symptoms and functioning, including the SADS.

Results: (1) During the ten-year follow-up period over 60% of schizophrenia patients experienced one or more full depressive syndromes. (2) The data indicate that the relationship between recurrent psychosis and depression was significant ($p < 01$). (3) Schizophrenia patients treated with traditional neuroleptics were significantly more anhedonic at several successive followups ($p < 05$). (4) Schizophrenia patients with post-hospital depression showed significantly poorer work functioning ($p < .05$) and significantly poorer overall adjustment ($p < .05$).

Conclusions: When studied longitudinally, a surprisingly large percentage (over 60%) of schizophrenia patients show full depressive syndromes during the post-hospital period. The post-hospital depression was often associated with recurrent psychosis and recurrent schizophrenia episodes, and interferes with post-hospital functioning. Traditional neuroleptic treatment may increase the risk of anhedonia in some schizophrenia patients by blocking dopamine reward systems.

No. 60D
ANTIDEPRESSANTS AND BENZODIAZEPINES IN SCHIZOPHRENIA

Samuel G. Siris, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks NY 11004;* Paul C. Bermanzohn, M.D., Dawn Oughourlian, B.A.

SUMMARY:

Adjunctive "polypharmacy" with antidepressants and/or benzodiazepines is often encountered in clinical practice, even though many of the studies that would provide conclusive evidence of efficacy for these treatments simply have not been undertaken due to their difficulty and/or expense.

This paper reviews those studies that have been reported and that shed light on the appropriate use of these agents in the treatment of individuals with schizophrenia, emphasizing the randomized, placebo-controlled trials, which are most informative. A fruitful strategy for exploring this topic involves identifying subsets of patients with identifiable associated affective or anxiety syndromes, and examining the outcomes when antidepressants or benzodiazepines are employed. The use of these agents in the absence of neuroleptic medication offers little benefit and, at least in the case of antidepressants, appears to add to the risk of psychotic exacerbation. However, the adjuctive use of antidepressants or benzodiazepines together with neuroleptic agents may hold benefit in appropriately selected patients. This paper explores the boundaries of those category definitions and discusses the reasonable extrapolations from those studies, which have been done, to other similar medication interventions that might be helpful but that have not been specifically tested in the same way. Potential benefits, of course, need to be weighed against the risks of side effects and pharmacokinetic interactions.

No. 60E
IS PANIC A SCHIZOPHRENIA SUBTYPE?

Paul C. Bermanzohn, M.D., *Department of Psychiatry, Hillside Hospital, 87-80 Merrick Boulevard, Jamaica NY 11432;* Donald S. Rae, M.A., Linda Porto, M.S.N. Samuel G. Siris, M.D.

SUMMARY:

Background: Studies of schizophrenia (scz) patients have reported prevalence rates of panic attacks ranging from 11% to 63%. Our investigation of the phenomenology of panic in scz has revealed that scz patients with panic attacks almost universally feel they are being watched and evaluated and many patients with "panic attacks" and scz describe "paranoid attacks" whose relationship to panic attacks is unclear. Such experiences are similar both to paranoia and social phobia, making the epidemiologic findings difficult to interpret.

Panic attacks usually precede the onset of scz, and may predict its development. Treatment studies for panic in scz have been generally favorable, but have included only small pharmacological studies and one pilot study of cognitive-behavioral therapy (CBT). We have been studying panic in scz in two ways:

Method 1: Patients diagnosed with scz and panic attacks were treated with a 16-week course of CBT adapted from methods used for nonschizophrenics with panic. Panic and psychosis were assessed before and after the treatment.

Results 1: While these results are not yet available, they will be presented at this symposium.

Method 2: The ECA database was reexamined looking for a relationship between panic and paranoia in scz. A total of 20,871 persons were surveyed and 344 received diagnoses of scz or schizophreniform disorder.

Results 2: The two symptoms were closely related. The odds ratio of having paranoia if one had panic was 2.89 (chi square 20.25, df = 1, $p < .001$) among those with scz and 10.57 (chi square 387 with 1 degree of freedom; $p < .001$) among those without scz.

Conclusions: The durability of panic in scz and the possibility that it may be treatable suggest that panic symptoms in scz may be a viable clinical subgroup of schizophrenia. However, the relationship between panic and paranoia needs to be further investigated as does the treatability of panic in scz.

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SYMPOSIUM 61—ANXIETY SPECTRUM DISORDERS: A NEW MILLENNIUM

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the anxiety spectrum disorders, understand the role of specific brain mechanisms in expressing the anxiety related phenomena, and effectively manage these patients in the new milenium.

No. 61A
THE ANXIETY SPECTRUM AND THE OBSESSIVE-COMPULSIVE SPECTRUM

Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustav Levi Place Box 1230, New York NY 10029;* Cheryl M. Wong, M.D., Charles Cartwright, M.D., Bonnie A. Aronowitz, Ph.D., Concetta M. DeCaria, Ph.D., Gina Delgiudice-Asch, M.D., Tomer Begaz, B.A.

SUMMARY:

As we approach a new millenium, we may reflect on past DSM developments in the diagnostic classification system of the anxiety disorders, and the need for a new approach or paradigm shift necessitated by the rapidly emerging fields of genetics, molecular biology, and neurobiology. The promise of biological psychiatry and neuroscience has not achieved fruition in the anxiety disorders specifically because current nosological systems have been inadequate for incorporating findings from molecular biology and neurobiology. With this in mind, a spectrum approach to the anxiety disorders, which links together common phenomenology, course of illness, neurobiology, genetics, and treatment response, may better evaluate the similarities and differences amongst the anxiety disorders. This approach may cut across traditional diagnostic boundaries and may facilitate genetic strategies and new drug development approaches, which may have a profound effect on the cost-effective clinical management of these disorders.

With this in mind, discussion of the OCD spectrum as a partially overlapping subset of the anxiety spectrum will be undertaken. Research findings that suggest the need for nosological changes in anxiety and OCD spectrum disorders, and that impact on the clinical management of these patients, will be highlighted.

No. 61B
NEW FINDINGS IN THE NEUROBIOLOGY AND TREATMENT OF PANIC

Jack M. Gorman, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York NY 10032*

SUMMARY:

Scientists have increasingly pointed to the fact that anxiety alone among pathological human emotions can be successfully modeled in experimental animals. Although animals do not routinely exhibit emotions that are reminiscent of depression, psychosis, or mania, they do show the full range of fear and avoidance behaviors that are seen in human patients with anxiety disorders. This has enabled scientists in recent years to make predictions about the neuroanatomy of human panic. We know that patients experiencing panic attacks manifest signs of autonomic nervous system activation, including increases in blood pressure, heart rate, and respiration, and decrease in heart rate variability. These can be traced back to specific loci in the brainstem. From preclinical studies, we know that the central nucleus of the amygdala is critical for the development of conditioned fear and that stimulation of the amygdala produces secondary activation of the same autonomic nervous system centers as is seen in human panic. Further, the amygdala itself is controlled by higher cortical centers. Investigators are now examining whether the amygdala and its associated "fear network" are also involved in human panic. This has important implications for the treatment of panic disorder. Medications, such as SSRI's, which are known to be effective in treating panic probably work by reducing amygdala and brainstem activation, thereby blocking panic. Cognitive-behavioral and other psychosocial interventions probably work by appealing to higher cortical control mechanisms. Together, the treatments should be synergistic.

No. 61C
SOCIAL PHOBIA: PART OF A SHYNESS SPECTRUM?

Murray B. Stein, M.D., *Department of Psychiatry, Univ. of California, San Diego, 9500 Gilman Drive, #0985, La Jolla CA 92093-0985;* Denise Chavira, B.A.

SUMMARY:

Social phobia is a disorder characterized by fear and/or avoidance of situations in which the individual may be exposed to the possible scrutiny of others. Recent research has shown that the prevalence of social phobia in the community is in the range of 7% to 8%, but that the determined rate is very sensitive to subtle alterations in the definitions of severity and functional disability. Within the diagnostic rubric of social phobia, there is also considerable variation in terms of severity and the scope of situations avoided. For example, whereas 10% of adults have extreme fears of public speaking and evidence some level of impairment as a result, it is apparent that persons with "speaking only" fears are considerably less disabled by their symptoms than persons with more pervasive social fears.

When considering the taxonomy of social anxiety and social phobia, one must wonder about the extent to which social phobia is part of a shyness spectrum. Data examining the relationship between shyness and social phobia will be presented. At the other end of the continuum, data will be presented that suggest that avoidant personality disorder is an extreme form of social phobia.

No. 61D
PTSD

Joseph Zohar, M.D., *Department of Psychiatry, Chaim Sheba Medical Center, Tel Hashomer 52621, Israel*

SUMMARY:

Post-traumatic stress disorder (PTSD) has been given many names, probably reflecting the differing attitudes toward the disorder across the years. It has been called "shell-shock," "soldier's heart," "combat neurosis," "operational fatigue," and "traumatic neurosis," to name a few. In recent years, there has been increased awareness of the importance of PTSD both in relation to its prevalence and its devastating impact on the quality of life. Patients who suffer from PTSD act and feel as if the traumatic event were actually reoccurring, and experience intense psychological and physiological distress while exposed to it. They attempt to avoid stimuli associated with the trauma and experience a numbing of general responsiveness. The classic presentation of PTSD is the result of a war; however, there are also increasing reports of PTSD following events such as earthquake, fire, rape, robbery, or car accident. In recent years the importance of the late onset of PTSD has surfaced, an example being war veterans who develop PTSD following a terrorist attack or even a reunion of their unit. Brain imaging studies have directed our attention to the hippocampal area in PTSD and have advanced our knowledge, as have neuroendocrinal studies, regarding the pathophysiological basis of trauma. These recent advances may help us to better understand, diagnose, and conceptualize the trauma spectrum in the future.

No. 61E
DIAGNOSING AND TREATING COEXISTING ANXIETY AND DEPRESSION

Norman Sussman, M.D., *Department of Psychiatry, NYU School of Medicine, 20 East 68th St., Suite 204, New York NY 10021-5836*

SUMMARY:

Despite the absolute separation of anxiety disorders and mood disorders in DSM-IV, it is widely recognized that symptoms of anxiety and depression frequently occur at the same time, regardless of the official diagnosis. Worry, ruminations, muscle tension, feeling keyed-up or on edge, and restlessness are part of both major depression and many anxiety disorders. Discussion has focused on how to best diagnose these patients. Among the possibilities are major depression (with anxiety and psychomotor agitation), major depression and coexisting anxiety disorder, and a "subsyndromal" mixed anxiety depression disorder. Recent data suggesting that antidepressant drugs are effective in treating a broad range of anxiety disorders make it less imperative that an absolute diagnosis be made prior to selecting a therapeutic agent. Tricyclics, SSRI's, nefazodone, and mirtazapine have all been shown to reduce anxiety and agitation. Some agents have the advantage of having been studied for these properties in controlled trials and are thus better understood. There are also significant differences in the time course of their therapeutic and side effects that impact on depression and anxiety.

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SYMPOSIUM 62—JUVENILE OFFENDERS: MODERN ISSUES FOR CHILD PSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To understand a systems approach strategy to improving and expanding mental health services to incarcerated juvenile offenders.

No. 62A
A SYSTEMS APPROACH TO MENTAL HEALTH IN JUVENILE FACILITIES

William M. Womack, M.D., *Department of Psychiatry, Children's Hospital & Med Ctr., 4800 Sandpoint Way NE, Ch13, Seattle WA 98105*

SUMMARY:

Purpose: This presentation will discuss a systems approach to improving the identification of mental health needs and mental health services to incarcerated youth in Washington State institutions.

Method: In the spring of 1996, the child psychiatry division of the University of Washington School of Medicine developed a contract with the state of Washington to assess mental health services and to make recommendations for improving mental health services.

Results: In the past 18 months an interdisciplinary "mobile team" has developed that provides core and advanced trainings to line staff, consultation to each institution, development of uniform instruments for identification of the need for mental health services, and the implementation of quality improvement protocols.

Conclusion: Juvenile offender populations are typically underserved. This model discusses strategies for improving access through consultation, training, and ultimately being involved in policy and decision making. These issues are of major importance to contemporary child and adolescent psychiatry.

No. 62B
TEACHING CLINICAL SKILLS TO CORRECTION STAFF: A NECESSITY, NOT AN OPTION

Lisa M. Boesky, Ph.D., *Department of Psychiatry, Children's Hospital & Med Ctr., P.O. Box 5371, Ch13, Seattle WA 98105;* Jana Ewing, Ph.D.

SUMMARY:

Objective: To present a model of how to provide correction staff with the skills required to manage severely mentally ill children and adolescents in a correctional facility within the context of a belief system where mental illness and acting-out behavior cannot co-exist. At the conclusion of the presentation, the participant should be able to "recognize the challenge of increasing numbers of severely mentally ill youth entering and remaining in the juvenile justice system, and the necessity of providing clinical training to correction staff to help them identify and manage these youth while they are incarcerated.

Method: Training takes place within correctional facilities and is attended by correction staff working with juvenile defenders. Correction staff are required to "counsel" and manage severely mentally ill youth, but lack formal mental health training. Our team provides "core" mental health training helping staff identify and manage youth with psychiatric disorders and severe disruptive disorders, as well as engage in basic counseling skills. Training on assessment and intervention with incarcerated youth who are suicidal and/or who self-mutilate is also provided. Correction staff receive a number of "specialty" trainings addressing specific issues related to mentally ill juvenile offenders including, but not limited to psychiatric medication, grief and loss, fetal alcohol syndrome, families of mentally ill offenders, and developmental disabilities.

Results: Following the training, correction staff are better able to identify mentally ill children and adolescents, make more appropriate referrals to the psychiatrist, engage in fewer physical restraints with youth, design more individualized treatment plans, and treat youth in a more rehabilitative manner while they are incarcerated.

Conclusion: At this time in the juvenile justice system, bringing clinical training on mental health issues to correction staff is as important as providing direct services by trained clinicians in order to manage the increasing number of severely mentally ill juvenile offenders entering and remaining in the system.

No. 62C
SUICIDAL AND SELF-MUTILATING BEHAVIOR IN INCARCERATED ADOLESCENTS

Jana Ewing, Ph.D., *Department of Psychiatry, Children's Hospital, P.O. Box 5371, Ch13, Seattle WA 98105;* Lisa M. Boesky, Ph.D.

SUMMARY:

Objective: This presentation will profile children and adolescents at high risk for serious suicide attempts and self-mutilation in juvenile correctional facilities. At the end of this presentation the participant will be able to identify clinical features and assessment and evaluation methods, factors specific to correctional settings, which increase the risk of suicidal and self-mutilating behavior in incarcerated adolescents.

Method: Given the documented range and severity of psychiatric disorders in incarcerated youth, many children and adolescents entering the juvenile justice system are at extraordinary risk for a suicide attempt or act of self-mutilation. Unfortunately, the most common risk factors of suicidal youth do not reliably identify youth at risk in correctional facilities. As much as 70% of suicidal and self-mutilatory behaviors remain outside the patterns predicted by most indicators of suicidal and self-mutilatory behaviors currently used in corrections and community mental health settings. Factors specific to incarceration/correctional facilities significantly impact a youth's risk of self-harm. Relevant slides and videotaped interviews with youth, as well as other interactive materials will be utilized to discuss the above issues.

Results: Juvenile justice institutions, responsible for managing aggressive and violent youth, are experiencing "unexpected" suicides and severe self-mutilation at a rate higher than any other institution, including inpatient psychiatric hospitals.

Conclusions: Correctional facilities must be educated on significant clinical features and psychiatric diagnoses related to adolescent suicide and self mutilation, dynamics of incarceration that contribute to the risk of suicide and self-mutilation, reliable suicide and self-mutilation assessment and screening methods, and institutional safeguards and dangers.

No. 62D
TREATMENT OF TRAUMATIC BEREAVEMENT WITH INCARCERATED YOUTH

Edward K. Rynearson, M.D., *The Mason Medical Center, 1100 9th Avenue, Seattle WA 98101*

SUMMARY:

It has been noted that 50% of incarcerated youth have experienced the death of a friend or family member from unnatural dying (homocide, suicide, or accident).

Previous research with adult family members has demonstrated a high degree of post-traumatic signs and symptoms to the traumatic forms of dying that complicate recovery from concurrent grief and separation distress. It would appear that this traumatic response to death is responsive to a therapy that deals directly with its attendant fear and disruptive flashblack and dreams.

The purpose of this program is to outline a short-term therapy applied to incarcerated youth who have been identified as unrecovered from the unnatural death of a friend or family member. It will describe a screening procedure and measurements of trauma distress that alert the clinician to the probability of clinical nonrecovery. The remainder of the presentation will describe focus and techniques of the group-based, 10-session intervention.

This program will have particular relevance for clinicians caring for youth since unnatural dying is the number one cause of death before age 40 and its effects are often persistent.

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SYMPOSIUM 63—DETECTION AND TREATMENT OF STIMULANT ABUSE
Collaborative Session With the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize stimulant abuse in patients, diagnose its common psychiatric comorbidities, and treat it effectively using both psychosocial and pharmacological modalities.

No. 63A
DETECTION OF STIMULANT ABUSE

Jeffery N. Wilkins, M.D., *Department of Psychiatry, West Los Angeles VAMC, 11301 Wilshire Blvd., Los Angeles CA 90073*

SUMMARY:

Detection of stimulant abuse in a particular patient may be more or less difficult, depending on the duration and severity of use and the timing of contact with the clinician in relation to the last stimulant use. Patients presenting during acute stimulant intoxication or withdrawal will likely have typical signs and symptoms suggestive of stimulant abuse, although these must be distinguished from common psychiatric disorders that are phenomenologically similar. Under any circumstances, detection will be almost impossible unless the clinician maintains stimulant abuse on his/her list of differential diagnoses. Objective confirmation of stimulant use is possible through assay of a variety of body fluids and tissues. These vary in their potential window of detection, from several hours for blood to several months for hair. In a treatment setting, detection of changes in amount of drug use and distinguishing new drug use from residua of prior drug use have significant implications. These are difficult to do with standard qualitative ("clean" vs. "dirty") drug assays, but may be accomplished by quantitative assays and the use of explicit decision algorhythms.

No. 63B
PSYCHOSOCIAL TREATMENT FOR STIMULANT ABUSERS

Douglas M. Ziedonis, M.D., *Department of Psychiatry, Yale University, 34 Park Street, New Haven CT 06508*

SUMMARY:

Psychosocial treatments are very important in the overall treatment of individuals with stimulant abuse. This presentation will review how to blend specific psychotherapy approaches including motivational enhancement therapy, relapse prevention, psychoeducation, 12-Step facilitation, contingency management, and community reinforcement. Clinical examples will be presented, focusing on clinical strategies and treatment-matching approaches, and highlighting psychotherapy research findings that support the efficacy of these approaches. Stimulant dependence gives rise to unique clinical issues during the course of individual, family, and group therapy. Strategies

to better engage the low-motivation patient into treatment and the skills necessary for short-term and long-term sobriety will be discussed. The progressive stages of recovery will also be reviewed, including different models such as the neurobehavioral model, the developmental model of recovery, and the Pavillon Stages of Recovery. The recommended psychotherapeutic approach varies according to the stage of recovery. Polysubstance abuse, dual diagnosis, and other compulsive activities are often complicating factors that require adaptations in the treatment.

No. 63C
PHARMACOLOGICAL TREATMENT OF STIMULANT ABUSE

David A. Gorelick, M.D., *NIDA Addiction Reser Ctr, PO Box 5180, Baltimore MD 21224-0180*

SUMMARY:

Stimulant abuse remains a significant public health problem in the U.S., one for which no broadly effective treatment is yet available. Numerous pharmacological treatments acting through a variety of neuropharmacological mechanisms have been evaluated, but none has been consistently effective in controlled clinical trials. Some medications undergoing initial clinical trials are showing promise, such as selegiline, a selective MAO inhibitor. Others have received publicity but have not yet been rigorously evaluated, such as the combination of fenfluramine and phentermine (fen-phen). Some promising new approaches are undergoing preclinical evaluation. These include compounds (e.g., GBR 12909) that bind to the presynaptic dopamine transporter, a major site of action for cocaine; antibodies that bind cocaine peripherally, thus preventing it from entering the brain (cocaine vaccine); and enhancement of cocaine metabolism with the naturally occurring enzyme butyrylcholinesterase. A particularly difficult group of patients to treat are those abusing other drugs in addition to stimulants (e.g., "speedballers"). Buprenorphine, a partial mu-opiate agonist, has shown some promise in the treatment of such patients.

No. 63D
PSYCHIATRIC COMORBIDITY IN STIMULANT ABUSERS

Richard N. Rosenthal, M.D., *Department of Psychiatry, Beth Israel Medical Center, First Ave at 16th Street, New York NY 10003*

SUMMARY:

Psychiatric comorbidity is common among stimulant abusers and alters the course of the substance use disorder and the recommended treatment. This presentation will focus on the epidemiological, diagnostic, and treatment issues of the dually diagnosed. Stimulant abusers often present for treatment with complaints of psychiatric symptoms, especially depression and anxiety. Stimulants can also induce a variety of psychotic symptoms, which differ according to the drug (cocaine or amphetamines). As a result, there are pitfalls in the diagnosis of psychiatric disorders. These will be outlined in this presentation. Not surprisingly, psychiatric comorbidity negatively impacts treatment. However, treatment is more effective when traditional substance abuse and mental health treatment approaches are integrated and address differences in severity of both illnesses. New approaches to treatment of the dually diagnosed will be presented, with suggestions on how to modify the core substance abuse psychotherapies for the dually diagnosed and how to integrate specific mental health therapy approaches. Pharmacotherapy strategies will also be reviewed, including the psychiatric and addiction medications.

No. 63E
METHAMPHETAMINE ABUSE: NEW DEVELOPMENTS

Steven L. Batki, M.D., *Dept of Psych Ward 93, San Francisco General Hos, 1001 Potrero Avenue, San Francisco CA 94110*

SUMMARY:

Methamphetamine abuse is a serious and growing problem in the United States. Deaths involving methamphetamine use have increased in recent years and the spread of methamphetamine is particularly extensive in the western states including the Pacific Northwest, Arizona, Hawaii, and especially California. Methamphetamine is prominently associated with severe forms of psychiatric and medical morbidity. Psychiatric effects include psychosis and depression with suicidal behavior (Baberg, 1996). Among the most serious medical consequences may be an increase in HIV risk. Methamphetamine use has been closely linked to high-risk HIV behaviors, and methamphetamine users have some of the highest HIV seroprevalence rates among drug users. Relatively little work to date has been done to find medical treatments of methamphetamine abuse and there are no established, effective pharmacotherapies, although a number of medications are theoretically plausible to utilize. Treatment remains primarily psychosocial, focusing on motivational counseling and relapse prevention in a group setting. This presentation will review the epidemiology, assessment, and treatment of methamphetamine abuse and dependence.

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SYMPOSIUM 64—THE RELATIONSHIP BETWEEN SEASONALITY, EATING AND MOOD

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the symposium, the participant should be able to recognize the shared epidemiologic, phenomenologic, biologic, and treatment parameters in patients with seasonal affective disorder (SAD) and bulimia nervosa (BN), and appreciate the implications of these findings for understanding the pathophysiology of mood and eating dysregulation in these disorders.

No. 64A
SEROTONIN DYSFUNCTION IN BULIMIA AND SAD

Robert D. Levitan, M.D., *Mood Disorders, Clarke Institute, 250 College Street, Room 1135, Toronto ON M5T 1R8, Canada;* Allan S. Kaplan, M.D., Gregory Brown, M.D., Franco J. Vaccarino, Ph.D., Sidney H. Kennedy, M.D., Anthony J. Levitt, M.D., Russell T. Joffe, M.D.

SUMMARY:

Purpose: To examine whether abnormalities in the serotonin system could account for changes in eating behavior and mood in bulimia nervosa (BN) and seasonal affective disorder (SAD), two syndromes that occur primarily in young women and involve both increased eating behavior and mood dysregulation.

Method: We administered the post-synaptic serotonin agonist MCPP to 16 patients with bulimia, 14 patients with SAD, and 18 normal controls. A double-blind, placebo-controlled paradigm was used and all patients were tested in the follicular phase of the menstrual cycle. SAD patients and SAD controls were tested in the fall/winter.

Results: Both the BN and SAD groups showed marked blunting of prolactin responses to MCPP. An unexpected finding was a very strong negative correlation between baseline cortisol levels and reversed symptoms of depression (i.e., carbohydrate craving and hypersomnia) in the bulimic group. A positive correlation between cortisol levels and reversed symptoms was found in the SAD group.

Conclusions: Overall, these data point to a shared dysfunction at or downstream to central serotonin receptors in BN and SAD. The relationship of plasma cortisol levels to reversed depressive symptoms was opposite in the two groups, suggesting that different biological mechanisms may be associated with this symptom cluster across DSM-IV diagnostic categories.

No. 64B
SEASONALITY OF MOOD AND EATING IN BULIMIA AND SAD

Allan S. Kaplan, M.D., *Department of Psychiatry, The Toronto Hospital, EN8-231, 200 Elizabeth Street, Toronto, ONT M5G 2C4, Canada;* Robert D. Levitan, M.D., Anthony J. Levitt, M.D.

SUMMARY:

To explore the phenomenologic relationship between BN and SAD, the SPAQ (Seasonal Patterns Assessment Questionnaire), modified to reflect the seasonality of the five DSM-IV BN criteria, was administered to a cohort of SAD (N=78), BN(n=103), and age-matched control (n=29) subjects. With regard to seasonal bulimic symptoms in SAD subjects without BN, compared with control subjects, SAD subjects were more likely to report binge eating (52% vs. 31%; p<.05), purging (14% vs. 0%; p<.05), preoccupation with body image (35% vs. 7%; p<.01), significant seasonal (fall/winter vs. spring/summer) change in binge frequency (45% vs. 3%; p<.05), purging (22% vs. 3%; p<.05), over concern with body image (40% vs. 17%; p<.05), and feelings of fatness (41% vs. 14%; p<.05). Compared with controls, SAD subjects scored significantly higher on the bulimia, body dissatisfaction, and ineffectiveness subscales of the EDI. With regard to seasonal mood changes in BN patients, 69% were seasonal positive. Five BN subjects met full SAD criteria and an additional nine had at least a 100% increase in binge frequency in the fall/winter period. These data suggest that patients with SAD and BN share common features. Some SAD patients have a high degree of dysregulation in eating behavior and preoccupation with body image while some BN subjects have significant seasonal dysregulation in mood and eating. These findings have implications for understanding the pathophysiology and treatment of conditions where dysregulated eating and mood are prominent.

No. 64C
COMORBIDITY OF SAD AND BULIMIA IN A CLINIC AND COMMUNITY SAMPLE

Anthony J. Levitt, M.D., *Department of Psychiatry, Sunnybrook Hospital, 2075 Bayview Avenue, North York ON M4N 3M5, Canada;* Allan S. Kaplan, M.D., Robert Levitan, M.D., Michael Boyle, M.S.W.

SUMMARY:

Alteration in eating behavior is one of the most common symptoms reported in seasonal depression (SAD), and patients with bulimia frequently have a history of major depression. It is, therefore, likely that there is significant overlap between SAD and eating disorders. This presentation will focus on two studies that evaluate the overlap of bulimia and related syndromes (BN) and SAD, the first in a clinic sample of SAD and non-seasonal depressives (non-SAD), and the second a community survey. The clinic sample consisted of 65 subjects with SAD and 40 subjects with non-seasonal depression. Subjects were not selected for the presence or absence of an eating disorder. Using the SCID for diagnosis, significantly more subjects with SAD had BN (SAD = 10.4%; non-SAD = 0.8%: chi-square = 6.7, p<.01). The community sample consisted of 1,605 subjects, aged 20 and older, who were respondents to a telephone survey in the province of Ontario that used a new validated interview to diagnose major depression, SAD, and eating disorders. Of the 30 subjects who had BN, two (6%) had SAD that was significantly greater than the proportion of the entire sample who had SAD (1.7%; Fisher's Exact test, p<.0001). Among subjects with SAD, 7.1% had BN, while among non-SAD, 3.2% had BN (Fisher's exact test p<.0001). These findings suggest that in both clinic and community samples bulimia is common in SAD patients, and SAD is more common in BN. The relevance of these findings to the phenomenology of the two conditions will be discussed.

No. 64D
BULIMIA NERVOSA AND SAD: OVERLAPPING TREATMENT

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

SUMMARY:

There is considerable overlap between seasonal affective disorder (SAD) and bulimia nervosa (BN) in studies of symptoms, pathophysiology, and treatments. Controlled studies of serotonergic medications, such as SSRI antidepressants and d-fenfluramine, have found benefit in both SAD and BN. Bright light therapy is an effective treatment for SAD, and light therapy has also had positive effects on mood and eating behavior in two studies of BN (Lam, et al, 1994; Blouin, et al, 1996). We also have data from a four-week, open study of light therapy (10,000 lux, cool-white fluorescent light box, 30 minutes daily) in 15 women with comorbid SAD and BN. Patients had significant clinical improvement, with mean reductions in weekly depression scores, binges, and purges of 56%, 50%, and 42%, respectively. Within the limitations of the open study design, it appears that improvement with light therapy, in both mood and eating symptoms can be sustained over at least four weeks. The overlap between the drug and light treatments for these disorders may be explained through a serotonergic hypothesis. There is increasing evidence that light therapy has effects on the serotonin system, as supported by neuroendocrine challenge studies and tryptophan depletion studies. Combination approaches may thus be the most effective treatment for seasonal BN.

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SYMPOSIUM 65—PERSONALITY DISORDERS RESEARCH IN CANADA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To provide an overview of Canadian research on the etiology, outcome, and treatment of personality disorders.

No. 65A THE ETIOLOGY OF PERSONALITY DISORDER TRAITS

John Livesley, M.D., *Department of Psychiatry, University of British Columbia, 2255 Westbrook Mall, Vancouver, BC V6T 2A1, Canada;* Kerry L. Jang, Ph.D.

SUMMARY:

This paper reports on studies of the genetic and environmental etiology of personality disorder traits. In earlier studies the traits delineating personality disorders were identified by literature review and clinical judgment. Multivariate statistical procedures were used to reduce these traits to 18 lower-order dimensions. A self-report instrument was developed to assess these traits. Subsequent analyses indicated a four-factor, higher-order structure underlying these traits. These factors were labeled emotional dysregulation, dissocial, inhibition, and compulsivity.

Genetic and environmental effects on the lower order and four higher order traits were investigated in a sample of 686 twin pairs. The heritability of the lower order traits ranged from .35 for rejection to .56 for callousness. Estimates for the higher order traits were: emotional dysregulation .53, dissocial .50, inhibition .52, and compulsivity .38. Environmental effects were confined to specific or unique factors. Multivariate genetic analyses yielded four genetic factors that closely resemble phenotypic structure. Analyses of the residual heritability of the lower order traits when the effects of the higher order traits were removed revealed a significant heritable component. Implications for classification and future research on the etiology of personality disorder will be discussed.

No. 65B PROSPECTIVE FOLLOW-UP OF BORDERLINE PERSONALITY: MECHANISMS OF CHANGE

Paul S. Links, M.D., *Turner Wing, Rm 706, 160 Wellesley Street E, Toronto, ONT M4Y 1J3, Canada;* Ronald Heslegrave, Ph.D.

SUMMARY:

This report presents the findings of a seven-year prospective follow-up study of subjects with borderline personality disorder (BPD) assembled initially from an inpatient setting. The prospective nature of the study allows for the examination of possible mechanisms explaining how borderline patients "burn out" in middle age. Paris (1996) hypothesized that the mechanisms include biological maturation or gradual social learning. In addition, change over time may be explained by treatment factors. At inception of this cohort, 88 of 130 subjects scored 7 or higher on the Diagnostic Interview for Borderlines (DIB) indicating a definite diagnosis of BPD. Forty-two subjects scored less than 7 on the DIB, thus not meeting full criteria. At seven-year follow-up, 81 (62.3%) of the original cohort were examined, two (1.6%) were deceased, six (4.6%) suicided, 36 (27.7%) refused to participate, and five (3.8%) were not located. As for the hypothesis of biological maturation using three follow-up points, there were significant differences between "remitted" and "persistent" patients with regard to the initial level of impulsivity and the change in impulsivity over time. The "remitted" patients had significantly lower levels of initial impulsivity and significantly more rapid declines in impulsivity than the "persistent" patients. Outcome data suggest that "remitted" patients show improved social functioning over time and demonstrated significantly higher GAS at follow-up ("remitted" patients mean 73.8 versus "persistent" patients mean 62.8 p = 0.0064). Exposure to hospitalization did not differ across the two groups over the follow-up period, suggesting that treatment was not a major variable leading to resolution of the borderline syndrome.

Our findings suggest that both biological maturation and social learning are involved in the recovery of borderline patients. The two mechanisms may interact, so that at lower levels of impulsivity patients can take advantage of social learning opportunities.

No. 65C IMPLICATIONS OF RESEARCH ON PSYCHOLOGICAL RISK FACTORS IN BPD

Joel F. Paris, M.D., *Psychiatry, Jewish General Hospital, 4333 Cote Ste Catherine Road, Montreal, PQ H3T 1E4, Canada*

SUMMARY:

A large body of research on childhood adversities associated with personality disorders consistently shows that borderline patients report a large number of traumatic events, including sexual abuse, physical abuse, emotional neglect, family breakdown, and family dysfunction. However, the interpretation of these findings needs to be qualified. First, reports of a traumatic childhood are not universal. In our large sample of personality disorders of both genders, a third of patients with BPD reported no trauma, and a third reported only minor incidents. Severe adversities were concentrated in another third, a subgroup in which childhood trauma is most likely to play an etiological role. Second, community studies show that most individuals with significant histories of childhood trauma do not develop psychopathology later in life. Third, all studies of trauma in borderline patients have been retrospective, and none has validated patient reports independently. Fourth, recent research points to a significant heritable component in borderline pathology. The effects of childhood adversities in BPD can be best understood using a stress-diathesis model. Trauma has different effects on children with different personality structures. Borderline pathology is an amplification of underlying dimensions of impulsivity and affective instability. Children with these traits need not develop BPD, but are at risk if they suffer psychosocial adversities. Children with other trait profiles exposed to the same adversities will be at risk for other personality disorders, but not for BPD.

No. 65D RISK FACTORS FOR BORDERLINE PATHOLOGY IN CHILDREN

Jaswant Guzder, M.D., Department of Psychiatry, Jewish General Hospital, 4333 Cote St. Catherine Road, Montreal, PQ H3T 1E4, Canada; Phyllis Zelkowitz, Ed.D., Joel F. Paris, M.D.

SUMMARY:

Our research program focuses on the causes and outcome of borderline pathology in children, a probable precursor of personality

disorders in adolescence and adulthood. The first stage of our research involved a chart review study of 98 children assessed for day treatment. Using the child version of the Diagnostic Interview for Borderlines (C-DIB), we divided the sample into borderline (n=41) and non-borderline (n=57) groups. The risk factors that differentiated the borderline group were sexual abuse, physical abuse, severe neglect, and parental substance abuse or criminality. Sexual abuse and severe neglect were also significant in multivariate analysis, with scores for cumulative abuse and cumulative parental dysfunction being higher in the borderline group. In the second stage, we conducted a cross-sectional study of 83 children attending the day treatment program. We used the C-DIB to divide the sample into borderline (n=35) and non-borderline (n=50) groups. The psychosocial risk factors significantly more common in the borderline groups were similar to those in the chart review study (sexual abuse and neglect). Moreover, neuropsychological testing (using the Wisconsin Card Sorting Test, the Continuous Performance Test, and the Quick Neurological Screening Test) showed that the borderline group had more problems with attention, impulsivity, and conceptual tasks. The next stage of our work will involve prospective follow-up of both of these cohorts during their adolescence, to examine their functional status and to determine whether childhood variables predict the development of personality disorders.

No. 65E
DEFENSES IN PERSONALITY AND DEPRESSIVE DISORDERS

J. Christopher Perry, M.D., *Department of Psychiatry, Jewish General Hospital, 4333 Cote St. Catherine Road, Montreal, PQ H3T 1E4, Canada*

SUMMARY:

Objective: Personality disorders (PD), such as BPD, often co-occur with depression. Some believe that BPD in particular is a variant of affective disorder. This presentation reviews three studies that have examined defense mechanisms in PD and/or depressive disorders to explore whether defenses may partially explain the vulnerability to either or both of these types of disorders.

Method: Data will be presented from three studies: (1) outpatients with a personality or mood disorder, (2) treatment-resistant patients in a residential setting, and (3) an outpatient sample of individuals treated for major depression. Defenses were rated using the Defense Mechanism Rating Scales in each sample. Regression analyses examined the relationship between defense and diagnosis (samples 1 and 2) and outcome (sample 3).

Results: Lower adaptive level defenses were associated with PD's, while a subset of these were also associated with depression. BPD subjects in samples 1 and 2 and those with poorer prognosis depressive disorders in sample 3 shared certain defenses (e.g., passive aggression, splitting). PD's such as ASP or NPD did not share as many defenses with depression.

Conclusion: Defenses appear highly related to certain PD's and depression. Defenses found in both BPD and poorer prognosis depression are good candidates for a therapeutic focus in the treatment of either or both disorders. We hypothesize that as use of these defenses diminishes, patients would experience improvement in both disorders. An ongoing naturalistic study examining how these defenses change in psychotherapy will be described.

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5. Hoglend P, Perry JC: Defensive functioning predicts improvement in major depressive disorder J Nerv & Ment Dis, in press.

SYMPOSIUM 66—DYNAMIC PERSPECTIVES ON TREATMENT RESISTANCE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) recognize contributions to treatment resistance that come from enactments between patient and treater, conflicts that arise between psychotherapist and psychopharmacologist, inappropriateness or inadequacy of treatment modality, and lack of intrapsychic readiness for change; (2) list approaches to resolve treatment resistance.

No. 66A
TREATMENT RESISTANCE AND THE DYNAMICS OF THE DUAL TREATMENT RELATIONSHIP

James M. Ellison, M.D., *20 Wall Street, Burlington MA 01803*

SUMMARY:

Dual treatment, the provision of psychotherapy by one clinician and pharmacotherapy by another, is widespread and often highly advantageous to all. The alliance of a pharmacotherapist with a psychotherapist, however, yokes together two clinicians who likely differ in discipline, ideology, priorities, availability, and even temperament. All may proceed smoothly with routine cases, but the inherent weaknesses of the collaboration are brought to the fore with treatment resistance. Treatment-resistant patients, who typically possess complex and comorbid disorders, place additional demands on a system with few, if any, guidelines or standards. There are no generally accepted approaches for conflict resolution between therapists. Although improved integration might prove more effective than more aggressive parallel treatment approaches, a unimodal therapist may assert the importance of his or her approach while focusing on shortcomings of the complementary modality. This allows the therapist to disown both a personal sense of failure and a need to experience and address the patient's angry frustration. Finally, dynamic issues that should find their way into the psychotherapy and medical issues that should be addressed in pharmacotherapy can be inappropriately diverted to the wrong caregiver, undermining treatment effectiveness. Case examples and treatment implications will be discussed.

No. 66B
READINESS FOR CHANGE IN TREATMENT RESISTANCE

Barri A. Belnap, M.D., *Department of Psychiatry, Austen Riggs Center, P.O. Box 962, Stockbridge MA 01262-9999*

SUMMARY:

For most patients with mood disorders medications provide necessary changes in *the biological environment of the psyche* that free patients from symptoms interfering with their ability to make choices

and take responsibility for their lives. Similarly, for some treatment-resistant patients, particularly those with Axis II pathology, response to medication requires a particular psychological readiness for change. Some patients use the expectation that medication will resolve symptoms to confirm their belief in an all-powerful remedy coming from outside them. In their hopes for an exogenous cure, they abdicate personal agency and responsibility for their emotional troubles, in the process creating a reality they have come to expect—that they depend on others who inevitably fail them. Sometimes patients cling to symptoms in the service of dedifferentiation or in pursuit of *motives* inimical to the aim of symptom relief. These motives are often complex, but clues to them may be found in the symptom's dynamic meanings, for example, the wish to evoke feelings of guilt in others. This presentation will review case examples suggesting that dynamic understanding of the meaning of symptoms along with careful selection of target symptoms for medication leads to treatment response in some treatment-refractory patients.

No. 66C
ENACTMENT AND TREATMENT-REFRACTORY DEPRESSION

Eric M. Plakun, M.D., *Admissions, The Austen Riggs Center, P.O. Box 962, 25 Main St., Stockbridge MA 01262*

SUMMARY:

Twenty-first century psychiatrists will be increasingly called upon to lead clinical teams dealing with the most difficult to treat patients. Many of these will be patients presenting with the syndrome of treatment-refractory depression. Although residencies prepare psychiatrists for psychopharmacologic approaches to these patients, few still provide sophisticated training in concepts that may be relevant to planning a comprehensive and integrated psychodynamic approach to such patients. This presentation will introduce the recently developed psychoanalytic concept of "enactment," defined as an interactive process *involving both doctor and patient,* in which both are engaged in mutual projective identification. Enactment will be differentiated from near neighbor phenomena like acting out, countertransference, and the patient's projective identification. Through case examples, the paper will explore and illustrate how unrecognized enactment may be a significant psychosocial contributor to treatment-refractory depression. Cultivation of a reflective space through case presentation, supervision, and/or personal therapy allows enactments to be detected and responded to in a way that can resolve impasses and lead to enhanced response to treatment.

No. 66D
TREATMENT RESISTANCE: A COGNITIVE-BEHAVIORAL PERSPECTIVE

Michael E. Thase, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh PA 15213*

SUMMARY:

The term treatment resistance connotes both a descriptive fact, (i.e., the patient has not responded to particular treatments), and a psychotherapeutic process, (i.e., the patient-therapist dyad has not been able to engage productively). This presentation will review a cognitive-behavioral approach to treatment-resistant depression. Importantly, this approach is prescriptive and collaborative and builds upon an assessment of the patient's strengths and limitations in intrapersonal, interpersonal, and vocational domains. The abiding view is that the resistant patient is not sabotaging therapy or unconsciously defending against change but, rather, that each case of "resistance" reflects a unique combination of poor coping skills, pessimism and hopelessness, inadequate social support, complicated grief, neurophysiological liabilities, information processing difficulties, a strained therapeutic alliance, and "bad luck." Therapy follows an explicit step-wise format, initially emphasizing behavioral goals and interventions reminiscent of rehabilitation medicine. Evidence that this approach can make a significant difference for 40% to 60% of antidepressant nonresponders will be presented.

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SYMPOSIUM 67—PATHWAYS TO HOMELESSNESS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants should be aware of the prevalence of mental disorders, neuropsychiatric impairment, personality disorders, and HIV infection in homeless individuals as well as able to recognize common pathways to homelessness and able to understand implications for service delivery.

No. 67A
AN INTEGRATIVE APPROACH TO RESEARCH WITH HOMELESS PERSONS

George S. Tolomiczenko, Ph.D., *Department of Psychiatry, Clark Institute, 250 College Street, Hlth Syst., Toronto ON M4N 1R8;* Paula N. Goering, Ph.D., Donald A. Wasylenki, M.D., Katherine Boydell, Ph.D.

SUMMARY:

The Pathways into Homelessness project relied on an integrative approach to handling both practical and methodological issues that often pose challenges to investigators within areas of applied research. The methodological dilemma of choosing between the breadth offered by a quantitative, epidemiological study focused on psychiatric assessment and sociodemographic factors on the one hand, and by a qualitative, in-depth, study of persons able to relate their particular stories on the other, was avoided by combining the two approaches. Some of the practical problems involved in recruiting a sample reflecting the characteristics of the population of homeless single adults were mitigated by including service providers and municipal planners in an advisory committee, which provided direct feedback to the research team throughout the planning and execution phases of the project. Finally, access to community service databases maintained in Toronto by the city's Hostel Services Division facilitated an accurate description of the population of shelter users, which enabled a stratified sampling approach. This paper will outline the phases involved in executing this integrative approach, namely, conducting a preliminary survey (N=561), achieving a sampling strategy, collecting the data (N=300) and, finally, organizing findings to inform both academic and local service planning communities.

No. 67B
PREVALENCE OF MENTAL ILLNESS AMONG HOMELESS PERSONS

Donald A. Wasylenki, M.D., *Department of Psychiatry, Wellesley Hospital, 160 Wellesley St. East RM 314A, Toronto, ONT M4Y 1J3, Canada;* George S. Tolomiczenko, Ph.D., Paula N. Goering, Ph.D., Tammy Morrell-Bellai, Ph.D., Michael Higgins, B.A., Nicole A. Tenn-Lyn, B.S., Carole Bentley, B.A.

SUMMARY:

The DIS-IV was used to assess all subjects (N=300) for DSM-IV diagnoses of PTSD, affective disorders, psychotic disorders, and alcohol abuse. Surprisingly high prevalence rates for these disorders were found. Most significantly, 45% of the sample met criteria for lifetime diagnosis of major depression (12% single episode, 33% recurrent). Of this group, almost two-thirds (62%) had had a qualifying episode during the prior 12 months. A total of 84% reported that their first depressive episode had preceded the first time they were without adequate housing; 31% had been hospitalized overnight for depression at least once (though only 6% in the year prior to the current period of homelessness). Lifetime prevalence rates for other disorders in the sample (including comorbid cases) were: bipolar disorder 10% (types I & II), dysthymia 5%, schizophrenia or schizophreniform disorders 6%, and PTSD 37%. Only 34% of the sample did not have any psychiatric diagnosis when those who met alcohol abuse or dependence criteria were excluded (62%). Including the latter diagnoses reduced the number without a psychiatric diagnosis to 16%. The implications of these findings with regard to unmet need and public health issues will be discussed.

No. 67C
PATHWAYS INTO FIRST-TIME HOMELESSNESS

Paula N. Goering, Ph.D., *Department of Psychiatry, Clark Institute, 250 College Street, Hlth. Syst, Toronto ON M5T 1R8;* Tammy Morrell-Bellai, Ph.D., Michael Higgins, B.A., Katherine Boydell, Ph.D., George S. Tolomiczenko, Ph.D., Donald A. Wasylenki, M.D.

SUMMARY:

Factors that initially precipitate homelessness may differ from those that perpetuate a chronic course. For prevention, it is critical to understand pathways for the first time homeless (n=133). Although 80% have a lifetime diagnosis, it cannot be assumed that mental illness and substance abuse are direct contributors to first homeless episodes. Only 21% identified them as such. In-depth interviews with 15 individuals reveal various pathways. In the *acutely ill* subgroup psychiatric symptoms clearly disrupt interpersonal relationships and living arrangements. Discharges to shelters from inpatient care may be a final stage in such pathways. Several *previously well* individuals had functioned successfully. They describe how symptoms of depression and distress reactive to negative life events contribute to loss of income and housing. *Young adults in transition* report a series of failed accommodation arrangements, primarily due to interpersonal problems. Troubled families, bad judgment, and inadequate social skills seem to play a larger causal role than do symptoms of anxiety and depression. Another *vulnerable* subgroup have deprived and/or abusive childhoods and histories of serious substance abuse or emotional problems. Still, they manage to establish some stability in their lives until a series of events precipitate a crisis. Each of these four subgroups requires specifically tailored prevention strategies. Job and housing markets influence them all.

No. 67D
NEUROPSYCHOLOGICAL AND PERSONALITY FACTORS

George S. Tolomiczenko, Ph.D., *Department of Psychiatry, Clark Institute, 250 College Street, Hlth Syst., Toronto ON M4N 1R8;* Teresa Sota-Royes, M.A., Paula N. Goering, Ph.D., Donald A. Wasylenki, M.D.

SUMMARY:

A total of 105 subjects participated in a supplementary project involving neuropsychological and personality assessment. The former consisted of a two-hour comprehensive battery of tests of cognitive functioning including verbal skills, memory, attention, concentration, mental flexibility, executive motor functioning, and visuospatial skills. The Personality Assessment Inventory (PAI) was used to generate adult-normed clinical, treatment, and interpersonal dimension scores for all subjects. Both neuropsychological and personality variables are summarized and used in cluster analyses to sort subjects into subgroups. These subgroups include subjects who are relatively unimpaired on a functional level yet display personality traits that interfere with help seeking and maintaining social support, subjects who are functionally impaired without such personality traits, and those who fit in neither of these clusters. Critical neuropsychological and personality factors and patterns of covariation that cleanly discriminate between these subgroups will be presented and discussed. Finally, the incremental utility of these types of data in accounting for chronicity of homelessness and in discriminating between other important dimensions of subject clusters (e.g., shelter users versus those who avoid any emergency supports, diagnostic groups, etc.) will be evaluated.

No. 67E
HIV PREVALENCE AND RISK FACTORS IN AN ADULT HOMELESS POPULATION

Mark H. Halman, M.D., *Department of Psychiatry, Wellesley Hospital, 160 Wellesley St. E, Ste JB334, Toronto, ONT M4Y 1J3, Canada;* George S. Tolomiczenko, Ph.D., Paula N. Goering, Ph.D., Donald A. Wasylenki, M.D., Carol Major, MLT

SUMMARY:

Objectives: To determine the HIV prevalence rate among a representative cohort of adult homeless persons in a Canadian HIV epicentre and to examine correlations of HIV positive status in this population, based on known HIV acquisition risk factors.

Methods: A random, representative sample of 300 adult, shelter-using homeless persons in Toronto was accrued from August 1996 to July 1997 to participate in the Pathways into Homelessness study. All subjects were invited to participate in an anonymous, unlinked HIV prevalence study using saliva sample testing. Demographic and HIV acquisition risk factors were recorded for each subject on a summary data sheet, unlinked to the pathways project, for correlational analyses. Data specifics were limited to mitigate against inadvertent linkage. Factors included gender and lifetime history of: (1) injection drug use; (2) crack use; (3) exchanging sex for drugs, cigarettes, or money; (4) sex with injection drug user; (5) sex with men who have sex with other men (for women only); (6) sex with other men (for men only); (7) self-definition as gay or bisexual (for men only); (8) major mental disorder, defined as major depression, bipolar disorder, or schizophrenia on the Diagnostic Interview Schedule (DIS).

Results: A total of 282 (94%) of the 300 pathways subjects agreed to participate in the HIV component. Zero subjects admitted previously testing positive for HIV. Five (1.8%) of the 282 tested positive. As no women tested positive, correlational analyses were done on the 226 men only. Of the risk factors examined, only lifetime

history of crack use was found to significantly correlate with HIV positive status. Five (5.15%) of 97 crack users were HIV positive ($p<.015$; Fisher's exact test).

Conclusion: The overall HIV prevalence rate in this representative random sample of adult homeless persons in Toronto was 1.8%. Positive status was significantly correlated with lifetime history of crack use. The lack of significant correlation with either sexual behaviors or injection drug use may suggest that prevention efforts should continue to focus on safer sexual and injection drug use behaviors, but be broadened to better encompass the significant risk associated with crack use.

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4. Seidman LJ, Caplan BB, Tolomiczenko GS, Turner WM, et al: Neuropsychological function in homeless mentally ill individuals. Journal of Nervous and Mental Disease. 185:(1) 3–12, 1997.
5. Zolopa AR, Hahn JA, Gorter R, Miranda J, et al: HIV and tuberculosis infection in San Francisco's homeless adults: prevalence and risk factors in a representative sample. JAMA 272(6):455–461, 1994.

SYMPOSIUM 68—PSYCHOSOCIAL ASPECTS OF HIV RISK AMONG YOUNG IV DRUG USERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the role of psychological trauma in the lives of young IDU's, recognize psychosocial correlates of HIV risk among young IDUs, and provide a sensitive treatment environment for young IDU's.

No. 68A
OVERVIEW OF THE COLLABORATIVE INJECTION-DRUG USERS STUDY (CIDUS II)

Edgar Monterroso, M.D., *Center for Disease Control, 1600 Clifton Rd. N.E. E-45, Atlanta GA 30333*

SUMMARY:

Research Objectives: (1) to determine incidence of HIV infection among young or recently initiated IDU's that are street recruited, (2) to identify risks factors for HIV infection associated with the drug injecting behavior of younger populations of IDU's, (3) to determine risks associated with sharing drug injecting paraphernalia among young IDU's, (4) to evaluate needle exchange program participation among young IDU's, (5) to determine risk factors for HIV infection associated with sexual behavior in young IDU's, (6) to determine social network interaction in terms of HIV transmission in young IDU's, and (7) to determine how violent behaviors play a role in HIV infection in young IDU's.

Project Description: The Collaborative Injection Drug Users Studies in Younger Injectors and Recent Initiates (CIDUS) II are six studies that will measure HIV seroconversion rates in street-recruited, out-of-treatment young or recently initiated injecting drug users. Each of these studies is unique in that each site is working with a specifically targeted population and investigating issues of local importance. Each site has a different methodology for their study and a different strategy to reach their targeted population. The only bind between all sites is a document of core questions developed by the CIDUS scientific steering committee, formed by all principal investigators and the project officer from CDC. Each site has a data collection instrument unique to the site that includes the core questions developed by the CIDUS II scientific steering committee.

No. 68B
PSYCHOPATHOLOGY AND HIV RISK BEHAVIOR AMONG YOUNG INJECTION-DRUG USERS

Patricia Simon-Morse, Ph.D., *Department of Psychiatry, LSU Medical School, 1542 Tulane Avenue, New Orleans LA 70112;* Edward Morse, Ph.D.

SUMMARY:

Recent epidemiological trends indicate that AIDS cases are increasing disproportionately among injection drug users (IDU's), minorities, and adolescents. Additionally, the region of the United States that has seen the steepest rise in AIDS cases is the South. As part of the CDC-funded CIDUS II multisite study of young injection drug users, investigators in New Orleans from Tulane and LSU medical schools examined the profile and prevalence of psychopathology among young recent injection drug users. This paper presents data from a non-treatment sample of young African-American and Caucasian ("gutter punk") injection drug users surveyed in their New Orleans communities. Using standardized instruments, the relationship between psychiatric symptomology profiles and HIV-related sexual and drug use risk behaviors are examined. Theories of self-imaging and decision balance are used to explain young recent IDU initiates' engagement in risk behavior. Implications for prevention and treatment as they relate to mental health, injection drug use, and HIV are discussed.

No. 68C
INJECTION-DRUG USERS AND HIV RISK IN CHICAGO DEMOGRAPHICS AND GANG BEHAVIOR

Lorna Thorpe, M.P.H., *Dept. of Public Health, University of Illinois, 2121 W. Taylor St., Chicago IL 60612;* Lawrence Ouellet, Ph.D., Antonio Jimenez, M.A., Wendell Johnson, Ph.D., Mike Hansen, M.P.H., Wayne Weibel, Ph.D.

SUMMARY:

Data collected in four distinct areas of Chicago, as part of a CDC multisite study of younger injection drug users (CIDUS II), will be used to examine social network transmission profiles that suggest the HIV epidemic among younger injection drug users may follow distinctly different patterns *within* a single city. Data are presented examining the impact of socioeconomic, racial/ethnic, gender, geographical, and gang-related variables on drug injection initiation, drug use patterns, HIV drug- and sex-related HIV risk practices; and the prevalence of HIV, hepatitis, chlamydia, and gonorrhea among injection drug users who are 18 to 30 years old. These data will demonstrate the importance of providing geographically and culturally sensitive prevention and intervention programs.

No. 68D
VIOLENCE, TRAUMA AND HIV AMONG YOUNG INJECTION-DRUG USERS

Nance Sohler, Ph.D., *Center for Urban Studies, 1216 Fifth Avenue, New York NY 10029;* Theresa Diaz, M.D., Ezra S. Susser, M.D.

SUMMARY:

Most new HIV infections in New York City occur among young injection drug users (IDU's). As part of the CDC-funded multisite Collaborative Injection Drug Users Study (CIDUS), recent and young injectors living in Harlem were surveyed about HIV-related risk behaviors and exposure to violence. Using a validated survey instrument that measures traumatic experiences, data will be presented that examine: (1) whether young recent initiate IDU's represent, in fact, a traumatized population; (2) the relationship between traumatic experiences and risk-taking behaviors; (3) how individual traumatic experiences affect personal violence experiences as either perpetrator or victim; and (4) if specific traumatic events lead to post-traumatic stress disorder (PTSD) or if they are instead part of a "trauma syndrome." Understanding the role of psychological trauma in this population will better inform prevention and intervention programs targeting young injection drug users.

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1. Rodriguez EM, de Moya EA, Guerreo E, Monterroso ER, et al: HIV-1 and HTLV-1 in sexually transmitted disease clinics in the Dominican Republic. Journal of Acquired Immune Deficiency Syndromes. 6(3):313–8, 1993.
2. Simon PM, Morse EV, Balson PM, Osofsky HJ, Gaumer HR: Barriers to human immunodeficiency virus related risk reduction among male street prostitutes. Health Education Quarterly Summer 20(2):261–73, 1993.
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4. Susser E, Valencia E, Sohler N, Gheith A, et al: Interventions for homeless men and women with mental illness: reducing sexual risk behaviors for HIV. International Journal of STD & AIDS 2:66–70, 1996.

SYMPOSIUM 69—THE MANY FACES OF THE DRUG PROBLEM
Joint Session With the InterAmerican Council of Psychiatric Organizations

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of this symposium, the participants should be able to appreciate and understand the complexities of the substance abuse problem in the United States, particularly among Hispanic populations.

No. 69A
SUBSTANCE ABUSE: A VISION FROM THE UNITED STATES

Pedro Ruiz, M.D., *Department of Psychiatry, University of Texas, 1300 Moursund Street, Houston TX 77030;* Rodolfo D. Fahrer, M.D.

SUMMARY:

During the last two decades, the total incidence of substance abusers has progressively decreased in the United States. However, the number of Hispanics who abuse heroin and crack still surpasses that of the general population. Moreover, the impact of intravenous drug use among Hispanics in the United States vis-a-vis the HIV/AIDS epidemic has been devastating: as of December 1996, 27% of the adult/adolescent AIDS cases and 23% of the pediatric AIDS cases reported in this country were Hispanics. However, only approximately 8.4% of the U.S. population is of Hispanic origin. Undoubtedly, socioeconomic and cultural factors play a role in the rate of substance abuse among Hispanics and in its negative impact with respect to HIV/AIDS. Additionally, the current policy of criminalization in this country has not so far positively impacted on the substance abuse problem.

It is within this context that this presentation will address the most relevant socioeconomic, cultural, psychological, and legal factors that impinge on the drug abuse problem in the Hispanic population of the United States. Additionally, some of the potential solutions for this problem, with particular emphasis in the geopolitical dynamics of the American continent, will be examined.

No. 69B
SUBSTANCE ABUSE: A SOUTH-AMERICAN PERSPECTIVE

Carlos Leon-Andrade, M.D., *Department of Psychiatry, Metropolitan Hospital, Casilla 17-16-127 CEQ, Quito, Ecuador*

SUMMARY:

The substance abuse problem has had devastating effects in many South American countries, especially in Ecuador, Venezuela, and Peru. Additionally, the substance abuse problem in South America has contributed to the HIV/AIDS epidemic currently seen in many of the South American countries, especially Brazil. In this presentation, an attempt will be made to assess the extent of the drug problem in South America, and attention will be paid to the strategic plans for intervention recently developed in Ecuador. It is expected that the exchange of experiences with respect to the fight against drug abuse will permit the development of new and bold methods of intervention against this difficult problem. This symposium will offer a unique opportunity to debate and find potential solutions to the drug problem, which is currently affecting the continent.

No. 69C
THE INTERNATIONAL DRUG TRAFFICKING

Roberto E. Chaskel, M.D., *Psychiatry, University Nacional, Calle 103 No. 15-76 (#101), Bogota, Colombia;* Ruben J. Hernandez-Serrano, M.D., Luis G. Ruiz, M.D.

SUMMARY:

The drug traffic problem in the Americas for a long time has been a most complex issue, particularly for the United States. Among the approaches to reduce drug demands and, thus, reduce international trafficking, has been the method of harm reduction, which has been partially implemented in several countries. However, there has been much resistance to this method. The United States government, for example, has for some time approached the international drug trafficking problem from a hard line of criminalization of the activity. This approach, however, has not been totally successful. In this presentation, different perspectives will be examined, particularly the Colombian one. Colombia has been at the core of the international drug trafficking problem. However, most of the policies being implemented there so far have emanated from the United States. Hopefully,

this presentation and symposium will shed light on this most difficult situation.

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No. 69D
SUBSTANCE ABUSE AND HIV/AIDS: A PROBLEM FOR THE AMERICAS

Rodolfo D. Fahrer, M.D., *Mental Health, University of Buenos Aires, J Salguero, 2436-8th, Buenos Aires 1425, Argentina*

SUMMARY:

As drug addiction spreads into every corner of America, so does the HIV/AIDS epidemic. Currently, intravenous drug use is one of the most common methods of HIV infection. The HIV/AIDS epidemic is rapidly expanding in Latin American countries and regions such as Mexico, Brazil, Argentina, and the Caribbean. Strategies considered for reduction of the HIV/AIDS epidemic from a substance abuse perspective have not been fully accepted as yet due to socio-cultural considerations, as well as legal philosophies. For example, needle exchange programs, while proven effective, have not been fully accepted by governments and society. Likewise, decriminalization of addiction still is considered dangerous from a legal perspective and is thought to have the potential to increase drug use. However, the spread of HIV infection due to drug use is steadily increasing. In this presentation, an attempt will be made to examine the effectiveness and risks for each of these potential means of intervention, including methadone maintenance programs.

No. 69E
SUBSTANCE ABUSE: A CARIBBEAN PERSPECTIVE

Sharon C. Harvey, M.D., *Brigade House Med. Ctr, The Garrison, Christ Church, Barbados W.I.*

SUMMARY:

The drug problem has become an international puzzle. No nation or region in the world can escape the tribulations caused by drug trafficking. The Caribbean region, particularly Barbados and Puerto Rico, are not exceptions to this broad problem. This region is particularly vulnerable to drug trafficking because of its multiple islands and the poverty that prevails in most of the countries. Parallel to the drug problem, we can also note a major increase in the HIV infection rate as a consequence of intravenous substance use and abuse. The high flow of tourism in this region makes this situation much worse. In this presentation, we will address this issue from different viewpoints, including the social, cultural, economic, and psychiatric perspectives. Hopefully, the discussion, which will be generated by the presentation, will offer an opportunity to understand the roots of this problem, as well as entertain potential solutions.

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3. Bayer R, Openheimer GM: Confronting Drug Policy. New York, Cambridge University Press, 1993.
4. Friedman SR, Des Jarlais DC: HIV among drug injectors: the epidemic and response. AIDS Care, 3:239–250, 1991.

SYMPOSIUM 70—DOCTORS AND DRUG COMPANIES: UNHOLY ALLIANCE OR MATCH MADE IN HEAVEN?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize and identify administrative, educational, clinical, and ethical problems arising in the relationship between the pharmaceutical industry and psychiatrists as well as psychiatric organizations, most particularly the practice of gift-giving and the funding of education programs; and to appreciate the consequences for patients and the profession.

No. 70A
PROMOTION IN THE GUISE OF EDUCATION

Irwin N. Hassenfeld, M.D., *Department of Psychiatry, Albany Medical College, 47 New Scotland Avenue, A-164, Albany NY 12208*

SUMMARY:

In 1989 $5 billion of the $32.4 billion in total domestic sales for the U.S. pharmaceutical industry was spent on marketing. In 1996 the figures had jumped to $12.3 billion of $58 billion in sales (22.5%, an increase of 7% in seven years). The target of a substantial portion of this growing expenditure is the medical profession (estimated at $8,000 per physician in 1989). That same year the industry spent $165 million on promotional items, including symposia. Another $200 million is spent annually for "medical education." This presentation will argue that much of what goes under the name of education is actually promotion. Examination of one industry-sponsored symposium will be used to illustrate this premise. Also discussed will be the scientific accuracy of medical information provided by pharmaceutical representatives. Finally, the issue of full disclosure in research and education will be explored.

No. 70B
THE DEVELOPMENTAL HISTORY OF A PHARMACEUTICAL LECTURE

Joseph Di Giacomo, M.D., *111 E Montgomery Ave, Ardmore PA 19003-2503*

SUMMARY:

The presenter has lectured on psychopharmacology for 25 years. The developmental history of his relationship with the pharmaceutical industry and of the evolution of his lecturing will be discussed. This will include initial contacts with the drug company, justification for lectures, positive reinforcement, and addicting quality of this activity in relation to the merits of the pharmaceutical agent. The presentation will conclude with suggestions for enhancing pharmaceutical company participation in psychiatric education.

No. 70C
PSYCHOLOGY AND ETHICS OF GIVING AND RECEIVING

Carl Mindell, M.D., *44 Union Avenue, Slingerlands NY 12054*

SUMMARY:

This presentation will focus on the relationship between the pharmaceutical companies and the individual physician. It will look at physicians' acceptance of gifts (e.g., pens, pads, dinners) without so-called substantial value. It will be argued that it is improper for physicians to accept these gifts, even those "without substantial value"; that accepting a gift changes the relationship between giver and receiver; that physicians' prescribing habits *are* influenced by gifts; that it is improper for the physician to incur hidden fees when treating patients; and, finally, that it is improper for physicians to serve as billboards for pharmaceutical companies.

No. 70D
ORGANIZATIONAL PERSPECTIVE ON INDUSTRY SUPPORT

Carolyn B. Robinowitz, M.D., *Assoc. Dean for Students, Georgetown University, 3900 Reservoir Road, N.W., Washington DC 20007-2197*

SUMMARY:

Government support for education and research has declined. There are limits to organizational dues increases which, in any case, are poorly tolerated by the membership. The role of industry as a source of additional income has expanded. In the best instance, unrestricted industry funding is used to support high priority programs unrelated to industry specific products with no donor input or control of program content. The APA and other psychiatric organizations use such arrangements to support or enrich important projects and directions; funding of the APA Office of Education is an example. However, industry support of organizations raises administrative and educational issues and poses ethical dilemmas. The most blatant misuses, e.g., the recent agreement between the AMA and Sunbeam, are easily recognized. A more insidious and less easily recognized problem arises with the increasing sophistication and presence of pharmaceutical company-sponsored programs at meetings, to the point where the tail may now be wagging the dog. The result may be over-emphasis of pharmacologic treatment and a not so subtle message to psychiatrists and residents about psychiatric leadership and education. This presentation will also address practical aspects of the relationship, and offer approaches to evaluate cost/benefit ratios of industry support.

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1. Bero LA, Galbraith A, Rennie D: The publication of sponsored symposiums in medical journals. NEJM 327:1135–40, 1992.
2. Thompson WG: The ethics of physician-pharmaceutical company relations. Can Med Assoc J 139:835–6, 1988.
3. Waud DR: Pharmaceutical promotions—a free lunch? NEJM 327:351–3, 1992.
4. Kassirer JP, Angell M: The high price of product endorsement. NEJM 337:700, 1997.

SYMPOSIUM 71—MEDICATION: CHANGING A PERSON OR TREATING A PATIENT?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to demonstrate increased understanding of the relationship between Axis I disorders treated with medication and changes in aspects of personality including personality disorders, personality organization, and their biological correlates.

No. 71A
STABILITY OF PERSONALITY DISORDERS WITH TREATMENT FOR CHRONIC DEPRESSION

Robert M.A. Hirschfeld, M.D., *Department of Psychiatry, University of Texas, 1200 Graves Bldg. Rt. D-29, Galveston TX 77555-0429;* James P. McCullough, Jr., Ph.D., James M. Russell, M.D., Martin B. Keller, M.D.

SUMMARY:

Personality disorders are defined as longstanding maladaptive personality traits that arise early in life and persist. By their very nature they should be highly resistant to treatment. Depression, which persists for many years, may have much in common with personality disorders.

Chronic depression may be considered to be an abnormality in personality rather than a mood disorder, and may be expected not to respond to treatment, particularly antidepressant medication.

A recently completed study examined the effect of antidepressant pharmacotherapy on chronic and double depression in patients with and without personality disorders. Independent assessments of personality disorders as well as depression were performed. The study addressed several questions relevant to the response of personality disorders to antidepressant therapy. They included: (1) Does the presence of a personality disorder predict a poor response to pharmacotherapy in chronic and double depression? (2) Are independent assessments of the presence of DSM-III-R personality disorders stable over six months? (3) Does successful response to pharmacotherapy for chronic depression result in improvement of comorbid personality disorders as well?

The data came from the Chronic Major and Double Depression Maintenance Study, a 10-site collaborative program involving acute, continuation, and maintenance treatment with sertraline or imipramine in patients with chronic or double depression.

Analysis revealed that there was no difference in response rates among those with chronic depression or those with double depression on the basis of having a personality disorder or not. The results did not change when personality disorders were clustered or when looked at individually. Nearly two-thirds of those who responded positively to pharmacotherapy for depression also recovered from their personality disorder.

This study also demonstrates that personality disorders can be reliably assessed in samples of patients with chronic depression, and that the features of personality disorders respond positively to pharmacotherapy.

No. 71B
DOES MEDICATION CHANGE PERSONALITY ORGANIZATION?

Carlos Blanco, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York NY 10032;* Linda S. Mullen,

M.D., Susan C. Vaughan, M.D., John F. Clarkin, Ph.D., Michael R. Liebowitz, M.D., Steven P. Roose, M.D.

SUMMARY:

Clinicians have long believed that an individual's personality is a stable structure that is identifiable regardless of affective state and has a slow rate of change over time. However, a number of studies have shown that personality diagnoses based on a phenomenological diagnostic system such as DSM-IV are in fact state dependent. There is disagreement about whether the phenomenological approach captures what clinicians consider to be enduring about a person. An alternative to conceptualizing personality as a syndrome of behaviors is Otto Kernberg's model of levels of personality organization, e.g., neurotic, borderline, and psychotic.

In this study, patients with Axis I affective and anxiety disorders completed the Inventory of Personality Organization self-report measure at baseline and at completion of a randomized clinical trial of medication. Data analysis will answer the following questions: (1) Does level of personality organization correlate with type or severity of Axis I disorder?, (2) Is personality organization stable over time or does it change significantly depending on response to treatment? (3) Does level of personality organization predict drop-out independently of the severity of the Axis I disorder?

No. 71C
DEFENSE MECHANISMS AND AXIS I: SEARCHING FOR STABILITY

Linda S. Mullen, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 89, New York NY 10032;* Carlos Blanco, M.D., Susan C. Vaughan, M.D., James H. Kocsis, M.D., Roger Vaughan, Ph.D., Steven P. Roose, M.D.

SUMMARY:

There is a longstanding belief that personality represents a structure that is stable over time, and changes, if at all, very slowly. Nonetheless, clinical and empirical evidence supports the notion that the diagnosis of personality disorders using DSM criteria may vary with comorbid Axis I disorders, suggesting that personality as assessed by phenomenological systems is state dependent. Some data may even suggest a continuum between Axis I and Axis II disorders. An alternative to the DSM phenomenological system of conceptualizing personality is the dynamic concept of character, that is, a predictable pattern of both adaptive and pathological defense mechanisms. This presentation will review data from a new study designed to test the hypothesis that defense mechanisms remain relatively stable in patients treated for Axis I disorders, irrespective of clinical improvement. Patients meeting DSM-IV criteria for PTSD, social phobia, dysthymic disorder, major affective disorder, and anorexia nervosa entered randomized, controlled medication trials. Defensive functioning was evaluated with the Defense Style Questionnaire (Bond, et al, 1983) both at baseline and at the completion of the clinical trial. Data were analyzed for whether a specific Axis I disorder was associated with a particular pattern of defensive functioning, and whether an individual's pattern of defense mechanisms was stable regardless of treatment of an Axis I disorder. Results of the study address the question of whether there are personality characteristics that are enduring and that can be appreciated irrespective of the presence of an Axis I disorder.

No. 71D
BIOLOGICAL STUDIES IN PERSONALITY DISORDERS

Emil F. Coccaro, M.D., *Department of Psychiatry, MCP Hahnemann, 3200 Henry Avenue, Philadelphia PA 19129-1137*

SUMMARY:

Despite the long-held view that personality disorder is largely due to developmental and/or psychological deficits, research over the past 15 years has identified evidence of several biological correlates of personality dimensions in personality disordered individuals. The two most compelling of these biological correlates relate to schizotypy and impulsive aggressiveness. For the former, positive symptoms of schizotypy (e.g., illusions, paranoid ideation) have been correlated directly with cerebrospinal fluid (CSF) and plasma levels of the dopamine metabolite homovanillic acid (HVA), while negative symptoms (e.g., constricted affect) have been correlated with impaired smooth pursuit eye movements (SPEM). For the latter, a wide variety of measures of serotonin (5-HT) activity have been inversely correlated with measures of impulsive aggressiveness. This presentation will review the biological correlates of personality as it relates to personality disorder, and present data regarding the efficiacy of psychopharmacologic intervention (e.g., neuroleptics, serotonin uptake inhibitors) in selected subjects with personality disorder.

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3. Bond M, Gardner ST, Christian J, Sigal JJ: Empirical study of self-rated defense styles. Archives of General Psychiatry 40, 333–338, 1983.
4. Coccaro EF, Siever LJ: The neuropsychopharmacology of disorder, in Psychopharmacology: The Fourth Generation of Progress. Edited by Bloom F, Kupfer D. Raven Press, New York, 1995. pp. 1567–1579.

SYMPOSIUM 72—HERBAL MEDICINE: ANCIENT ROOTS TO MODERN USE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) recognize potential drug interactions between herbal medications and prescribed psychotropics, and (2) understand potential benefits and risks of kava, St. John's Wort, and Ayahuasca.

No. 72A
HERBAL MEDICINE AND PSYCHIATRY: POTENTIAL FOR TOXICITY

Michael W. Smith, M.D., *Department of Psychiatry, Harbor-UCLA REI, 1124 West Carson Street/B4 S, Torrance CA 90502;* Oscar V. Rosas, M.D., Mariana Delgado, M.D.

SUMMARY:

The recent surge in the popularity of alternative medicines has refocused both the public and the scientific community's interest in identifying beneficial treatments. This is especially true of herbal medications, where the lay concept that "herbs will do you no harm," often overrides any healthy caution or skepticism. The situation is further complicated by the lack of scientific information available about these preparations, which is due in part to the lack of FDA regulations as well as the absence of any obvious profit potential (i.e., You can't patent a plant). Although some of these herbal preparations have been used safely for hundreds of years, little if any information is available on the safety of combining them with prescribed medications.

Our research indicates that the cytochrome P450 drug metabolizing enzyme system may be particularly sensitive to changes in exposure to xenobiotics such as diet and herbal medication. Certain flavones found in grapefruit juice, plums, and corn can inhibit the metabolism of substrates of P450 3A3/4, such as nifedipine, terfenadine, and alprazolam. These flavones are also found in many of the herbal preparations, often times in higher concentrations. This is especially of concern since many of the newer antipsychotics, as well as antidepressants, are also metabolized through this pathway. In addition, many of these herbal preparations display affinity for CNS receptors such as GABA, dopamine, and serotonin, which in part explains their effectiveness, but also increases the potential for synergistic or antagonistic effects when combined with prescribed psychotropics.

No. 72B
KAVA: ANCIENT BEVERAGE TO MODERN PSYCHOTHERAPEUTIC MEDICINE

Dennis J. McKenna, Ph.D., *Heffer Research, Box 224, Marine on St Croix MN 55047*

SUMMARY:

Kava is a relaxing, mildly psychoactive beverage prepared from the root of *Piper methysticum*, a member of the pepper family (Piperaceae), which is widely cultivated throughout the South Pacific, from Hawaii to New Guinea. The root is used in the preparation of a recreational beverage, known by a variety of local vernacular names (e.g., Kava, Yangona, or 'Awa) that occupies as prominent a position in the social, ceremonial, and daily life of Pacific island peoples as coffee or tea does in our own culture.

Kava has long been utilized in European phytomedicine as a sedative, tranquilizer, muscle relaxant, treatment for menopausal symptoms, and treatment for urinary tract and bladder disorders. Some of these applications have been substantiated by well-designed clinical trials. Currently, over 17 phytopharmaceutical products derived from kava are available in the European market. In the United States, it can be sold as a dietary supplement under the provisions of the Dietary Supplement Health and Education Act of 1994.

The active, psychotropic constituents of kava are arylethylene-a-pyrone derivatives known as kavalactones. Approximately 17 kavalactones have been isolated and chemically characterized; however, only six are considered major constituents and the variation in psychotropic activity is probably due to the varying amounts and proportions of these components.

There is considerable interest in the potential applications of kava and kavalactones as safe and efficacious sedatives, muscle relaxants, analgesics, and anxiolytics. This presentation will review the traditional uses of kava, and the current understanding of the chemistry, the chemotrypic characteristics of kava cultivars, the pharmacological basis of its activity, and the clinical and other therapeutic uses of kava.

No. 72C
ANTIDEPRESSANT ACTIVITY OF HYPERICUM PERFORATUM: ST. JOHN'S WORT

Jerry M. Cott, Ph.D., *NIMH, 5600 Fishers Lane, Rockville MD 20857*

SUMMARY:

Hypericum perforatum (St. John's Wort) has been used since ancient Greece for its many medicinal properties. Modern usage is still quite diverse and includes wound healing, kidney and lung ailments, insomnia, and depression. While it has been assumed by most researchers that hypericin and related compounds are the primary active agents, pharmacologic evidence is lacking. A standardized extract of the flowering top of this plant is registered in Germany for the treatment of mild to moderate depression, where it outsells all other antidepressants combined. Controlled trials with more than 3,000 patients have been done in Germany. The authors of a recent meta-analysis of these trials concluded that the herb was significantly superior to placebo, and appeared comparable to standard antidepressants while producing fewer side effects (Linde, et al., 1996). While several mechanisms of action have been proposed for *Hypericum*, none are particularly convincing. The most often cited effect, MAO inhibition, has not yet been shown in vivo, and no drug interactions or side effects have been reported that are consistent with either MAO inhibition or monoamine uptake inhibition. In vitro receptor binding studies show significant affinity for adenosine, $GABA_A$, $GABA_B$, benzodiazepine, and IP_3 and inhibition of both MAO_A and MAO_B.

No. 72D
PLANT ENTHEOGENS AS MEDICINE

Charles S. Grob, M.D., *Box 498, Harbor-UCLA Medical Center, 1000 West Carson Street, Torrance CA 90502-2004*

SUMMARY:

The use of plant entheogens (hallucinogens) for healing extends back to pre-history, although their properties and medicinal potential have gone largely ignored by modern medical science. This presentation will examine anthropological, ethnobotanical, biochemical, and medical perspectives of these psychoactive substances. Properties and effects of such plants as *Banisteriopsis caapi, Psychotria viridins, Stropharia cubensis, Lophophora williamsii, Trichocereus peruvianis, Tabernanthe iboga*, and *Salvia divinorum* will be discussed. Data and implications of a pilot bio-medical-psychiatric research investigation of Ayahuasca use in the Brazilian Amazon will be presented. The importance of implementing alternative treatment paradigms and structures to achieve optimal salutary effect will be contrasted with the known abuse potentials of these substances.

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SYMPOSIUM 73—CLASSIC AND ATYPICAL NEUROLEPTICS IN DEMENTIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to demonstrate understanding of the rationale, indications, and expected outcomes for the use of classic and atypical neuroleptics in demented persons.

No. 73A
A NEUROCHEMICAL RATIONALE FOR THE USE OF NEUROLEPTICS IN DEMENTIA

Dario F. Mirski, M.D., *Department of Psychiatry, Medical University of S.C., 171 Ashley Avenue, Charleston SC 29425*

SUMMARY:

A review of the neuro-anatomical literature reveals that specific and discrete areas appear to be involved in the control of aggressive behaviors in animal models and humans. These areas include the amygdala, the hippocampus, the hypothalamus, and the septal nuclei. These areas, as well as areas in the neo-cortex are hypothesized to affect aggressive and psychotic behaviors in demented persons. In addition, it has been suggested that specific neurotransmitters such as serotonin and dopamine could be involved in the pathophysiology of these symptoms in dementia.

Specifically, the presenter will discuss imaging studies using positron emission tomography (PET) supporting the relationship between psychiatric symptoms and regional cortical metabolism in dementia. In addition, a review of animal studies showing apomorphine and L-Dopa inducing aggressive behavior in animals as well as aggression and psychosis in humans will be presented. The implications of this literature in the treatment of aggression and psychoses in dementia will be discussed.

Finally, original data showing a correlation between hyperactivity in post-synaptic serotonin receptors and aggression in Alzheimer's disease will be presented. The possible correlation between these findings and neuroleptic treatment of aggression in demented persons will be discussed.

No. 73B
CLASSIC NEUROLEPTICS IN DEMENTIA

Davangere P. Devanand, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 722 West 168th Street, Box 72, New York NY 10032-2603*

SUMMARY:

Patients with Alzheimer's disease (AD) often develop behavioral disturbance (e.g., agitation), or psychotic features (e.g., delusions). There are limited data with typical neuroleptics in this patient population. Prior meta-analyses of these few studies suggest moderate efficacy for this class of medications.

In an initial pilot study, we found that doses of haloperidol above 4-5 mg daily could not be tolerated due to extrapyramidal side effects (EPS). In a more recent double-blind study, haloperidol in doses of 2-3 mg daily was more efficacious than both haloperidol 0.5 to 0.75 mg daily and placebo, which were indistinguishable from each other on measures of both efficacy and side effects. In this study, symptoms of agitation and aggression responded as well as symptoms of delusions and hallucinations. Approximately one-fourth of the AD sample on the higher dose (2-3 mg daily) developed moderate to severe EPS, but there were no clear predictors of patient susceptibility to EPS. Based on these findings, a starting dose of haloperidol 1 mg daily is recommended, with gradual, upward dose titration while assessing target symptoms and monitoring side effects. Differential side effect profiles tend to determine the choice of neuroleptic, for example, atypical neuroleptics like risperidone or olanzapine may be preferred in patients at risk for EPS, and high potency neuroleptics like haloperidol may be preferred in patients at risk for orthostatic hypotension, which can lead to falls and fractures.

No. 73C
ATYPICAL NEUROLEPTICS IN DEMENTIA

S. Craig Risch, M.D., *Psychiatry & Behav. Sci., MUSC Medical Center, 171 Ashley Avenue, Charleston SC 29425-0742*

SUMMARY:

Typical antipsychotics have proven beneficial in the treatment of psychosis; however, their efficacy is *limited.* This is particularly true in demented persons since these compounds often lack the ability to improve and may even cause cognitive deficits. In addition, they have significant adverse side effects, particularly extrapyramidal symptoms that can be especially detrimental in demented persons. In contrast, atypical antipsychotics have superiority over typical antipsychotics in the amelioration of positive symptoms and they are also effective in the treatment of negative symptoms and some of the cognitive deficits of schizophrenia. Importantly, they produce little or no extrapyramidal symptoms, which may predict a lower subsequent incidence of tardive dyskinesia. This profile makes atypical neuroleptics especially appealing for the demented population. The specific indications for their use in this population are still unclear.

This presentation will overview the pharmacological differences between the typical and atypical antipsychotics and specifically update the audience on the various new atypical antipsychotics, their dosage strategies, and side effects. The presenter will emphasize the specific possible indications of these compounds in dementia.

Finally, this lecture will overview the most recent conceptualizations of the possible link between pathophysiology and new pharmacological treatment strategies in this population. The presentation will emphasize the compartmentalization of different dopamine systems and their interactions with other neurotransmitter systems, specifically norepinephrine, serotonin, and glutamate, and correlate this concept with possible indications for use of atypical neuroleptics in dementia.

No. 73D
EFFICACY AND SAFETY OF ATYPICAL NEUROLEPTICS IN DEMENTIA

Jacobo E. Mintzer, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Room PH141, Charleston SC 29425*

SUMMARY:

Recent studies focusing on neurochemical and clinical studies provide rationale for the use of atypical neuroleptics in demented persons presenting with psychotic and aggressive symptoms.

Clozapine: Two studies have shown that clozapine can be effective in the treatment of this population with low incidence of extrapyramidal side effects. Adverse reactions such as gastrointestinal symptoms, hypotension, and agranulocytosis can be problematic.

Olanzapine: This agent has been reported to be safe and effective in schizophrenia with low incidence of extrapyramidal symptoms, but results of controlled studies in demented patients that are under way are still not available. The presenter will review available efficacy and safety reports.

Risperidone: This agent has been recently reported to be safe and effective in the treatment of psychoses and aggression in demented nursing home patients. This placebo-controlled, multicenter study included 645 subjects and showed significant improvement on 1 mg and 2 mg doses in symptoms of psychosis and aggression when compared with placebo.

Symptoms of hypotension and sedation should always be considered. The need of more controlled and long-term studies required to establish the safety and effectiveness of these compounds in demented persons will be underscored.

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SYMPOSIUM 74—CATATONIA AND OTHER MOTOR SYNDROMES: HOW CLOSELY RELATED?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The symposium is designed to provide the participants with current knowledge about the relationship of catatonia and other motor syndromes. Clinical issues of diagnosis and treatment will be stressed. The participants will receive a 21-item catatonia rating scale form to recognize motor and behavioral symptoms of catatonia.

No. 74A
DIAGNOSTIC AND THERAPEUTIC RELEVANCE OF CATATONIA

Brendan T. Carroll, M.D., *Department of Psychiatry, VA Medical Center, 17273 State Route 104, #116A, Chillicothe OH 45601*

SUMMARY:

DSM-IV separates catatonia along the lines of presumed etiology: bipolar, major depression, schizophrenia, and due to a general medical condition. The presence of catatonia holds implications for diagnosis and treatment that may outweigh those of the primary diagnosis. Recent literature examines the overlap between NMS and catatonia. In one prospective study, four of 26 (15.4%) patients with catatonia developed NMS during their treatment.

Meanwhile, the Leonhard classification recognizes catatonia as having prognostic significance in its presentation in cycloid psychosis, affective disorders, and schizophrenia. Leonhard further separates catatonic schizophrenia according to phenomenology: periodic catatonia, parakinetic, proskinetic, speech prompt, speech inactive, manneristic, and negativistic.

The prognostic and therapeutic significance of catatonia is not discussed in any one forum but rather is isolated to sections of the APA's and other treatment guidelines. This presentation is designed to bring together these disparate but important clinical guidelines as they relate to catatonia wherever it is found.

No. 74B
CATATONIA AND NON-CATATONIC MOTOR SYNDROMES IN SCHIZOPHRENIA

Peter Braunig, M.D., *Department of Psychiatry, Ruhr-Universitat, Alexandrinenstr. 1, Bochum 44791, Germany;* Stephanie Kruger, M.D., Jurgen Hoffler, M.D., Ingrid Borner, M.D., Gerald Shugar, M.D.

SUMMARY:

Objective: To investigate clinical significance of catatonia in schizophrenia and the hypothesis that a clinical association exists between extrapyramidal and catatonic motor symptoms in schizophrenia.

Method: We examined 34 catatonic (DSM-IV criteria) and 78 matched non-catatonic schizophrenic inpatients for extrapyramidal motor symptoms (tardive dyskinesia [TD], parkinsonism, akathisia), positive and negative symptoms of schizophrenia, global functioning (GAF), response to neuroleptic treatment, and other clinical and sociodemographic parameters, using well established standardized instruments (SANS, SAPS, BPRS, Simpson-Angus-Scale, Abnormal Involuntary Movements Scale, Rockland Scale, Hillside-Akathisia-Scale).

Results: Catatonic schizophrenics had more severe negative symptomatology; lower global functioning; poorer response to neuroleptics; a higher prevalence of TD, parkinsonism, akathisia, and alcohol abuse; and more suicide attempts than the non-catatonics. The prevalence of spontaneous involuntary movement disorders at first hospitalization was higher in the catatonic group. The association between catatonia and extrapyramidal motor symptoms was established by factor analysis.

Conclusion: The results indicate that catatonia is a marker of severity and poorer treatment response in schizophrenia and possibly a risk factor for the development of neuroleptic-induced extrapyramidal motor disorders.

No. 74C
SIMILARITY OF CATATONIA AND NMS

Andrew J. Francis, Jr., M.D., *Psych and Behav Sciences, Suny Hlth Sciences T-10, Stony Brook NY 11794;* Georgios Petrides, M.D.

SUMMARY:

Objective: To define common clinical features and treatment responsiveness for catatonia and NMS (neuroleptic malignant syndrome).

Method: We systematically screened psychiatric admissions for catatonia with the Bush-Francis Catatonia Rating Scale (BFCRS; Acta Psych Scand 1996; 93:129), yielding 28 cases of which three also met NMS criteria. A second study examined BFCRS catatonic signs in a retrospective series of 22 NMS cases.

Results: Autonomic signs (e.g., pyrexia, tachycardia, hypertension, diaphoresis) were prevalent (13/28) in catatonia and highly responsive to lorazepam treatment. Autonomic signs did not predict response of catatonia to lorazepam, which was 76% overall. Of 22 NMS cases, 16/22 met BFCRS research criteria for catatonia, 17/22 met DSM-IV criteria for secondary catatonia, and 21/22 met ICD-10 criteria for organic catatonia criteria. Mutism, immobility, staring, and posturing were common catatonic signs in NMS [27%-52%]. Three additional NMS cases were found to date, two of which had prominent catatonia. All three were treated with lorazepam monotherapy, which produced dramatic resolution.

Conclusion: The BFCRS facilitates study of catatonia and NMS. Autonomic disturbance is frequent in catatonia. Multiple catatonic signs accompany the characteristic autonomic disturbance of NMS. Lorazepam is an established treatment for catatonia and may improve selected NMS cases.

No. 74D
PREVALENCE AND CLINICAL SIGNIFICANCE OF CATATONIC SYMPTOMS IN MANIA

Stephanie Kruger, M.D., *Department of Neurology, Bergmannsheil, Burkle De La Camp Platz, Bochum 44791, Germany;* Peter Braunig, M.D., Gerald Shugar, M.D.

SUMMARY:

Objective: Since Kahlbaum's early reports of catatonic symptoms in mania, this area has been of interest to researchers. In our study, we systematically investigated the prevalence and clinical relevance of catatonic symptoms in mania and assessed the clinical characteristics of manic subjects with catatonia.

Method: Sixty-one inpatients with DSM-III-R bipolar disorder, manic or mixed episode, were assessed for catatonia by our 21-item

rating scale. Manic symptoms and general psychopathology were systematically assessed both at intake and following recovery. Current comorbidity was assessed by the SCID following recovery. The GAF was used to determine global functioning. Medications were compared for catatonic and non-catatonic manics.

Results: Nineteen patients fulfilled criteria for catatonic mania exhibiting between five and 16 catatonic symptoms. There was some overlap between catatonic and manic motor symptoms. Catatonic manics had more mixed episodes, more severe manic symptoms, more general psychopathology, a higher prevalence of comorbidity, longer hospitalizations, and lower GAF scores than the non-catatonics. Catatonic manics required more benzodiazepines than non-catatonic manics.

Conclusion: The results indicate that the presence of catatonic symptoms is a marker for more severe manic episodes, a more complicated course, and a worse outcome in mania. The diagnostic, differential diagnostic, and therapeutic implications of these findings are discussed.

No. 74E
NEUROLOGICAL SOFT SIGNS IN SCHIZOPHRENIA SUBTYPES

Oliver Rommel, M.D., *Department of Neurology, Ruhr-University, Bergmannsheil Clinic, Bochum 44789, Germany;* Peter Braunig, M.D., Jurgen Hoffler, M.D., Paul Kiwitt, Ingrid Borner, M.D.

SUMMARY:

Objectives: Neurological soft signs (NSS) have been reported to be more common in schizophrenia than in normal subjects. However, only a few studies have examined differences in occurrence of NSS in schizophrenic subtypes. We investigated the diagnostic value of NSS in schizophrenic subtypes compared with healthy volunteers.

Methods: We examined 20 normal controls and 79 DSM-III-R schizophrenics of all subtypes with a neurological examination scale (50 items) including nine NSS items compiled from the literature. Items were rated on a 0–2 scale and interrater reliability was assessed in 30 patients. Repeated examinations were performed in 20 patients. Seven other rating scales (i.e., BPRS, SANS, AIMS) were performed to evaluate psychopathological status and movement disorders.

Results: Median score for schizophrenics (17.2. points) was higher than for normal controls (3.5). Among schizophrenic subtypes catatonia scored the highest (25.2). Significant differences for several items were mainly observed between catatonic and paranoid subtype (10.0). Significant positive correlations were found in patients with high scores between the neurological evaluation scale and six other rating scales.

Conclusion: Subjects with catatonic schizophrenia have the highest prevalence of NSS among schizophrenia subtypes. Diagnostic and therapeutic implications are discussed.

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SYMPOSIUM 75—PRACTICE PROFILE OF UNITED STATES AND CANADIAN PSYCHIATRISTS
Joint Session With the Canadian Psychiatric Association

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the audience will understand the similarities and differences in the nature of psychiatric practice in the United States and Canada.

No. 75A
PRACTICE PROFILE SURVEY BY THE CANADIAN PSYCHIATRIC ASSOCIATION: STUDY, DESIGN AND RESULTS

D. Blake Woodside, M.D., *Department of Psychiatry, The Toronto Hospital, 200 Elizabeth Street, Toronto, ONT M5G 2C4, Canada*

SUMMARY:

The Practice Profile Survey is a national survey of psychiatrists commissioned by the Canadian Psychiatric Association. Conducted in Spring 1997, it assessed one 24-hour day (with a replacement date for non-responders). Participants gave general information about the 24 hours and details about one random hour (including the first patient seen) and the most severely ill patient seen that day. Domains assessed included services rendered; patient demographics, diagnosis, and impairment; and reimbursement source. The response rate was 44% (n = 1621) with 20% on holiday or absent from their practice. Of the remainder, 40% were on call (75% for 8 hours plus). A total of 50% of those on call provided no direct or indirect services, while 25% provided more than five hours and 10% more than eight hours of direct care. An average of 9 to 10 patients were seen during the day, with 80% of professional time spent on clinical activities. For patients seen during the random hour, 99% had at least one Axis I diagnosis, 33% at least two, and 44% a comorbid Axis II diagnosis. As expected, the most severely ill patients were considerably more impaired. This is a unique dataset providing useful information on the nature of psychiatric practice in Canada.

No. 75B
FINDINGS FROM THE AMERICAN PSYCHIATRIC ASSOCIATION'S PRACTICE RESEARCH NETWORK STUDY OF PSYCHIATRIC PATIENTS AND TREATMENTS

Harold Alan Pincus, M.D., *Office of Research, American Psychiatric Assn, 1400 K Street, NW, Washington DC 20005;* Deborah A. Zarin, M.D., Terri L. Tanielian, M.A., Ana P. Suarez, M.P.H., Julie L. Johnson, M.A., Joyce C. West, M.P.P., John S. McIntyre, M.D.

SUMMARY:

The Study of Psychiatric Patients and Treatments is an annual survey conducted by the APA Practice Research Network. The purpose of this study is to systematically characterize psychiatric patients and clinical treatment practice patterns. Following random assignment to a start date and time, PRN psychiatrists (n = 530) were asked to complete a patient log on the next 12 consecutive patients

seen. In addition, each psychiatrist was asked to report specific information regarding the demographic characteristics, financing of care arrangements, treatment services provided including medications, other treatment providers, psychiatric treatment history, and future treatments for three systematically selected a *priori* patients. Four hundred sixteen psychiatrists responded to this survey (79%), yielding general information on a total of 4,992 psychiatric patients and more detailed diagnostic and treatment information on 1,248 patients. Analyses of the data are underway. Presentation of these data will characterize the population receiving care from PRN psychiatrists, highlight the treatments they receive, and assess the medications provided. In particular, we will focus on how health care system factors may account for differences in the provision of treatments for the psychiatric patient population.

No. 75C
THE PRACTICE PROFILE STUDY BY THE CANADIAN PSYCHIATRIC ASSOCIATION: METHODOLOGICAL ISSUES

Elizabeth Lin, Ph.D., *Dept of Psychiatry, Clarke Institute, 250 College Street, Toronto, ONT M5T 1R8, Canada*

SUMMARY:

The CPA Practice Profile Study utilized a format designed to specifically address the goals of the organization in a fashion that could be respected as scientifically valid. After a long period of consultation and literature review, the final design included a self-administered mail-in consisting of six pages, which gathered general information about one of two designated 24-hour days, and detailed information about one "random" hour. The survey was produced in both English and French. Most questions required a checkmark for response with only a few items needing written answers. The content areas assessed were sociodemographics, on-call, primary activity for each hour with payment data if appropriate, activity for each 10-minute interval for the designated hour, diagnostic and severity information about both the first patient contact in this hour and the most severely ill patient seen on the survey day, disposition, and other services required by the patients. The presentation will review the rationale for the decisions made, and the success and/or failure of the decisions in the light of the actual survey results. The broader issues in the design and implementation of such surveys will also be discussed.

No. 75D
THE AMERICAN PSYCHIATRIC ASSOCIATION'S PRACTICE RESEARCH NETWORK STUDY OF PSYCHIATRIC PATIENTS AND TREATMENTS: METHODOLOGICAL ISSUES

Deborah A. Zarin, M.D., *Office of Research, American Psychiatric Assoc., 1400 K Street, NW, Washington DC 20005;* Harold Alan Pincus, M.D., Joyce C. West, M.P.P., Ana P. Suarez, M.P.H., Terri L. Tanielian, M.A., Julie L. Johnson, M.A., John S. McIntyre, M.D.

SUMMARY:

The APA developed the Practice Research Network to address the need for an additional research mechanism to provide data that help address gaps in the current knowledge base and to guide clinical and policy decision making. The methodology of practice-based research has allowed the APA's Practice Research Network to examine treatments being provided to psychiatric patients in routine clinical settings and to study how external factors (psychiatrist characteristics, type of health plan) impact on the provision of care. For the purposes of the 1997 Study of Psychiatric Patients and Treatments, 530 psychiatrist members of the Practice Research Network were asked to complete this study. Each psychiatrist was randomly assigned to begin data collection on one of 14 start day/times (e.g., Monday at noon). Following their assigned start time, psychiatrists were asked to fill out a patient log on the next 12 consecutive unique patients for whom they provided direct patient care. Three of the 12 patient rows on the patient log were "pre-highlighted" with instructions for the psychiatrist to complete a "Detailed Diagnostic and Treatment Form" for those patients. This presentation will discuss the issues considered in designing the study and present data from two methodological follow-up studies.

No. 75E
CANADIAN HUMAN RESOURCE SURVEYS: POLICY IMPLICATIONS

Nady El-Guebaly, M.D., *Dept Psychiatry, Foothills Hospital, 1403 29th Street N.W., Calgary AB T2N 2T9, Canada*

SUMMARY:

Major public policy forces are reshaping our health care delivery system, including the practice of psychiatrists. The results of the 1997 Canadian survey will be compared with a first survey in 1980. Changes in variables such as hours of practice, the proportion of patient care versus other activities, as well as the implications of change in psychiatrist demographics and health care delivery will be highlighted.

Comparing U.S. and Canadian practice data over time has implications for the design of a host of strategies. The data should inform negotiations with third-party payers regarding human resources and remuneration, the identification of "core" versus "optional" services within our universal Medicare system, the competence claims of other medical and non-medical service providers, as well as address the beguiling problem of human resource maldistribution. The analysis of current practice patterns also serves as a blueprint for training the psychiatrists of the future. Recommendations will be presented to ensure that our claims of expertise and leadership match our testimony.

While studies of what we do is increasing in sophistication, what we do in comparison with other providers remains nebulous. Our patients and families will also increasingly request data about the relative outcome of our interventions. These studies can be performed by multidisciplinary practice research networks.

No. 75F
THE AMERICAN PSYCHIATRIC ASSOCIATION'S PRACTICE RESEARCH NETWORK STUDY OF PATIENTS AND TREATMENTS: POLICY IMPLICATIONS

John S. McIntyre, M.D., *Department of Psychiatry, St. Mary's Mental Health Cter, 919 Westfall Road, Suite 210, Rochester NY 14618-2670;* Harold Alan Pincus, M.D., Deborah A. Zarin, M.D., Joyce C. West, M.P.P., Terri L. Tanielian, M.A., Ana P. Suarez, M.P.H., Julie L. Johnson, M.A.

SUMMARY:

The APA PRN was developed to complement traditional research methods as an additional mechanism to provide data that help address gaps in the current knowledge base and to guide clinical and policy decision making. Data from the PRN Study of Psychiatric Patients and Treatments can be used together with the psychiatrist level data from the APA's National Survey of Psychiatric Practice to provide a baseline for tracking trends in psychiatric practice. These data include psychiatrists' professional activities, work settings, and clinical caseloads, as well as detailed patient-level demographic, diagnostic, and treatment information. Using both of these data sets, the

PRN can assess the relationship of various psychiatrist, patient, and financing/service delivery factors to clinical treatment patterns. Data assessing the impact of these factors on the provision and quality of psychiatric care will be presented. Implications for clinical and policy decision making will be discussed.

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SYMPOSIUM 76—PSYCHIATRIC ASPECTS OF EPILEPSY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the most common psychiatric complications of epileptic patients, especially psychogenic nonepileptic events and epileptic psychoses, and the collaborations between psychiatry and neurology in the treatment of these patients.

No. 76A
DIAGNOSIS AND OUTCOME OF PSYCHOGENIC NONEPILEPTIC EVENTS

Andres Kanner, M.D., *Department of Neurology, Rush Epilepsy Center, 1653 West Congress Parkway, Chicago IL 60612*

SUMMARY:

Psychogenic nonepileptic events (PNEE) are recurrent paroxysmal episodes that mimic epileptic seizures (ES). An estimated 10% to 40% of patients treated for epilepsy have, in fact PNEE. Little is known about the outcome and treatment of PNEE. However, good outcome data have to rely on an accurate diagnosis. Since the advent of video-EEG telemetry, certain ES of mesial-frontal, orbitofrontal, and mesial-parietal origin have been found to mimic PNEE and yield a false positive diagnosis. In the initial part of this presentation, we will review the clinical criteria that can help distinguish those ES that mimic PNEE from the actual PNEE; we will also review the workup with V-EEG telemetry, neuroimaging, and laboratory studies that can help us reach the proper diagnosis. Once a diagnosis of PNEE is disclosed to patients, PNEE stop occurring in 30% to 50% of patients, even without any interventions. In a recently completed prospective study that looked at psychiatric and neurologic predictors of PNEE outcome, a history of abuse, personality disorder, and chronic major depressive disorder were highly predictive of persistence of PNEE following diagnosis. We will discuss the significance of these findings and their implication for treatment protocols.

No. 76B
BRAIN SPECT IN PAROXYSMAL PSYCHIATRIC EPISODES

Thomas H. Jobe, M.D., *Department of Psychiatry, University of Illinois, 912 South Wood Street, Chicago IL 60612;* Ovidio A. De Leon, M.D., Jerry Sychra, Ph.D., Michael Blend, D.O., Daniel Pavel, Quin Lin, Ph.D., Moises Gaviria, M.D.

SUMMARY:

The use of brain SPECT to help distinguish pseudoseizures (psychogenic nonepileptic events, PNEE) from dissociative states and altered personality states is in its inception. Despite the research that has linked all three states to a history of severe repeated childhood abuse, they may each represent a different brain physiological response this trauma.

The use of subtraction images in brain SPECT in which a voxel by voxel statistical analysis between a baseline resting state and an activated brain state can be developed into a color-coded brain surface map allows the complex topography of blood flow changes in these states to be characterized. Intersubject comparisons can also be developed using the technique of statistical parametric mapping (5PM).

Preliminary data reveal a characteristic pattern for each of the brain states under consideration. Dissociative states tend to show almost exclusively decreases in rCBF of 10% to 25% in frontal and temporal regions. Pseudoseizures (PNEE's) show a mixed pattern of increases and decreases in rCBF, often with high increases at 25% and above in frontal areas. Finally, altered personality states reveal a complex pattern of increases and decreases in rCBF but between 10% and 20%.

No. 76C
TREATMENT OF PSYCHOGENIC NONEPILEPTIC EVENTS

Prema V. Sanne, M.D., *Department of Psychiatry, University of Illinois, 912 South Wood Street, Chicago IL 60612*

SUMMARY:

Despite high prevalence of psychogenic, nonepileptic events (PNEE) and significant accompanying functional impairment, research in the area of clinically relevant treatment modalities has been limited. A comprehensive neurologic and psychiatric diagnosis followed by individually tailored treatment is crucial to prevent unnecessary exposure to long-term use of anticonvulsant medications. We will initially review the traditional psychological treatments like cognitive-behavioral therapy, psychodynamic psychotherapy, and hypnosis currently being used in this population. Drug therapies, which to date have been limited to the symptomatic treatment of associated psychiatric conditions like depression, will also be reviewed. The results of a recently conducted study by our group of the successful treatment of PNEE patients with histamine-H2 blocking agents will be presented. We will discuss the implications of the results in the pathophysiology of PNEE and for further research in the medication management of PNEE.

No. 76D
LAMOTRIGINE IN THE TREATMENT OF EPILEPTIC PSYCHOSIS

Ovidio A. De Leon, M.D., *900 N Lake Shore Drive #1903, Chicago IL 60611;* Kevin Furmaga, Pharm.D.

SUMMARY:

Background: Patients with epilepsy sometimes present psychosis that occurs in the setting of increased seizure frequency. These patients may require treatment with a neuroleptic. To date, all known neuroleptics can lower the seizure threshold. Also, patients on AED's that increase hepatic metabolism will have lower serum levels of neuroleptics and may require higher doses to achieve clinical effect.

Methods and Results (case studies): Mr. A is a 44-year-old patient who had onset of seizures at age 9. He presented GTCS and PCS that were difficult to control. At age 39 he developed persecutory delusions, aggression, and hallucinations. He had several psychiatric admissions and was treated with haloperidol decanoate. Seizures were treated with phenytoin and carbamazepine with poor response. At age 45 he was hospitalized due to extreme aggression; risperidone was titrated up to 4 mg daily without response. Lamotrigine was added and titrated up to 450 mg daily with good response of both seizures and psychosis. Risperidone was tapered and discontinued. During two years of followup he has relapsed twice due to discontinuation of lamotrigine. Clinical improvement resulted after reinitiating the drug.

Ms. B is a 39-year-old patient with onset of seizures at age 38. She had GTCS and CPS that did not respond to treatment with phenytoin, carbamazepine, valproic acid, and gabapentin. She presented gradual deterioration of her cognitive functions and psychosis. She felt persecuted, indicated that her thoughts were broadcast on television, was hallucinating, and violent. She failed haloperidol and risperidone treatment. CSF studies and brain MRI were noncontributory. Ultrastructural examination of brain biopsy revealed few typical lipofuscin granules but no fingerprint profiles. Lamotrigine was added to phenytoin and risperidone and titrated to 400 mg daily with gradual decrease in seizure activity and abatement of her psychosis. Risperidone was later tapered and discontinued. During two years of followup she presented two relapses of seizures and psychosis after discontinuation of her medication with subsequent improvement after reinitiating lamotrigine.

Conclusions: No firm conclusions can be drawn from anecdotal case studies. These two cases, however, strongly suggest that lamotrigine can be of benefit in the treatment of psychosis arising in the course of epilepsy. Controlled studies are needed to confirm these findings.

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SYMPOSIUM 77—NEW ANTICONVULSANTS IN MOOD DISORDERS: AN UPDATE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be familiar with the emerging evidence that the anticonvulsants lamotrigine and gabapentin hold promise as adjunctive or alternative therapies.

No. 77A
PHARMACOLOGY AND PHARMACOKINETICS OF NEW ANTICONVULSANTS

Terence A. Ketter, M.D., *Psychiatry and Behav Sci, Stanford University Sch of Med, 401 Quarry Road, Room 2124, Stanford CA 94305-5723;* Mark A. Frye, M.D., Timothy A. Kimbrell, M.D., Robert M. Post, M.D.

SUMMARY:

Five new anticonvulsants—felbamate, gabapentin, lamotrigine, fosphenytoin, and topiramate—have recently been marketed, and four more—tiagabine, oxcarbazepine, vigabatrin, and zonisamide—are in advanced stages of development. These agents have varying mechanisms, metabolism, drug interactions, and adverse effects. Two important complementary mechanisms are enhancing GABAergic inhibition and suppressing glutamatergic excitation. Felbamate has antiglutamatergic, GABAergic, and sodium channel blocking properties, and is metabolized to inactive and glucuronide metabolites. Felbamate is restricted to refractory epilepsy due to aplastic anemia and fatal hepatitis. Gabapentin is a substrate and inhibitor of the large neutral amino acid carrier system, blocks sodium channels, and is excreted unchanged in the urine. Gabapentin may cause sedation, dizziness, and ataxia. Lamotrigine decreases glutamate release, blocks sodium channels and 5HT3 receptors, and is metabolized to inactive glucuronides. Lamotrigine may cause rash, headache, and sedation. Topiramate has antiglutamatergic, GABAergic, sodium channel blocking, and carbonic anhydrase inhibiting properties, and is mainly excreted unchanged in the urine. Topiramate can cause sedation, fatigue, psychomotor slowing, and renal calculi. Except for gabapentin, all of these agents have hepatically mediated drug interactions, and knowledge of their pharmacokinetics is required for optimal therapeutics, should they be combined with psychotropics in epilepsy or treatment-resistant affective illness, or with other (nonpsychotropic) drugs in patients with medical comorbidity.

No. 77B
LAMOTRIGINE IN BIPOLAR DISORDER

Joseph R. Calabrese, M.D., *Department of Psychiatry, Case Western Reserve Univ., 11400 Euclid Avenue, Ste 200, Cleveland OH 44106-3986*

SUMMARY:

New mood stabilizers are needed that possess equal efficacy for all phases of bipolar disorder. Lamotrigine, an anticonvulsant approved by the FDA in 1994, has now been studied in a total of 99 patients with treatment-refractory bipolar disorder. In the largest study, the spectrum of efficacy of lamotrigine (either as add-on or monotherapy) was examined in a 48-week, open-label, prospective trial of 75 patients. Of the 41 patients presenting depressed, 68% showed moderate to marked responses. Of the 31 presenting hypomanic, manic, or mixed, 84% exhibited moderate to marked responses. The drug was generally well tolerated and serious adverse events were uncommon. Rash was the most common reason for drug discontinuation. In a study by Walden, et al (1996), lamotrigine was added to valproate and considerable improvement of the patient's condition was noted after several days and lasted over one year. Mandoki (1997) retrospectively reviewed the records of 10 juveniles treated with lamotrigine in combination with valproate and showed improvement. Sporn and Sachs (1997) evaluated lamotrigine in 16 patients and showed a 50% response rate after five weeks of follow-up. These data suggest that lamotrigine possesses a broad spectrum of activity in the management of the depressed, hypomanic, manic, and mixed phases of bipolar disorder and is well tolerated. A broad-based, industry-sponsored drug development effort is currently evaluating the spectrum of activity of lamotrigine in bipolar disorder

through a series of double-blind, placebo-controlled acute and maintenance studies.

No. 77C
AN OPEN TRIAL OF GABAPENTIN IN BIPOLAR DISORDER

L. Trevor Young, M.D., *Mood Disorders, Hamilton Psychiatric Hospital, P.O. Box 585, Hamilton ON L8N 3K7, Canada*

SUMMARY:

Novel anticonvulsants may have a role in the treatment of bipolar disorder. Gabapentin, a GABA analogue, has been suggested to have mood stabilizing and possibly antidepressant properties. In an open-label fashion, gabapentin was given as adjunctive therapy to refractory patients who were treated with standard mood stabilizers at therapeutic blood levels. Patients were enrolled if they met DSM-IV criteria for bipolar disorder type I or II, were currently depressed (HamD > 16), or had a rapid cycling course. Participants received gabapentin as an oral dose twice or three times daily for six weeks with the target dose between 1,000 and 2,000 mg. To date 45 patients have received this medication. In our first analysis of 15 depressed patients, there was a significant reduction (T = 3.00, df14, p = 0.01) comparing the six-week and baseline HamD scores. Eight of the 15 subjects (53%) responded (3 marked, i.e. > 50% reduction in HamD and 5 partial, i.e. 25 to 50% reduction in HamD). Recent findings from the expanded depressed group and the rapid cycling group will be presented. These data are preliminary findings indicating the need for future controlled trials of this novel agent.

No. 77D
GABAPENTIN AND LAMOTRIGINE MONOTHERAPY IN MOOD DISORDER: AN UPDATE

Mark A. Frye, M.D., *Bldg 10, Room 3N-212, National Institute of Mtl Hlth, 10 Center Drive/MSC 1272, Bethesda MD 20892;* Terence A. Ketter, M.D., Elizabeth A. Osuch, M.D., Timothy A. Kimbrell, M.D., Andrew M. Speer, M.D., Robert M. Dunn, M.D., Robert M. Post, M.D.

SUMMARY:

In this paper, we discuss the emerging evidence that lamotrigine and gabapentin hold promise as adjunctive or alternative therapies for patients with mood disorder.

After a double-blind, two-week washout period, patients with refractory mood disorders received, in a randomized, double-blind trial, either gabapentin (GBN) monotherapy, lamotrigine (LTG) monotherapy, or placebo for six weeks with two subsequent crossovers so that each individual would receive all three agents.

The primary outcome measure was the Clinical Global Impression-Bipolar version (CGI-BP). The response data (based on a CGI rating of moderate or marked improvement) for LTG was 50% (9/18) and for GBN was 39% (7/18). The 50% LTG responders, by the CGI-BP, were significantly different from nonresponders by week 3. The 33% GBN responders by the CGI-BP, in comparison to nonresponders, noted a significant response by week 1 (p = 0.002) with an apparent loss in antidepressant effect by week 5. It is unclear if this finding is an acute response with subsequent tolerance, "overshooting" a therapeutic window, or a higher dose to achieve an anticycling response vs. antidepressant response. Overall CGI response by diagnostic subtype (bipolar I, bipolar II, and unipolar) for lamotrigine was 100% (4/4), 44% (4/9), and 20% (1/5), respectively; for gabapentin 60% (3/5), 50% (4/8), and 0% (0/5). Overall CGI response by rapid cycling vs. non-cycling status for lamotrigine was 64% (7/11) and 50% (1/2); for gabapentin 60% (6/10) and 33% (1/3).

The preliminary data of this ongoing study suggest that lamotrigine and gabapentin may ultimately become important additions to the mood disorder pharmacopoeia.

No. 77E
NEUROIMAGING OF RESPONSE TO LAMOTRIGINE AND GABAPENTIN

Timothy A. Kimbrell, M.D., *BPB/Bldg 10, Rm 3N-212, Nat'l Inst of Mental Health, 10 Center Drive/MSC 1272, Bethesda MD 20892;* Terence A. Ketter, M.D., Mark A. Frye, M.D., Robert M. Dunn, M.D., Andrew M. Speer, M.D., Elizabeth A. Osuch, M.D., Robert M. Post, M.D.

SUMMARY:

Our group has previously reported fluorine-18 deoxyglucose (FDG) scan data demonstrating differential regional cerebral metabolic glucose utilization (rCMRglu) patterns in a heterogenous mood disorder patient population who responded to carbamazepine and the calcium channel blocker nimodipine. We have prospectively collected baseline placebo FDG scans prior to entry into a randomized, double-blinded, controlled study of the anticonvulsants lamotrigine and gabapentin in a refractory mood disorder population. Additionally, we have obtained five oxygen-15 water scans at the end of each medication/placebo trial.

This combined approach allows for comparison of patient placebo data rCMRglu and cerebral blood flow (CBF) with a matched control group, and the assessment of significant CBF changes and their relationships to drug effects and clinical response within individual patients throughout the study period. Making use of individual scan data will be of benefit in better defining subgroups in a heterogenous patient population and better defining response to these two promising agents.

Preliminary analysis of these data obtained by performing a voxel-by-voxel t-test demonstrated that responders to lamotrigine or gabapentin compared with controls have decreased rCMRglu (p < .005) in bilateral superior temporal regions, right insula, and left dorsolateral prefrontal cortex, and increases in bilateral medial temporal regions, right caudate, bilateral thalamus, and occipital regions. Analysis of rCBF over the course of the study has shown normalization of global and anterior paralimbic rCBF in responders.

This approach to neuroimaging should provide further insights into illness subtypes and therapeutic response markers.

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SYMPOSIUM 78—COLLABORATIVE STUDY OF PERSONALITY DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will have learned about the beginning of a five-site collaborative longitudinal study of DSM-IV personality disorders.

No. 78A
AN OVERVIEW OF THE STUDY AND THE SAMPLE

John G. Gunderson, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont MA 02178-1048;* Thomas H. McGlashan, M.D., Leslie C. Morey, Ph.D., M. Tracie Shea, Ph.D., Andrew E. Skodol II, M.D.

SUMMARY:

This presentation summarizes the aims, significance, and design of the Collaborative Longitudinal Study of Personality Disorders (CLPS). This NIMH-funded study involving sites at Brown, Columbia, Harvard, Vanderbilt, and Yale has collected extensive baseline data on four distinctive and representative PD's (avoidant, borderline, obsessive-compulsive, and schizotypal) as well as a comparison sample of major depressives without PD.

This presentation will also describe the demographics (age, gender, race, socioeconomic status) of the study's sample and the issues encountered in selection and recruitment.

No. 78B
DIAGNOSTIC INTERVIEW FOR DSM-IV PERSONALITY DISORDERS: TEST-RETEST AND INTERRATER RELIABILITY

Mary C. Zanarini, Ed.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont MA 02178;* Donna Bender, Ph.D., Regina Dolan, Ph.D., Elizabeth Schaefer, Ed.M., Charles Stanislow, Ph.D.

SUMMARY:

Our main diagnostic instrument for the Collaborative Longitudinal Study of Personality Disorders (CLPS) is the Diagnostic Interview for DSM-IV Personality Disorders (DIPD-IV). Both the interrater and test-retest reliability of the DSM-III and DSM-III-R version of this semistructured interview have been tested extensively. For the present study, we are gathering data on 120 test-retest interviews (30 per each data collection site). We are also in the process of taping 60 interrater reliability interviews that will be viewed by each of the other seven raters in the study. These latter interviews will allow us to assess both intra- and across-site reliability. Data will be presented on each of the three types of reliability being assessed (test-retest, intra-, and across-site interrater reliability). The methodological difficulties that occur in achieving high reliability levels in this type of multisite study will be discussed. Strategies for attaining and maintaining the desired levels of reliability will be presented.

No. 78C
FUNCTIONAL IMPAIRMENT IN FOUR PERSONALITY DISORDER TYPES

Andrew E. Skodol II, M.D., *Department of Psychiatry, NYS Psychiatric Institute, 722 West 168th Street, New York NY 10032;* M. Tracie Shea, Ph.D., Robert T. Stout, Ph.D., Thomas H. McGlashan, M.D., Martin B. Keller, M.D., John M. Oldham, M.D., Regina Dolan, Ph.D.

SUMMARY:

Impairment in interpersonal relationships or occupational functioning is integral to the concept of personality disorder (PD), yet PD's are often underappreciated sources of patient morbidity. The purpose of this study was to compare the extent and kinds of functional impairment found in four different PD's, using baseline data from the Collaborative Longitudinal Study of Personality Disorders. Three hundred subjects with rigorously diagnosed schizotypal, borderline, avoidant, and obsessive-compulsive PD's and depressed controls were interviewed with the Longitudinal Interval Follow-Up Evaluation-Baseline (LIFE-Base) and completed the Social Assessment Scale-Self Report (SAS-SR) to assess psychosocial functioning. The four PD types were found to differ significantly on educational level attained; status of occupation; current employment status; and impairment in work, life satisfaction, global social adjustment, and global functioning (GAFS) in the past month and, for the most part, over the past two years. In general, patients with OCPD, AVPD, or major depression and no PD functioned at higher levels and with less impairment than patients with BPD or STPD. Although only 23% of the subjects were currently married or living with someone (57% single, 19% separated or divorced), and social functioning was only fair over the entire sample, differences in social impairment between PD's was not evident.

These preliminary results indicate significant recent and past functional impairment, especially among patients with schizotypal and borderline personality disorders.

No. 78D
AXIS II COMORBIDITY OF DSM-IV PERSONALITY DISORDERS

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

SUMMARY:

Objective: This study aimed to examine the comorbidity of the DSM-IV personality disorders (PD's). The nature and degree of diagnostic co-occurrence represent descriptive measures of the homogeneity and boundaries of the PD diagnoses.

Method: Subjects were 300 adult patients (aged 18 to 45) participating in the Collaborative Longitudinal Study of Personality Disorders. The presence of all 11 DSM-IV-defined PD's was assessed with the semistructured Diagnostic Interview for Personality Disorders-Version IV (DIPD-IV). Assessments were performed reliably by a trained and monitored research evaluation team. This study reports on co-occurring DIPD-IV Axis II diagnoses at baseline for the following four PD's: schizotypal, borderline, obsessive-compulsive, and avoidant PD's.

Results: Diagnostic overlap was extensive and characteristic of each of the PD's. Frequencies of co-occurrence of all PD's with these four PD's will be presented. Overall, the average co-occurrence rate was 31% for schizotypal, 17% for borderline, 12% for avoidant, and 8% for obsessive-compulsive personality disorders. Certain associations between co-occurring diagnoses will also be presented to detail patterns of relatedness between diagnostic constructs.

Conclusions: These preliminary results of Axis II co-occurrence are based on a recruitment procedure that samples treatment-seeking patient groups for personality disorders. With this in mind, we note that given the presence of a personality disorder, the presence of several personality disorders is common. Overall, although Axis II co-occurrence is broad, our preliminary analyses suggest that avoid-

ant and obsessive-compulsive PD's have relatively clear boundaries within the universe of Axis II phenomenology.

No. 78E
STABILITY OF PERSONALITY DISORDER: DIAGNOSES AND CRITERIA

M. Tracie Shea, Ph.D., *Department of Psychiatry, Brown University, 700 Butler Drive, Providence RI 02906;* Robert T. Stout, Ph.D., Regina Dolan, Ph.D., Andrew E. Skodol II, M.D., Leslie C. Morey, Ph.D., Mary C. Zanarini, Ed.D.

SUMMARY:

A major objective of the CLPS is to test the assumption that personality disorders (PD's) are stable. This presentation will report initial findings on stability of PD diagnoses and criteria, as evidenced during the first six months of followup for the four PD's under study (schizotypal, borderline, avoidant, and obsessive-compulsive). We anticipate that six-month data will be available for approximately 250 of our PD subjects. Our follow-up assessment includes the Diagnostic Interview for Personality Disorders Follow-Along Version (DIPD-FAV). The interview covers the follow-up interval; ratings of individual PD criteria are made on a monthly basis. We will present findings regarding (1) diagnostic stability of the four PD's, and (2) stability of the individual PD criteria. Analyses of diagnostic stability will include examination of the proportion of those with intake diagnoses that continue to meet full criteria throughout the six months of followup, and the proportion in each PD group that evidence a "remission", i.e., at least two consecutive months with minimal or no evidence of criteria for that PD. Analyses of stability at the level of individual criteria will include examination of the frequency with which individual criteria rated as positive at intake "remit", i.e., are rated as absent for most or all of the follow-up interval. The monthly ratings of the PD criteria will also be used to examine the relative persistence of the individual criteria within each of the four PD's, i.e., whether some criteria are more stable in their manifestation than others.

No. 78F
DIMENSIONS AND CATEGORIES IN PERSONALITY DISORDER

Leslie C. Morey, Ph.D., *Department of Psychology, Vanderbilt University, 301 Wilson Hall, Nashville TN 37240;* John G. Gunderson, M.D., Michael J. Lyons, Ph.D.

SUMMARY:

The relative merits of dimensional and categorical models of personality disorder have been a subject of debate for some time. Although the promise of dimensional models is well documented, the potential existence of interactive relationships among dimensional elements is an example of an instance where a categorical approach may have a clear advantage. This study examines the potential increment arising from the use of interactive models derived from theory, above and beyond that obtained using a simple linear combination of personality dimensions in describing the DSM-IV personality disorders.

Subjects were 300 adult patients (ages 18 to 65) who were assessed for the presence of categorical diagnoses with the semistructured Diagnostic Interview Schedule for Personality Disorders (DIPD). The five-factor dimensional model of personality disorder was assessed using the Schedule for Nonadaptive and Adaptive Personality (SNAP). The incremental contribution of interactive elements as related to categorical diagnoses was examined in a series of hierarchical regression analyses that explored the increment of these elements beyond additive linear models derived from the two-dimensional approaches. The presence of significant interactive incremental variance represents a clear advantage of the categorical model, as category membership can provide a convenient summary of interactive relationships that are difficult to model and understand dimensionally. The results are described in regard to how the individual personality disorder may best be represented in future editions of the DSM.

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SYMPOSIUM 79—CURRENT TRENDS IN RUSSIAN PSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation the participant should be able to describe the new ideological basis for reforms in psychiatry in Russia.

No. 79A
DEVELOPMENT OF RUSSIAN PSYCHIATRY: CURRENT CONDITION AND TRENDS

Valery N. Krasnov, M.D., *Borderline Disorders, Moscos Inst. of Psychiatry, Poteshanaya Ul 3, Moscow 107076, Russia*

SUMMARY:

Starting from the late '80's considerable changes have occurred in psychiatry in Russia, especially after 1992 when the Law on Psychiatric Care was adopted. The law significantly expands patients' rights, restricts the forms of involuntary hospitalization, and envisions provision of treatment on the basis of informed consent. However, serious difficulties exist in psychiatric care: its extreme centralization, financial problems with reconstruction of some large psychiatric hospitals, domination of biologically oriented therapy, and underestimation of psychological and social aspects of psychiatric care. Russia has 14,000 psychiatrists (including 1,600 psychotherapists), only 1,000 medical psychologists, and a very few social workers in psychiatric facilities. The main directions of reforms in Russian psychiatry are as follows: (1) legal reform (protection of the rights of persons with mental disorders); (2) reconstruction of psychiatric facilities, development of different forms of psychiatric care, partial integration into general medical service, and enforcement of outpatient care; and (3) education and training of clinical psychologists and social workers for psychiatric service.

No. 79B
ECONOMIC RESEARCH PROGRAM IN RUSSIAN PSYCHIATRY

Vassiey Yastrebov, M.D., *Department of Psychiatry, Institute of Psychiatry, Zagozodnoje Shosse 2/2, Moscow 113152, Russia;* Lioubov S. Chevtchenko, Ph.D.

SUMMARY:

Traditionally, the mental health care system in Russia has been public and free of charge. The state model of psychiatric services did not encourage the use of economic methods of research. Changes in the socioeconomic situation in Russia and the transition to market relations entailed reforms in how much funding will be allocated to psychiatry now, and how much will be allocated in the future depending on demands of the service. What are the sources of the allocations? In our center economic research is carried out in the following directions: (1) assessment of cost of treatment of mental disorders; (2) the study of the burden of mental diseases for society, taking into consideration incidence, disability, and mortality rates based on DALY's approach; (3) estimation of economic losses, caused by disability and temporary disablement; (4) working out common procedures of the estimation of the costs of medical services; (5) working out the medical-economic standards of rendering psychiatric help.

The practical realization of the results of our study will give an opportunity to define the place of psychiatry in the system of priorities of public health development and to encourage personnel and psychiatric facilities to work effectively.

No. 79C
PSYCHIATRIC CARE IN RUSSIA: SITUATION AND PERSPECTIVES

Isaac Ya. Gurovich, Ph.D., *Org. Psych. Services, Moscow Res. Inst. Psych., Poteshnaya 3, Moscow 107076, Russia;* Yanina A. Storozhakova, Ph.D., Alexander B. Shmukler, Ph.D.

SUMMARY:

Objective: To study the current situation with psychiatric care in Russia and the ongoing changes (also long-term) connected with structural and legal reform and in conditions of economic crisis.

Method: Analysis of standard statistical forms for psychiatric facilities—regional and national data (1990-1996); unselective study of outpatients and inpatients in two facilities; and, analysis of the data of two questionnaires for chief psychiatrists of regional services.

Results: The number of newly registered mental patients, which had increased from 1990 to 1994 from 26.8 to 51.1 per 10,000 population (mainly due to nonpsychotic forms), returned in 1995 to 1996 to the level of 1991 (33.3 and 34.1). The hospitalization rate, highest in 1987, decreased and remains significantly lower, though it has recently showed an increase (40-44 per 10,000), which is not consistent with the deinstitutionalization concept. Low indices of involuntary examinations and hospitalizations (respectively, 3.2-5.2 and 15.3-18.5 per 100,000), which strongly vary throughout regions, testify to the inadequate application of legal regulations in the territories. Chronic patients showed a low social functioning level; the primary disability rate increased from 2.51 in 1990 to 3.88 in 1996 (per 100,000).

Conclusions: Economic crisis hampers psychiatric care reform in Russia (transition from medical to biopsychosocial model, legal regulation, diminished stigmatization, improved structure, and material basis) and has exposed mental patients' social vulnerability. Reform promotion requires these tendencies to be considered.

No. 79D
RUSSIAN PSYCHIATRY AND THE LAW: FACTS AND PROBLEMS

Svetlana Polubinskya, *Institut of Stand Law Ras., Znamenka 10, Moscow 119841, Russia*

SUMMARY:

Objective: To describe and analyze facts and problems of implementation of the Russian Federation Law on psychiatric care.

Methods: Historical, legal, and sociological. The Russian Federation Law "On Psychiatric Care and Guarantees of Citizens' Rights in Its Provision" was adopted on July 2, 1992, and inforced from January 1, 1993. The main purpose of the Law was to link psychiatry by legal rules and bring human rights into psychiatric practice in Russia. Five years of the Law's implementation demonstrated the legal "machinery" is not alien for the Russian psychiatry: formal mechanisms and guarantees for human rights in this medical field are working. The Law began to regulate the named medical profession. But it will be early to say that the Russian psychiatry is totally reformed and free from the heritage of the former Soviet psychiatry. There are some examples that the spirit of the Law does not come to every day psychiatric practice.

No. 79E
ALCOHOL AND SUBSTANCE ABUSE DISORDERS IN RUSSIA FOR THE LAST TWO DECADES (1976-1996)

Alexander V. Nemtsov, Ph.D., *Dept. of Information, Moscow Inst. of Psychiatry, Poteshmaya UL 3, Moscow 107076, Russia*

SUMMARY:

In 1976 the Soviet leadership organized a specialized state narcological service to treat alcoholics (in 1984 more than 2.7 million). The new leadership started the anti-alcoholic campaign in 1985. Between 1985 and 1987 real consumption decreased by 24.1%. Accordingly, there was a decrease in all alcohol-related variables. However, there was a sharp increase of illegal production of alcoholic beverages. All alcohol-related variables increased, but with a certain lag. In 1992 market reforms began as well as the withdrawal of the state monopoly on production and sales of alcoholic beverages. The new growth of consumption and the sharp increase of all alcohol-related variables resulted (lethal alcohol intoxications grew by 57-1% in 1992 to 75,6% in 1993). In 1994 almost all alcohol-related variables reached their peak and considerably exceeded the level of 1984. From 1995 to 1996 there was increased state anti-alcoholic activity in the area of alcoholic policy. In this period there was a decrease of lethal alcohol intoxications and other violent deaths as well as of alcohol psychoses. In the last decade there has been an increase in substance abuse disorders.

No. 79F
BIOLOGICAL TREATMENT OF MENTAL DISORDERS IN RUSSIA

Sergey N. Mosolov, M.D., *Therapy, Moscos Inst. of Psychiatry, Poteshanaya Ul 3, Moscow 107076, Russia*

SUMMARY:

Despite the certain limits in efficacy, side effects, and ethical doubts about its use, pharmacotherapy remains the most widespread method of treatment of mental disorders in Russia. Major psychotropic classes are routinely used, including atypical neuroleptics (clozapine, zotepine, olanzapine), last generation of antidepressants (SSRI's, moclobemide), contemporary anxiolitics (alprazolam, buspiron), normothymics (lithium salts, carbamazepine, sodium val-

proate, Ca-channel blockers), and new anticonvulsants (lamotrigine, gabapentine). Some drugs were originally developed in Russia: disinhibitory neuroleptic—carbidine; tetracyclic reversible MAO inhibitor—pirlindol; potent anxiolytic—phenazepam; nootropics with some tranquilizing activity—pantogam, picamilon, phenybut, mexidol. The majority of contemporary psychotropic drugs have passed comparative clinical trials and the test of everyday clinical practice, but in many cases exact indications and clinical and biological predictors of their efficacy remain unclear. There is an increasing number of therapy-resistant patients where a change of drug or augmentation therapy is needed. Some other nonpharmacogenic methods can be useful in these cases (ECT, laser therapy, normobaric or hypobaric hypoxitherapy, plasmapheresis, phototherapy, sleep deprivation, fasting therapy, acupuncture etc.).

No. 79G
CRITERIA OF DEPRESSION IN GENERAL SOMATIC PRACTICE

Olga P. Vertogradova, Ph.D., *Affective Diseases, Moscow Inst. of Psychiatry, Poteshnaya UL 3, Moscow 107076, Russia;* Igor L. Stepanov, M.D.

SUMMARY:

Objective: Isolation of criteria of early diagnosis of depression in general somatic practice. The necessity for possibly early isolation of affective disorder is defined by considerable incidence and high level of comorbidity with morbidity of both mental and somatic level.

Methods: Psychopathological and clinical statistical analysis.

Results: Non-selection observation in the conditions of the primary care department (200 patients). A continuum was revealed of depression ranging from single transistor symptoms (32%) to complete syndromes (68%). Computer-basic analysis of depression structure isolated hypothymia, anhedonia, feeling of worthlessness, as well as existence of anxiety components, somatovegetal disorder on the background of emotional lability as the most significant symptoms. Cluster analysis revealed two types of depressive states: a deeper sadness—apathetic with anhedonia, retardation, asthenia, prevailing sympathicotonia; and a less deep anxious, with agitation, somatovegetal and senesto-algic disorder in the presence of mixed sympathic and parasympathic disorder. The second type is more characteristic of initial stages and masked (anxious) variants. Long-term (over five year) depressive states prevailed.

Conclusions: The reduction of social and mental adaptation level has a reliable relation with the degree of manifestation of anhedonia, motor retardation, and the feelings of worthlessness.

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SYMPOSIUM 80—MEDICATIONS DEVELOPMENT FOR SUBSTANCE DEPENDENCE
Collaborative Session With the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The objective of this symposium is to teach psychiatrists about new medications to treat dependence on opioids and stimulants.

No. 80A
TARGETED SUBGROUPS FOR COCAINE PHARMACOTHERAPIES

Thomas R. Kosten, M.D., *Dept. of Psychiatry-116A, Yale University VA, 950 Cammpbell Avenue, Rm. 953M, West Haven CT 06516*

SUMMARY:

Cocaine abusers are relatively heterogeneous and may need specific targeted pharmacotherapies based on predominant cocaine-induced psychopathology or premorbid psychiatric disorders. One premorbid disorder that may identify patients who will specifically respond to stimulant substitution therapy with agents such as methylphenidate is attention deficit hyperactivity disorder in childhood. While this medication has not been effective when applied broadly to cocaine abusers, a substantial subgroup of up to 30% of cocaine abusers may have had this disorder and be responders. A second subgroup may develop mild cognitive impairment from cocaine abuse related to the cerebrovascular toxicity of cocaine through both platelet abnormalities and vasoconstriction. Cognitive enhancers and anti-stroke agents may be useful in these patients. A third subgroup with depression may have both premorbid psychopathology and cocaine toxicity to dopaminergic systems contributing to their dysfunction. Human neuroimaging studies have shown reductions in dopamine receptors and elevations in dopamine transporters as a substrate for a relative dopamine deficiency that could precipitate depression in vulnerable patients and form a basis for response to antidepressant therapy with reduction in cocaine abuse as well as in depressive symptoms. Clinical trials addressing these subgroups will be reviewed.

No. 80B
TARGETS FOR MEDICATION TO PREVENT RELAPSE

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

SUMMARY:

There are distinct phases of addiction treatment that can be identified: detoxification, maintenance (agonist or antagonist), and relapse prevention. Research has focused on medications that facilitate detoxification (e.g., clonidine) and medications that block or diminish the effects of the addicting drug (naltrexone). Medications to be used in a drug-free former addict to prevent relapse are difficult to conceptualize.

Relapse is a complex phenomenon that in any single patient has multiple causes. CNS plasticity is likely to play a role. The abstinent former addict has residual effects (memories, reflexes) produced by thousands of administrations of the drug during the active phase of the addiction. Environmental cues that have been repeatedly associated with drug effects or drug withdrawal have been reliably shown in former human addicts to elicit involuntary physiological reactions and desire to resume drug use. Behavioral treatments can reduce but not extinguish these responses. Medication combined with behavioral treatment is a potentially effective option. Recent data from animal models show that certain medications can block or diminish the power of conditioned cues to reinstate cocaine self-administration in formerly dependent subjects. The early results from clinical trials with these medications will be presented.

No. 80C
LEVOMETHADYL ACETATE HYDROCHLORIDE AND BUPRENORPHINE TREATMENT

Eric C. Strain, M.D., *Department of Psychiatry, Johns Hopkins University, BPRU, 5510 Nathan Shock Drive, Baltimore MD 21224-1253*

SUMMARY:

The primary pharmacotherapy used for the treatment of opioid dependence has been methadone. Methadone treatment has been available for over 25 years, and over 100,000 patients in the United States currently receive daily methadone. However, liabilities to methadone treatment such as the need for daily dosing and the requirement that methadone be delivered through a highly regulated treatment system have prompted, in part, the development of new medications for the treatment of opioid dependence. LAAM, a mu-agonist opioid similar to methadone, is currently approved for use in the United States. LAAM's primary distinction is a long duration of effects, so that dosing can occur on a less-than-daily basis. Buprenorphine, an opioid mixed agonist-antagonist, is currently under development for the treatment of opioid dependence in the United States. It is anticipated that buprenorphine will be formulated in combination with naloxone, to decrease the potential of diversion and thus allow use of buprenorphine/naloxone in other treatment settings besides the methadone clinic. The availability of these medications will provide greater clinical flexibility in the treatment of opioid dependence. This presentation will review the pharmacology of these medications, their efficacy and safety, and their clinical use.

No. 80D
COCAINE PHARMACOTHERAPY: HUMAN LABORATORY STUDIES

Marian W. Fischman, Ph.D., *Department of Psychiatry, Columbia Univ. Med. School, 722 W. 168th Street, Unit 54, New York NY 10032*

SUMMARY:

The search for pharmacological agents useful in treating cocaine abusers has attracted substantial attention from the research community. Despite the explosion in basic neurophysiological research, progress toward the development of an effective pharmacologic treatment for cocaine abuse has been inconsistent. A variety of medications have been tested, based on their relationship to cocaine's actions, its post-withdrawal effects, or data from laboratory studies with non-humans. So far, of the more than 40 medications tested, the success rate in replicated, double-blind, placebo-controlled trials is minimal. Since controlled clinical trials can be both time consuming and costly, innovative testing approaches are currently being implemented to evaluate promising new pharmacotherapies as they become available. Early testing of potential pharmacotherapies with human participants, using a laboratory model of cocaine abuse, can be helpful in screening new pharmacotherapies, and data have been collected that are consistent with the clinical trials data. The human laboratory model, developed to mimic cocaine use outside the laboratory, will be presented and the data evaluating safety and preliminary efficacy of a number of medications will be described.

No. 80E
PHARMACOTHERAPY FOR OPIATE AND STIMULANT DEPENDENCE

Frank J. Vocci, Ph.D., *MDD, NIDA, 5600 Fishers Lane, Rockville MD 20857*

SUMMARY:

Addiction to opiates and stimulants is a persistent public health problem in the U.S. The majority of individuals with opiate or stimulant dependence are currently not receiving treatment for their disorder. It is estimated that only 1/4 to 1/5 of the heroin addict population is receiving treatment at any given time. The untreated population is at high risk for serious morbidity and death, particularly injection drug users. Almost 50% of new cases of HIV infection occur in the injection drug user population. Agonist pharmacotherapy for opiate dependence is an effective treatment for the primary addiction as well as an effective public health measure. Similarly, of the more than 2 million cocaine dependent individuals, slightly more than 1/10 are receiving treatment at any time. Although there are multiple factors responsible for undertreatment in these populations, the effectiveness and efficiency of the treatment system could be improved by the development of new medications. Approaches to the development of cocaine dependence therapies derived from preclinical studies will be reviewed.

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SYMPOSIUM 81—HORMONES AND DEPRESSION: TREATMENT IMPLICATIONS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

After completing this symposium the participant will have a better understanding of the complex psychobiology of the thyroid, adrenocortical, and gonadal hormone axes, particularly as they relate to depressive illnesses; and will be aware of current data regarding the use of exogenous hormones in the antidepressant regimens of selected patients.

No. 81A
TESTOSTERONE AND MALE DEPRESSION: A CLINICAL REVIEW

Stuart N. Seidman, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York NY 10032*

SUMMARY:

Background: The relationship of the hypothalamic-pituitary-gonadal (HPG) axis to male depressive illness is poorly understood, as is the role of exogenous testosterone (T) in antidepressant treatment.

Objective: The purpose of this review is to describe and organize the data on these relationships, and to present preliminary data from a randomized trial of T replacement for male depression.

Method: We reviewed data from all published, English-language studies that have assessed: T secretion in depressed men, the psychiatric effects of T replacement, and the efficacy of androgen treatment for depression. In a randomized, double-blind trial we enrolled depressed men with low-normal T level and administered T 200mg or placebo weekly for six weeks.

Results: In some, though not all, studies, a subgroup of depressed men (particularly older men) have reduced T levels and blunted T secretion while depressed, which may normalize when they recover. Exogenous androgen treatment consistently elevates mood, libido, appetite, and energy in hypogonadal men. T administration appears to be an effective antidepressant for certain subgroups of depressed men (e.g., HIV positive, SSRI refractory, hypogonadal). In a six-week, randomized trial with 10 hypogonadal, depressed men, 2/5 remitted on T and 1/5 remitted on placebo.

Conclusion: There are indications that in some depressed men there is HPG axis disturbance, and that exogenous T may be an effective antidepressant treatment.

No. 81B
EXOGENOUS DHEA AND ANTIGLUCOCORTICOIDS IN DEPRESSION

Victor I. Reus, M.D., *Langley Porter NPI, Univ of California, 401 Parnassus Avenue, San Francisco CA 94143-0984;* Owen M. Wolkowitz, M.D.

SUMMARY:

Background: Although hypercortisolism is the most investigated biologic abnormality in depression, the question remains as to whether disturbances in pituitary-adrenal regulation represent a non-specific marker of stress or a centralized neurotransmitter disturbance, or, conversely, whether they play an integral role in shaping the character of the symptom complex itself.

Objective: The purpose of this presentation is to briefly review HPA pathophysiology in depression, and to present data on the psychotropic actions of glucocorticoids and DHEA, with a focus on treatment applications.

Method: In a series of controlled studies, we administered various glucocorticoid compounds and DHEA to normal individuals and to depressed patients.

Results: Administration of glucocorticoids in normals was found to change various plasma and CSF markers of monoamine function. Behavioral effects were variable, though there was a consistent increase in commission errors on verbal memory tasks. In addition, there was a direct correlation between subjective changes in mood and drug-induced reductions in peak alpha and increases in theta wave activity on quantitative EEG and neurochemical profile. In depressed individuals, the administration of ketoconazole, a drug that has prominent cortisol biosynthesis, inhibition, and glucocorticoid receptor antagonist properties, was associated with a reduction in HAM-D and a parallel decrease in errors of commission in recognition memory. Double-blind, controlled trials of the effects of this agent and of DHEA are currently under way and will be presented.

Conclusion: Elevations in circulating glucocorticoid levels may contribute to specific depressive signs and symptoms. Exogenous antiglucocorticoid and DHEA may be effective antidepressant treatments.

No. 81C
ESTROGEN AND DEPRESSIVE DISORDERS IN WOMEN

Mary F. Morrison, M.D., *Department of Psychiatry, University of Pennsylvania, 3400 Spruce Street/1 Maloney, Philadelphia PA 19104*

SUMMARY:

Objective: The purpose of this review is to describe the clinical data on the relationship between gonadal steroids, such as estrogen and progesterone, and depressive disorders in women, such as premenstrual dysphoric disorder (PMDD), and peri-menopausal and post-menopausal depressive disorders.

Method: We will review data from studies that assessed the relationship between reduced estrogen level and depressive symptoms and clinical trials of estrogen treatment for depressive symptoms. We will also present preliminary data from a trial of estrogen in post-menopausal women.

Results: Much of the data on natural and surgical menopause, as well as clinical observations of women on anti-estrogen therapy for breast cancer, suggest that estrogen deficiency may contribute to depressive symptoms and lack of response to antidepressants. In PMDD, preliminary evidence suggests symptomatic improvement with an estradiol patch. In peri-menopausal women with depression, results of a prospective trial of estrogen replacement suggests significant improvement in symptoms of tearfulness, mood instability, and depression. There is also evidence that estrogen replacement can prevent depressive symptoms and improve quality of life in post-menopausal women, but the effect has been inconsistent. Some preliminary evidence suggests that estrogen's antidepressant effect may be mediated by cortisol, monoamine oxidase, and serotonin; and that the SSRI-estrogen combination may be particularly effective for some patients.

Conclusion: The available evidence suggests that estrogen replacement therapy may lead to an improvement in depressive symptoms in some women.

No. 81D
THYROID HORMONES AND MOOD DISORDERS

Gregory M. Sullivan, M.D., *60 W 85th Street #4B, New York NY 10024-4579;* Julie A. Hatterer, M.D., Jack M. Gorman, M.D.

SUMMARY:

Wide variations in free thyroid levels often result in mood and neurovegetative symptoms clinically indistinguishable from those in affective disorders. Also, thyroid supplementation of antidepressants can improve response rate, convert refractory patients to responders, and has a beneficial effect on rapid cycling bipolar patients. A restricted "central" hypothyroidism may exist in affective illness with dysfunction in CNS thyroid function despite normal peripheral indices.

This presentation will review the current data and conceptualizations of thyroid function, testing, and supplementation in affective illness. Results from our study of the CNS thyroid transport protein transthyretin (TTR) in depression will also be presented. Lumbar puncture CSF TTR levels of 19 hospitalized subjects with major depression and one with bipolar illness, depressed (all medication free for two weeks and without history of thyroid disease) were compared with 24 healthy controls.

Distribution of CSF TTR protein concentrations was normalized by natural log transformation. ANCOVA of main effects for diagnosis and sex, with age as a covariate, demonstrated a significant difference between patients and controls ($F = 6.2$, $df = 1$, $P = 0.02$). The HPT axis appears to have abnormal central functioning in depressive illness, and T4 transport to the CNS by TTR may play a role.

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SYMPOSIUM 82—PSYCHIATRIC ETHICS: FACING THE 21ST CENTURY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be more aware of and informed about the central ethical challenges facing psychiatry as we enter an uncertain new century.

No. 82A
MISUSE AND ABUSE OF PSYCHIATRY: A FIFTY-YEAR OVERVIEW

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

SUMMARY:

Based on a 50-year career in psychiatry, I surveyed some of the major ethical issues facing the profession today. Reasons for the increased interest in ethics are noted and discussed. The chief source of ethical derelictions is misuse and abuse of the power adhering to the profession. This occurs both in the doctor-patient relationship, and as a consequence of the psychiatrists's role as intermediary between the patient and the state or employing institutions. In the former instance, ethical transgressions occur when the psychiatrist exploits the relationship for his own purposes—for sexual gratification, to satisfy pathological needs, or for financial gain. Gross examples of divided loyalties were the perversions of psychiatry seen under the Soviet and Nazi regimes. Although posing warnings for present-day practitioners, divided loyalty problems currently more pertinent are the conflicts psychiatrists experience between their patients and reimbursing third parties, and especially managed care.

I foresee that the main ethical conflict confronting psychiatrists of the future will be that between their sole and exclusive Hippocratic loyalty to their patients and their obligations also to take into account population-based health considerations for the good of society.

No. 82B
PROFESSIONAL BOUNDARIES IN PSYCHIATRY

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

SUMMARY:

The field of psychiatric ethics has only recently included a consideration of professional boundaries. While sexual contact between psychiatrist and patient has always been strictly forbidden, other professional boundaries have been widely neglected. With the awareness that most sexual boundary violations originate with a descent down a "slippery slope" of nonsexual boundary violations, the field has finally become much more aware of the need to monitor a variety of different boundaries as potential indicators of countertransference gone awry. These include time management, the handling of fees, the location of sessions, the degree of self-disclosure by the psychiatrist, dual relationships involving financial matters or social interactions, and gifts, to name a few. These boundaries cannot be applied to the clinical setting as simply a list of "rules" that need to be followed. Rather, boundaries must always be considered *in context* to determine if the crossing of a boundary is harmful or constructive. Sexual contact with the patient, of course, is never acceptable, but the nonsexual boundaries must be applied with flexibility.

No. 82C
THE ETHICS OF MANAGED MENTAL HEALTH CARE

Stephen A. Green, M.D., *Department of Psychiatry, Georgetown University, 3800 Reservoir Road, N.W., Washington DC 20007*

SUMMARY:

Escalating medical costs over the past three decades have dramatically highlighted the growing scarcity of health care resources in the United States. There is considerable evidence that the cost of mental health care has significantly contributed to this situation, in large measure because of a fundamental flaw of the fee-for-service system, which lacks incentives for cost efficiencies as it is driven by patients' demands for services and guided by practice standards primarily defined by medical professionals. These aggregate results have prompted a shift in the financing and delivery of mental health care to a managed care model grounded in a fundamental commitment to the principle of efficiency which, proponents argue, promotes a basic moral goal of conserving increasingly scarce resources. The author will argue that efficiency is a legitimate goal of health care, consistent with the Humean philosophy of satisfying competing moral claims of fairness to the individual and promoting the common good of society. However, there are basic ethical dilemmas associated with the treatment of mental and substance abuse disorders in a managed care setting, including concerns about the therapeutic relationship, confidentiality, informed consent, quality of care, access to care, and implications for training. The author will address each of these issues in an effort to evaluate the moral status of the evolving system of managed mental health care.

No. 82D
THE ETHICS OF FOR-PROFIT MANAGED CARE IS AN OXYMORON

Leon Eisenberg, M.D., *Dept. of Social Science, Harvard Medical School, 641 Huntington Avenue, Boston MA 02115*

SUMMARY:

Managed care has become the name of the game in the delivery of medical services. The for-profit sector of the medical care industry is by far its most rapidly growing segment. It claims greater efficiency and lower costs, contentions that have been challenged. What it has done effectively is to reduce access to specialist services, test procedures, and hospitalization by shaping the behavior of participating generalists by putting them as financial risk for prescribing care. The loyalty of the C.E.O. is to the stockholder, not the patient. Just as bad money drives good money out, bad managed care will drive good. There is no way an academic health science center can provide excellent care, serve the poor, teach students, do research, and compete for price with systems without a commitment to any of these public goods. Market driven care forces doctors to choose between the best interests of their patients and their own economic survival. There is a fundamental incompatibility between the ethics of the marketplace (let the buyer beware) and the ethics of medicine (no physician, in so far as he is a physician, considers his own good in what he practices, but the good of his patient).

No. 82E
CODES OF ETHICS AND PSYCHIATRY

Sydney Bloch, M.D., *Department of Psychiatry, University of Melbourne, St. Vincent's Hosp. FIT2ROY, Fitzroy, Victoria 3055, Australia*

SUMMARY:

Psychiatry, as a branch of the well-established profession of medicine, has throughout its history been influenced by codes of ethics, but it nonetheless remains unclear what role such codes can or should play in determining clinical practice. In this presentation, I trace the evolution of ethical codes in medicine from Hippocrates to the present; compare the different forms codes have assumed; discuss the diverse purposes to which they can be put, including the raising of moral consciousness, and protecting the "guild", as a means of education and as a tool in self-regulation. Focus on the last is complemented by an account of the potential relationship between codes of ethics and disciplinary procedures. The code of ethics of the Royal Australian and New Zealand College of Psychiatrists is used to illustrate these themes.

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SYMPOSIUM 83—ESTROGEN, PROGESTERONE, TESTOSTERONE AND DYSPHORIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The purpose of this symposium is to clarify the contribution of ovarian failure to dysphoric mood states in women.

No. 83A
ESTROGEN AND TESTOSTERONE: NATURAL ANTIDEPRESSANTS?

Susan Rako, M.D., *83 Walker Street, Newtonville MA 02160-1519*

SUMMARY:

Estrogen and testosterone are now known to have powerful effects on neurotransmitter systems involved in mood regulation, behavior, and cognition. This paper presents a review and discussion of published findings of the central effects of estrogen and testosterone, with particular attention to the contribution of estrogen and testosterone to dysphoric mood states.

Ovarian failure may occur naturally, or may be artificially induced through surgery or as a result of chemotherapy for breast or other cancers. During the several years of the perimenopause, estrogen surges interspersed with estrogen and/or testosterone deficiency states—"hormonal chaos"—generate clinical states of anxiety and dysphoria. Both estrogen and testosterone deficiency can develop several years prior to menopause. Since 8% of women experience a full, natural menopause prior to the age of 40, even women who have not had surgery or chemotherapy can demonstrate symptoms of estrogen and testosterone deficiency in their 30's.

Women deficient in testosterone present symptoms of lack of energy, loss of libido, and loss of experience of "well being" that must responsibly be distinguished from symptoms of depression of other etiologies. A review and discussion of recent advances in diagnosis and treatment of testosterone deficiency in women will be presented.

No. 83B
MENOPAUSE, MOOD, MAO AND HORMONE REPLACEMENT

Edward L. Klaiber, M.D., *121 Lincoln Street, Worchester MA 01605*

SUMMARY:

Estrogen replacement treatment in menopausal women has been reported to have a positive effect on mood states. The addition of a progestin partially negates this positive effect in some women. The opposite effects of estrogen and progestin on mood may relate to the opposite effects of these two hormones on adrenergic and serotonergic neural function. Adverse mood response to progestin occurs in women with a long duration of menopause, low pretreatment serum estradiol and testosterone levels, high pretreatment serum FSH levels, low pretreatment platelet MAO activity (a marker of adrenergic and serotonergic function), and pretreatment mood abnormalities. Serum estradiol levels also are statistically significantly elevated in women with a long duration of menopause while they are on a combination of estrogen and progestin. The estradiol elevation is probably secondary to a decreased metabolic clearance of estradiol induced by two factors: the administration of a progestine and long-term estrogen deficiency. In spite of the estradiol elevation, these women have a greater negative mood response to the progestin than women with a short duration of menopause who have significantly lower serum estradiol levels. This paradoxical finding relating to mood may be secondary to impaired functioning of the brain's estradiol receptors following long-term estrogen deprivation. This receptor impairment blocks estrogen from having its usual positive effect on mood.

No. 83C
SEX THERAPY IN WOMEN WITH TESTOSTERONE DEFICIENCY

Barbara D. Bartlik, M.D., *Department of Psychiatry, Cornell University Medical Col, 865 West End Avenue #7E, New York NY 10025*

SUMMARY:

This presentation will describe some of the common sexual problems of women with testosterone deficiency, as they present in a sex therapy practice. Perimenopausal women with the new onset of *global* sexual dysfunction—that is, affecting desire, arousal and orgasm—may be suffering from symptoms of testosterone deficiency. This may occur as the result of natural aging, hysterectomy, or chemotherapy.

Methods for assessing sexual dysfunction in these patients will be presented. It is not enough to ask about sexual frequency. Women with waning desire and arousal often continue regular sexual relations for the sake of their partners. It is necessary to inquire specifically about the woman's sexual responses within herself. Sexual fantasies, which had once been arousing, now have no effect. Orgasms, if they occur, require vigorous stimulation and are weaker and shorter.

Ways to differentiate between psychologically and physically based sexual problems will be discussed. When dysfunction occurs only in certain situations, the problem is usually psychogenic. Other possible causes of sexual dysfunction, such as mental depression, medications, or medical conditions will be covered. Resulting complications in the couple's sexual relationship, such as secondary male erectile disorder, also will be described.

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SYMPOSIUM 84—CUTTING-EDGE POLYPHARMACY FOR MOOD DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand and use both older and newer polypharmacy strategies, including lithium augmentation, SSRI's and TCA's, pindolol, buspirone, choline, and inositol to treat refractory mood disorders and/or to possibly hasten response.

No. 84A
SWITCHING STRATEGIES IN REFRACTORY DEPRESSION

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

SUMMARY:

Switching antidepressant medication is one of the most common strategies used in the treatment of refractory depression. This approach, perhaps more acceptable to patients than polypharmacy, is often used with the goal of obtaining a different neurochemical effect. One of the main disadvantages of this strategy is related to the risk of discontinuation-emergent adverse events, which may be a source of distress to the patient and may be mistakenly perceived as side effects of the agent newly started. Many clinicians switch patients from one antidepressant class to another, with the assumption that a change in neurochemical effect is accompanied by a relatively greater efficacy. However, recent studies have shown that patients who had failed to respond to one antidepressant may actually respond to another antidepressant of the same class. It appears that switching strategies are safe and effective approaches to the treatment of refractory depression. A review and critique of the relevant literature on this topic will be presented. Finally, the results of recent studies, which have examined the efficacy of switching to newer agents patients who had failed to respond to standard antidepressants, will be reviewed.

No. 84B
LITHIUM AUGMENTATION OF THE NEWER ANTIDEPRESSANTS

Andrew A. Nierenberg, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 812, Boston MA 02114-3117*

SUMMARY:

Lithium augmentation is the most widely studied pharmacological strategy to manage depressed patients who fail to respond to an antidepressant trial. Lithium increases serotonergic function acutely in animal models with synergistic effects on antidepressant-induced, post-synaptic serotonergic receptor changes. These observations led to clinical trials that initially suggested a clinical response to lithium augmentation within 48 hours. Subsequent clinical trials have not supported a rapid response to the addition of lithium and response can be delayed for as much as four to six weeks. Overall response rates approach 60%, with about half of these responders feeling very much improved. Most of the data available on lithium augmentation are for the tricyclics, heterocyclics, and monoamine oxidase inhibitors. Only a handful of studies have carefully examined the results of adding lithium to the newer generation of antidepressants, with even fewer studies of long-term outcome for patients treated with lithium augmentation. This presentation will critically review the theory, physiology, and clinical evidence for the use of lithium augmentation.

No. 84C
THE USE OF PINDOLOL TO POTENTIATE ANTIDEPRESSANT MEDICATION

Pierre Blier, M.D., *Department of Psychiatry, McGill University, 1033 Pine Avenue West, Montreal PQ H3A 1A1, Canada;* Richard Bergeron, M.D.

SUMMARY:

Selective serotonin (5-HT) reuptake inhibitors (SSRI) and monoamine oxidase inhibitors are thought to have a delayed onset of antidepressant action attributable in part to the decrease in firing activity of 5-HT neurons they produce upon treatment initiation. As cell body 5-HT_{1A} autoreceptors desensitize, 5-HT neurons gradually regain their normal firing activity level over a period of two to three weeks. The drug pindolol, through its 5-HT_{1A} receptor blocking property, has been shown to prevent the initial decrease in firing of rat 5-HT neurons produced by SSRI. Four open-labeled studies put into evidence a significant acceleration of the antidepressant effect of SSRI's using pindolol. In contrast, the antidepressant effect of drugs that do not activate the 5-HT_{1A} autoreceptor, such as the tricyclic desipramine, is not hastened by pindolol. Four of five placebo-controlled studies, involving a total of 398 patients, have confirmed the acceleration of the antidepressant effect of SSRI's by pindolol. Furthermore, combination of pindolol with a SSRI from the beginning of the treatment resulted in a greater rate of response at study endpoint in two of these controlled trials. The strategy of adding pindolol to the regimen of SSRI-resistant patients also appears to produce a therapeutic effect in a significant proportion of patients, but double-blind studies are still needed.

No. 84D
RATIONAL POLYPHARMACY FOR REFRACTORY BIPOLAR DISORDER

Andrew L. Stoll, M.D., *Department of Psychiatry, Harvard Medical School, 221 Longwood Avenue, Boston MA 02115;* Marlene P. Freeman, M.D.

SUMMARY:

This presentation will review the pharmacology and clinical usage of combinations of traditional as well as novel drug treatments for bipolar disorder. The use of various combinations of mood stabilizer drugs will be examined through an extensive review of the medical literature. Unfortunately, very little controlled data exist regarding the safety and efficacy of combinations of mood stabilizing drugs. Recent work regarding possible mechanisms of action of mood stabilizing compounds suggests that inhibition of post-synaptic signal transduction pathways may be a feature common to all agents with

acute and prophylactic efficacy in bipolar disorder. This work has critical implications for the development of safer and more rational combinations of mood stabilizing agents. The most commonly used mood stabilizer combination is lithium plus valproate. The clinical utility of this combination was determined empirically. However, recent basic science work on the mechanism of action of lithium and valproate suggests that they potentiate each other's inhibitory action at post-synaptic signal transduction effector sites. Further work with other proposed mood stabilizers may yield even safer and more effective combinations of agents. The next decade of bipolar research should produce major advances in our understanding and treatment of bipolar disorder.

No. 84E
INOSITOL: A NOVEL AUGMENTATION FOR MOOD DISORDERS

Robert H. Belmaker, M.D., *Faculty-Health Sciences, Ben Gurion Univ. of Nege, PO Box 4600, Beersheva, Israel;* Joseph A. Levine, M.D., Ora Kofman, Ph.D.

SUMMARY:

Inositol is a simple polyol precursor in a second messenger system important in brain. CSF inositol has been reported decreased in depression. A double-blind, controlled trial of 12 gm daily of inositol in 28 depressed patients for four weeks was performed. Significant overall benefit for inositol compared with placebo was found at week 4 on the Hamilton Depression Scale (HDS). No changes were noted in hematology, kidney, or liver function. Since many antidepressants are effective in panic disorder, 21 patients with panic disorder with or without agoraphobia completed a double-blind, placebo-controlled, four-week, random-assignment, crossover treatment trial of inositol, 12 gm per day. Frequency and severity of panic attacks and severity of agoraphobia declined significantly with inositol compared with placebo. Side effects were minimal. Since serotonin reuptake inhibitors benefit obsessive-compulsive disorder and inositol is reported to reverse desensitization of serotonin receptors, 13 patients with obsessive-compulsive disorder (OCD) completed a double-blind, controlled, crossover, trial of 18 gm inositol or placebo for six weeks each. Inositol significantly reduced scores of OCD symptoms compared with placebo. A controlled, double-blind, crossover trial of 12 gm daily of inositol for a month in 12 anergic schizophrenic patients, did not show any beneficial effects. These results suggest that inositol has therapeutic effects in the spectrum of illness responsive to serotonin selective reuptake inhibitors, including depression, panic, and OCD, and is not beneficial in schizophrenia.

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SYMPOSIUM 85—OKLAHOMA CITY: TRAUMA AND RENEWAL AFTER TERRORISM

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

(1) Participants will understand the general emotional and behavioral effects of the bombing on Oklahoma City community members. (2) Participants will recognize patterns of distress reported by city school children, bereaved mothers, adults in close proximity to the blast, and firefighters. (3) Attendees will demonstrate an awareness of coping strategies associated with resilience and recovery.

No. 85A
TERRORISM AND COMMUNITY RESILIENCE

Robert Vincent, Ph.D., *Department of Psychiatry, Univ. of Oklahoma, 920 Stanton L Young BlvdWP3440, Oklahoma City OK 73190;* Elaine Christiansen, M.S., Sara Jo Nixon, Ph.D., Betty Pfefferbaum, M.D.

SUMMARY:

In the midst of tragedy, the Oklahoma City bombing provides a unique opportunity to study the impact of a terrorist bombing. The differential effects of various elements of exposure, including the fact that almost 40% of the residents knew people who were killed or injured, are examined in contrast with residents of the Indianapolis MSA. The completed study will include data from three surveys of the two populations beginning in July of 1995 and concluding with a final near-term survey to be completed after the trial of Terry Nichols, which began in October 1997. The initial survey interviewed 1,010 Oklahoma citizens and 750 persons from Indianapolis. Some, but not significant, differences exist in the size of the samples, and the data were weighted demographically for the purpose of this analysis. This presentation will focus on aggregate symptom endorsement, which revealed initially that Oklahoma citians were significantly more affected by restlessness, helplessness, avoidance, and nightmares than their counterparts Indianapolis.

They were also angrier and more than twice as many reported drinking more. Some of these differences persisted at a significant level through the second year after the bombing, particularly startle response and avoidance.

No. 85B
TERRORISM IMPACTS OKLAHOMA CITY STUDENTS

Sandra Allen, Ph.D., *Department of Psychiatry, Oklahoma Health Sciences Center, P.O. Box 2691, Oklahoma City OK 73190;* Eric Dlugokinski, Ph.D., Sara Jo Nixon, Ph.D., Rick Tivis, M.P.H., Robin Gurwitch, Ph.D., Betty Pfefferbaum, M.D.

SUMMARY:

Clinical and research efforts with school children in Oklahoma City were initiated at the time of the bombing. Over 3,000 middle and high school students were assessed two months after the incident. Over 60% reported hearing and/or feeling the blast, over one-third reported knowing someone killed, and over 40% reported knowing someone injured. Post-traumatic stress symptomatology correlated

with sex, knowing someone killed or injured, and bombing-related media exposure.

Over 6,500 city school children (grades K-11) were interviewed in groups to assess their thoughts, feelings, and coping strategies to the bombing during the period six to 12 months after. A structured interview determined that younger children distorted facts more than older ones. Most reported feeling frightened immediately after, and later feeling angry and sad. Coping strategies included helping others and communicating about the event. A total of 586 children were identified as "potentially at risk" for future emotional problems. Of these, 390 agreed to individual assessment, and 211 received further counseling.

A random sample from 40,000 pieces of children's art sent to injured victims at Children's Hospital of Oklahoma will be shown. These were analyzed to assess most common feelings and coping strategies that were expressed in their art.

No. 85C
TRAUMATIC BEREAVEMENT IN MOTHERS AND GRANDMOTHERS

Suzanne W. Whittlesey, R.N., *Department of Psychiatry, Univ. of Oklahoma, 920 Stanton L Young BlvdWP3440, Oklahoma City OK 73190;* Betty Pfefferbaum, M.D., James R. Allen, M.D., Phebe M. Tucker, M.D., Nicholas McDonald, Ph.D., Michelle Rosa, Ph.D., Heather Huszti, Ph.D.

SUMMARY:

Psychosocial and physiological assessments were completed on women who lost children or grandchildren in the Oklahoma City bombing. The women participated in group sessions over a one-year period designed to identify issues unique to this traumatically bereaved population. Assessments of five women (ages ranging from 23 to 59 years; 3 African American, 2 Caucasian) included measures of depression (Beck scores ranging from 8 to 36), post-traumatic stress symptoms, and physiological arousal.

The women felt that their experiences could not be appreciated by others because of the severity of the physical trauma, the magnitude of their losses (most knew each other's children and felt they had lost all of the children), and the community response both positive (much support) and negative (media attention). The dynamics of the group included support, displaced anger, animosity, and jealousy. By 30 months after the bombing, most of the women have moved on in their lives; some have recently married and have or are expecting the birth of new children.

No. 85D
TRAUMA AND RECOVERY IN HIGHLY EXPOSED ADULTS

Phebe M. Tucker, M.D., *Department of Psychiatry, University of Oklahoma, 920 Stanton L. Young Blvd, Oklahoma City OK 73190;* Betty Pfefferbaum, M.D., Warren Dixon, Ph.D., Nicholas McDonald, Ph.D., Gwen Allen, M.S.W.

SUMMARY:

Short- and long-term effects of the bombing on adult community members seeking mental health assistance are discussed through results of a survey and individual case studies.

Eighty-six community members seeking help six months after the bombing were surveyed to determine peri-traumatic reactions predicting later PTSD symptoms. Demographics, trauma exposure, grief symptoms, peri-traumatic reactions (PRSS-2 subscale), current PTSD symptoms (PTSS subscale), and coping were measured. Subjects had close proximity to the blast. Pearson correlation coefficients correlated PRSS-2 scores with total PTSS to identify immediate bombing reactions predictive of later distress. Multiple regression analysis was then performed with total PTSS as dependent variable and as independent variable two PRSS-2 items correlating highly with PTSS total. Peri-traumatic responses of "being nervous and afraid" and "upset by how people acted" accounted for one-third of total variation of PTSS total. This differs from other disaster studies citing dissociation as more predictive of distress, and may differentiate terrorism from other traumas. Most common coping techniques are also identified.

Brief case studies of individuals seeking treatment during the two and a half years post-disaster will be discussed, illustrating strengths and coping during recovery. Patients were in the federal building, in the nearby downtown area, or bereaved from the event.

Comparisons are made with other community disasters to identify sources of renewal and strength.

No. 85E
RESILIENCY IN OKLAHOMA CITY FIRE FIGHTERS

Sara Jo Nixon, Ph.D., *Department of Psychiatry, University of Oklahoma, 920 Stanton L. Young Blvd, Oklahoma City OK 73190;* John Schorr, Ph.D., Angela Bourdeaux, B.S., Robert Vincent, Ph.D.

SUMMARY:

This study examined the mental health of OKC firefighters following the OKC bombing. A mail-out survey was forwarded to firefighters after the first anniversary of the event. Our specific focus was to clarify the relation between demographic factors, support, and perceived recovery.

A total of 324 (39.1% return rate) firefighters returned the survey. The demographic composition of the sample was consistent with the expected distribution (primarily male Caucasian under 50). Thirteen percent reported that the bomb had a "severe effect" on them; 50% a "moderate effect", 12% "didn't know"; 7% reported it had "no effect." Five percent reported they were "not recovered"; 47% reported they were "somewhat recovered." To account for the confound between perceived effect and recovery and job satisfaction, a variable combining these factors was derived. Analyses indicated that "effect" was related to both time on site and perceived administrative support. Individuals who reported higher levels of effect were also more likely to endorse the effectiveness of CISD. When regression analyses are applied, emotional support from faith and management and previous job-related injury were successful predictors. Interestingly, however, there appear to be relevant interactions involving age, which merit additional study.

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SYMPOSIUM 86—SOCIETAL AND CULTURAL ADAPTATIONS TO TRAUMA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize how different societies and cultural traditions affect how individuals adapt to trauma.

No. 86A
DOES VENGEANCE HEAL PSYCHIC TRAUMA?

James Gilligan, M.D., *Department of Psychiatry, Harvard Medical School, 21 Berkeley Street, Cambridge MA 02138*

SUMMARY:

For the past 30 years the United States has been in the midst of an epidemic of criminal violence, with murder rates ten times as high as at the turn of the century, ten times higher than in the nations of western Europe, and ten times higher among teenagers than they were ten years ago. This epidemic constitutes an ongoing national trauma. Political leaders have responded to the public sense of fear and outrage by creating an unprecedentedly expensive and increasingly punitive penal system. This can be seen as an attempt to heal our national trauma, by means of a strategy that is tipping the balance away from non-punitive limit-setting, education, and treatment, and toward punishment, revenge, and death. But this strategy raises the question: do revenge and punishment heal the psychic traumas that cause and are caused by acts of violence? This paper will differentiate between those strategies that have demonstrated success in healing the traumas that caused and were caused by violent crimes, and those that have exacerbated the problem.

No. 86B
INDIVIDUAL AND COMMUNAL RECOVERY IN BOSNIA-HERZEGOVINA

Judith L. Herman, M.D., *Department of Psychiatry, Cambridge Hospital, 1493 Cambridge Street, Cambridge MA 02139;* Aida Hasimbegovic, Ph.D., Seila Kulenovic-Latal, M.D., Momir Smitran, M.D., N. Becirivec

SUMMARY:

This paper reports on the observations of the trauma team of the Catholic Relief Services in Bosnia-Herzegovina. This is a group of psychiatrists and psychologists who provided direct services to traumatized populations in Bosnia during the war, and who are now participating in reconstruction efforts through a program of training and public education. The senior author, who will contribute the perspective of an informed outside observer, visited the trauma team in Sarajevo in July 1997. The paper will describe both the role of local initiatives within the Bosnian community and the role of international interventions in facilitating trauma recovery. The major obstacles to individual and collective recovery will also be identified, with particular emphasis on issues of accountability and impunity. The authors will discuss the central importance of creating a factually-based, publicly acknowledged narrative of the war as preconditions for re-establishing the relational basis for a civic society.

No. 86C
VIOLENCE TURNS ME ON: NAZI SKINHEAD ADOLESCENTS IN GERMANY

Annette Streeck-Fischer, *Inpatient Department, Tiefenbrunn, Rosdorf/Goettingen 37124, Germany*

SUMMARY:

The 1945 division of Germany into East and West provided a unique opportunity for projections about the legacy of WWII and the atrocities of the Nazi past. The split into two societies supported adaptations in which each society regarded the other as heir to the past, and itself as a new beginning. Social expressions of the trauma happened in different ways, beginning with socialist movements for "cleansing and hiding." However, despite massive denial of the realities of PTSD and other trauma-related problems in German families, there was little evidence that "those who fail to learn from the past are bound to repeat it." The fall of the Berlin wall was associated with a dramatic shift in people's view of history, probably in large part because former ways of coping were lost. This shift was not primarily a thoughtful reappraisal. Intense violence against foreigners by disenfranchised "skinhead" adolescents appeared, and they adapted Nazi symbols in their violence against "the others." This presentation will discuss how these adolescents reflect not only the state of certain families, but also the state of society, and will suggest that "Nazi skins" function as an avant-garde that confronts Germany, both with its past and with the conditions of the new society.

No. 86D
HUMAN RIGHTS ABUSES IN TURKEY: EXAMPLES AND CHALLENGES

Sahika Yuksel, M.D., *Baskurt Sok No 75076, Turkey*

SUMMARY:

In the past 40 years democracy in Turkey has been interrupted by three military coups. Since the last coup in 1980, nearly two million people have been imprisoned, and almost everyone detained and/or imprisoned during this time has been subjected to torture. House raids, extrajudicial executions, forced migration and destruction of villages, extreme restrictions on free speech—these are but a few of the traumas to which people in southeast Turkey have been continually subjected by the government. Relatives of persons who have disappeared and veterans of mandatory military service are two of the most traumatized populations in need of treatment, but such massive and ongoing violence has traumatized the society as a whole. The ongoing nature of the violence, combined with a profound lack of mutual trust, foster individual and collective denial and secrecy that prevent both mental health professionals and their clients from engaging in post-traumatic recovery work. This presentation will address these issues and make the case that brief psychotherapy alone cannot solve these multidimensional problems. The environment of oppression and violence should be taken into consideration, as well as the fact that only therapeutic interventions that are developed in the context of community action can promote individual recovery. Mental health professionals have an obligation to work together closely and internationally in order to overcome violence and its traumatizing effects.

No. 86E
AFTER APARTHEID: SOUTH AFRICA'S TRUTH AND RECONCILIATION

Merle Friedman, *Department of Psychiatry, University of Witwatersrand, 28 Spencer Avenue, Senaerwood, South Africa*

SUMMARY:

Although not the first attempt of this kind, the South African process of facing past atrocities has a more ambitious scope and set of goals than similar processes elsewhere. And unlike many other nations emerging from dark pasts, South Africa has not delayed the challenge of retribution or future deterrence to the justice system. Instead, the nation is engaging in a more substantive process of reconciliation and healing in the form of the Truth and Reconciliation Commission (TRC).

The revision of collective memory, as the truth of the phantasmagoric past emerges, dominates nightly television news. The exchange of the admission of full liability for amnesty remains highly contentious for many victims; and for bystanders the TRC is an often confusing and misunderstood construction that is perceived as a preoccupation with history, limiting the opportunity to move beyond the past and confront the future. This presentation will place the TRC in a theoretical context and compare it with other attempts to cope with collective traumatic memories, examining the psychological features that will facilitate or hinder individual and national reconciliation.

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SYMPOSIUM 87—THE ROLE OF COERCION IN PSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to state the place of coercion in the humane and effective care and treatment of the psychiatrically ill.

No. 87A
COERCION OF MOTIVATION: GENERAL ISSUES

Naomi B. Heller, M.D., *5225 Connecticut Avenue, NW, Washington DC 20015*

SUMMARY:

Conventional wisdom holds that psychiatric treatment must be voluntary if it is to be effective. We examine this belief in various settings, which demonstrate that coercion and motivation lie on a continuum and that successful treatment can take place at all points along that continuum.

We explore the nature of coercion when parents bring unwilling teenagers to the doctor, when employees must stop drinking to save their jobs, when judges order offenders to treatment or to jail, and when psychotic patients are committed to inpatient or outpatient treatment.

In many such situations coercion may be seen as external pressure that strengthens the patient's motivation, and that ultimately can lead to successful treatment.

No. 87B
THE HISTORY OF INVOLUNTARY TREATMENT

John P. Shemo, M.D., *1440 Pinedale Road, Charlottesville VA 22901-9418*

SUMMARY:

The issue of involuntary, or coercive psychiatry treatment is exemplified most overtly and publicly by the process of civil commitment. Public perception that involuntary treatment is used thoughtfully and caringly is a crucial concern to clinicians. The history of commitment has been described as a "200-year-old matter similar to see saw" as the balance has shifted between restrictive, legal, police power, doctrine, and a more medical, treatment-driven practice model.

This section will review the historical and legal trends related to civil commitment as well as data pertinent to professional, patient, and family perception of such treatment. Finally, patient and treatment factors that favor a positive outcome will be reviewed.

No. 87C
HISTORY OF INVOLUNTARY TREATMENT OF THOSE WITH ADDICTION

William W. Van Stone, M.D., *Dept of Veterans Affairs, 810 Vermont Avenue, NW, Washington DC 20420*

SUMMARY:

The most obvious example of coercion of adults into seeking substance abuse treatment is in the workplace. There, employers have good economic reasons for maintaining the health and productivity of their work force. Employee assistance programs (EAP's) have been one major experiment by industry in this regard. Coercion is also seen in the provocative issue of mandatory urine tests for employees suspected of drug abuse. Elements of coercion in successful EAP's are often hidden by industry's attempt to foster a benevolent, supportive image by emphasizing the voluntary nature of the referral and the confidentiality of the counseling process. Thus, mandatory referrals may be disguised as "administrative," "personnel or health service," and only reluctantly, "disciplinary" referrals. One study discovered that self-referral was associated with poor outcome. Clients forced into treatment did better than those who were self-referred in a controlled outcome study of drug addicts depending upon age, length of addiction, and treatment modality. The interaction between coercion and motivations is discussed. The threat of imminent job loss may serve to force a patient to confront reality, break through denial, and sustain the motivation that can lead to recovery. More recently, "drug courts" have become prominent advocates of mandatory drug treatment.

No. 87D
ROLE OF COERCION IN HOSPITAL MANAGEMENT

Lynn DeLacy, M.S., *Department of Nursing, Northern VA Mental Health, 3302 Gallows Road, Falls Church VA 22042*

SUMMARY:

Political, social, and clinical influences call on us to re-evaluate the role of coercion in inpatient psychiatric settings. Among the most potentially coercive activities is the use of seclusion and restraint. There is no greater challenge posed to inpatient psychiatry than that of managing violence within a hospital culture that demands the guarantee of patient and staff safety as well as the guarantee of least

restrictive care. Adding to the complexity of these simultaneous, seemingly contradictory expectations, is the demand for active patient and family involvement in treatment decisions.

Drawing heavily on Eileen Morrison's work on coercion and violence in hospital settings, this portion of the symposium will review one public psychiatric hospital's success in reducing seclusion and restraint hours by 98% over a two-year period. The importance of organizational culture and readiness to change as well as strategies to strengthen the collaboration between medical and nursing staffs will be considered.

No. 87E
ROLE OF COERCION IN TREATMENT OF THE HOMELESS MENTALLY ILL

Lien A. Hung, M.D., *2001 Barrowfield Road, Ft Washington MD 20744*

SUMMARY:

Homelessness has been on the national political agenda for years. Homeless mentally ill individuals are a result of "de-institutionalization without informed consent." These individuals have been unable gain access to care. Additional problems emerge from difficulties in maintaining their social/economic status. Many homeless mentally ill individuals feel the system of care delivery is too bureaucratic and insensitive to their needs. Forced treatment is often seen as a paternalistic approach, which abridges the rights of these patients. It remains to be seen whether or not this society will use this position as an excuse for inaction. There is evidence that some homeless mentally ill individuals are more receptive to treatment when hospitalized or imprisoned. Where clinically indicated, coercion can be used effectively to build alliances and to foster compliance. Treatment modalities can be used that give due consideration to the legal rights of these individuals.

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SYMPOSIUM 88—FINDING THE PERSON IN WRITING ABOUT PATIENTS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The participant should become more aware of the vast data missing from contemporary psychiatry and consider how this complexity might become more a part of our field.

No. 88A
KATHERINE HOLDEN: A PATIENT

Jeanne L. Steiner, D.O., *37 Greenway Street, Hamden CT 06517-1317*

SUMMARY:

It wasn't my turn to do rounds in the emergency room that week, but a senior psychiatrist had asked me to go one night for him, as a favor. I stopped by our triage desk on my way to the ER to find out if there were any potential admissions. The woman told me that there was one patient, Katherine Holden, who might need to come in to the hospital. I took a deep breath, and in a very even tone of voice, mentioned that I had gone to college with a Katherine Holden. "Well, this can't be her," the woman replied. "She's *much* older than you." Of course I knew it had to be, and that this was the night our paths would cross after so many years.

In our small college, Katherine was one of the stars. She was tall, black, with a resonating voice and a regal bearing. She had come North from a tiny rural town in the deep South. A relative had come before her to our school, and had recommended it to her. She was a natural leader, and we flocked to her and enjoyed her intelligence and charismatic wit. We always thought of her as a "character," whose creative juices were tinged with a bit of wildness and abandon. She and her friend Mattie taught us white girls how to dance, and we had great times together. Her senior performance was a musical tour. . . .

No. 88B
THE REUNION

Jaak Rakfeldt, Ph.D., *Southern CT State University, Lang House, 101 Farnam Avenue, New Haven CT 06515*

SUMMARY:

This was Steve's first class reunion. He hadn't come to the others. His mind fills with thoughts of where the years had actually gone. He had had his first psychotic break at 19, and spent years in and out of mental hospitals. He had hidden from his old high school friends, hadn't risked coming to a reunion. He now felt strong enough to face them.

He fretted for months over how he would explain away his empty years. He concocted a story of having worked in the Outback, digging mineral core samples for mining companies. He froze at the thought of people asking him more about Australia. He saw himself stammering, sputtering, as his transparent lie publicly unraveled. As it turned out, nobody much cared to hear about him. They all wanted to talk about themselves instead—what they had seen, done, accomplished.

Steve's whole body senses Susie's closeness, her sweet softness. Steve feels stirrings he hadn't had for years. He yearns to be closer. Susie asks about him. Before he realizes, he bursts out with how he'd gone crazy in college, how he'd been hospitalized so many times, how he'd lived in halfway houses, spent time in psychosocial clubs, worked at menial tasks for meager wages. He holds his breath. Would. . . .

No. 88C
ON ROUNDS IN A PSYCHIATRIC HOSPITAL

Dolly D. Jacobson, M.S.W., *Outpatient Department, CT Mental Health Center, 34 Park Street, New Haven CT 06519*

SUMMARY:

Can that be lovely Marilyn,
The bloated woman waddling by?
Neuroleptics surely helped her

She can function sometimes now
But what a price she's paid to do it
We shake our heads in sadness for
The beauty she once had, now gone.
Lorraine is hugely pregnant this time
So medication can't be given
She mumbles angrily all day
Sings quietly and rocks all night
Denies she's pregnant, hits her belly
So hard that we must tie her hands
What will she do with a new baby?
We move on, but they stay frozen
Endless parade of human pain
We've just put our fingers in the dike. . . .

No. 88D
JORGE'S STORY

Carole T. Goldberg, Ph.D., *Dept. of Mental Hygien, Yale University, 31 Bradford Drive, Cheshire CT 06410*

SUMMARY:

He smiles at me, then looks away. I can see he's thinner, but the pain that I imagine he's suffering, doesn't show on his face.

"I'm exhausted!" he exclaims in his usual good-natured manner. "I've been shopping for an urn for my ashes." He sighs, reinforcing his proclaimed exhaustion and falls silent. I remain still, lowering my eyelids slightly as if to narrow the experience for me, let his situation filter in slowly, not all at once. He's dying.

"I can't drive anymore, you know, so I have to take a bus but even that doesn't work all the time. Sometimes I get waves of diarrhea, chills, nausea. I have to get off before I get where I'm going, find a bathroom. Sometimes I don't make it!" He looks a little sheepish and smiles. Uncrossing his legs slowly, he strokes out some invisible wrinkles in his blue jeans, then rubs his hands along the top of his narrow thighs and down over the sharp angle of his knees. His frail body is barely visible under his clothes. A skeletal frame he dresses that shows little but hides nothing.

"When I started losing weight, ...

No. 88E
THE PORTRAIT

Charles D. Atkins, M.D., *186 Good Hill Rd, Woodbury CT 06798-2501*

SUMMARY:

I pressed the buzzer to his office, nothing had changed, the same button, the same raised letter plaque.

WILLIAM ADAMS, MD

Psychiatrist

I was buzzed in. Once inside, I shot for the bathroom. Finally, with my stomach a hair better. I ventured toward his office.

He stood in the open doorway. "Hi, Chad." His hair was grey in places, still full. His face less angular, the jaw-line softer, the eyes unchanged—dark and intelligent.

"Hi."

He extended his hand.

On impulse, I put my arms around him, like an anchor; I hugged him. Not something I normally did.

He didn't stiffen. "It's going to be all right," he said.

There was no way he could know that, but it felt good. "You have no idea."

"Probably not, but that's a good place to start." And we took up positions in over-stuffed chairs, like picking up a conversation that had stopped 15 years before.

"I feel like I never left." I said, checking out his office, looking for any. . . .

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SYMPOSIUM 89—FRENCH AND AMERICAN: VIVE LA DIFFERENCE!

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium the participant should be able to understand the differences in the way French and American psychiatrists view three areas where there are profound differences in approval: cultural psychiatry, the treatment of substance abuse, and the daily life of psychiatrists.

No. 89A
IS THERE A CULTURAL PSYCHIATRY IN FRANCE?

Jean-Charles Pascal, M.D., *Psychiatrie, Centre Jean Wier, 30 Rue Anatole France, Puteaux 92800, France;* Alexandra MacLean, M.D.

SUMMARY:

The question of cultural psychiatry in France has long remained within the limits of theoretical interest and in an almost ethnopsychiatric perspective. This research topic has been masterfully developed by the ethnopsychiatrist Georges Deuvreux, through a sociologic theory of mental illness that even led him to call schizophrenia a cultural psychosis.

The difficulty conceiving differences mainly comes from a position of universality always adopted in France about what concerns history or the mind, even an ill one. Little by little, however, the importance of the now immigrated population coming from Africa or Asia, a population that no longer expects essentially integration and led us to deal with problems in a much more concrete manner.

Actually, the question of cultural psychiatry overlaps the one of socio-genesis and bio-genesis of mental disorders, a question that was posed in France in the 19th century by the philosopher Auguste Comte and the psychiatrist Morel. In contrast with the socio-genesis/bio-genesis question is the nature/culture one, since for anthropologists, culture shapes and distorts personality, a thesis that has founded the American culturalist school, often considered in France as finally tending to deny the notion of personality.

No. 89B
IS THERE A CULTURAL PSYCHIATRY IN AMERICA?

Rodrigo A. Muñoz, M.D., *Univ. of California, San Diego, 3130 5th Avenue, San Diego CA 92103*

SUMMARY:

There is an emerging debate in the United States as to whether the concept of the "melting pot" is still tenable at a time when pockets of individuals interested in their own area in the world are leading the interactions between the U.S. and those areas. From Seattle, Wash., where major connections with the Pacific Ring are already in evidence, to the Miami pressure groups pushing toward

the Caribbean, to the two Californias, excelling in an increasingly interactive market, the leaders of the movement usually feel that they represent outside of the United States what they mean inside the country.

By the year 2040, many areas of the country will be populated with minorities that tend to keep in their ideas and traditions the precepts they have brought into this country. Nowhere is this more evident than in California, especially in cities like Los Angeles, where everybody is a minority.

My presentation discusses ways in which psychiatrists practice in the South County of San Diego, where Hispanics are rapidly becoming the majority. One predominant concept is that Hispanics will be successful in obtaining care if they become "culturally competent" in dealing with their non-Hispanic doctors. The interaction of different cultural groups is likely to be the prevailing situation in the practice of medicine in California for decades to come.

No. 89C
THE TREATMENT OF SUBSTANCE ABUSE IN FRANCE

Simon-Daniel Kipman, M.D., *Psychiatrie, Assoc. Francaise De, 7 Rue du Montparnasse, 75006 Paris 00110, France*

SUMMARY:

In France, the treatment of substance abuse has undergone significant changes in the last 50 years. For many years, persons abusing alcohol or drugs were either unrecognized or minimally treated by their general physicians. In the 1960's and 1970's, however, with the introduction of Antabuse and group therapy, treatment of substance abuse became widespread. Most recently, 12-step programs have become as available for drug abusers as for alcohol abusers.

In this presentation, I will conclude with a description of the comprehensive treatment of substance abuse now present in France, including inpatient and outpatient detoxification, rehabilitation utilizing drugs and group therapy, and 12-step programs.

No. 89D
THE TREATMENT OF SUBSTANCE ABUSE IN AMERICA

Robert B. Millman, M.D., *Department of Psychiatry, Cornell Univ. Medical Center, 411 East 69th Street, New York NY 10021-5603*

SUMMARY:

The effects of cannabis are quite variable and depend on the route of administration, and the personality, psychopathology, and expectations of the user and the setting. Given these complex interacting factors, it is often difficult for the most experienced clinicians to predict whether the drug might be useful or whether use might be associated with adverse consequences. Physicians attempting to prescribe this medication or recommending the use of this medication to patients must be aware of the possible indications for the drug and what the adverse effects might be. The potential medical indications must be better characterized if the drug is to prove medically useful. The influence of the various factors noted on adverse effects and the prevalence, nature, and severity of the adverse effects will be discussed. Despite the intensity of the belief systems fueling much of this controversy, the prevalence, nature, and severity of adverse effects are reasonably well understood. Since the indications for the drug, the route, and the dose are not based on reliable experimental data or consensually developed empirical observations, some of this discussion will be based upon conjecture.

No. 89E
A DAY IN THE LIFE OF A FRENCH PSYCHIATRIST WITH A LIBERAL PRACTICE

Jean-Michel Thurin, M.D., *FFP, 9 Rue Brantome, Paris 75003, France*

SUMMARY:

Private practice of psychiatry in France is an individual practice of proximity with patients suffering from psychotic disorders, depression, borderline states, major neurosis, and dependances. The approach, essentially psychotherapeutic and humanistic, lets the patient speak. Other levels than the classic syndromic criteria are opened, which contribute to the diagnosis: personal problems, life events, familial and social context, defense and coping mechanisms. The process of the pathology appears and becomes a path in which the psychiatrist becomes an important actor, for a time.

The relationship between the patient and his psychiatrist are marked with honesty and confidence and so, in psychotic disorders, the image of the insanity is completely modified. For example, it is nearly always possible to continue a true dialogue with a patient who is delirious. Delusions increase when the patient is alone and seriously anxious, but can disappear during the treatment session, when the dialogue is again open with the therapist.

The relationship between the patient and his psychiatrist is also marked by a mixture of dependence and autonomy-autonomy because the patient pays and chooses his practitionner; dependence because the relationship is very intense. Creation and play, life projects with dignity and ethics, are other aspects of this dynamic practice.

Finally, a liberal, humanistic, and psychodynamic approach opens new perspectives in the description and the understanding of mental disorders. Clinical examples will be submitted and discussed.

No. 89F
A DAY IN THE LIFE OF A PSYCHIATRIST IN AMERICA

Robert Michels, M.D., *Department of Psychiatry, Cornell Medical College, 525 East 68th Street, Box 170, New York NY 10021*

SUMMARY:

American psychiatry has evolved from the care of the severely disabled mentally ill in asylum to care for the most disabled with treatment for those who might profit from and desire it, primarily in the community, with institutions serving as a setting for the management of impending disasters and a haven of last resort. Although ideological rationalizations have been supplied at each step in this process, these shifts have been driven by economic and social forces largely external to the profession. The most powerful external force today is usually described as "managed care."

The contemporary American psychiatrist cares for a variety of patients from the severely disabled mentally ill to the psychopathologically normal who are coping with major stresses. He or she employs interventions including pharmacotherapy and a variety of psychotherapies. Treatment planning is dominated by a concern with constraints on resources and the result is often experienced as a compromise of professional ideals. Administrative burdens are significant. More than ever, psychiatrists are involved with the families, institutions, and community networks, which have replaced the asylum as the social setting of the lives of the mentally ill.

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SYMPOSIUM 90—MUSIC THERAPY IN PSYCHIATRIC CARE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) describe the development of music therapy in the United States, (2) understand the use of music therapy as an enhancement to cognitive behavioral therapy, (3) describe the range of music therapy intervention in the geriatric population, (4) understand some of the reimbursement issues of music therapy in clinical settings.

No. 90A
MUSIC THERAPY AND PSYCHIATRY: AN OVERVIEW

John S. McIntyre, M.D., *Department of Psychiatry, St. Mary's Mental Health Cter, 919 Westfall Road, Suite 210, Rochester NY 14618-2670*

SUMMARY:

Music therapy is very effective in the treatment of a wide spectrum of mental disorders. Psychiatric programs in music therapy can be divided into the following six major categories: recreational music, music and relaxation, music combined with other expressive arts, music and movement, music performance, and music psychotherapy. This presentation will focus on the use of music in psychotherapy. Different levels of music psychotherapeutic intervention will be explored: listening, recreating, improvising, and composing. Description of specific clinical programs will be included.

No. 90B
MUSIC THERAPY FOR AN AGING POPULATION

David S. Smith, Ph.D., *Music, Western Michigan University, School of Music, Kalamazoo MI 49008*

SUMMARY:

Currently, approximately 60% of older adults in the United States who require residential care have been diagnosed with irreversible dementia. Undoubtedly, increasing numbers of individuals will be diagnosed with dementia as the population continues to age. The utilization of music therapy as a treatment modality with older individuals who have dementia is gaining in popularity. Due in large part to the growth in research documenting its usefulness with this population, music therapy has become recognized as a treatment of choice in many instances for combating depression in early stage dementia, providing opportunities for multi-level involvement in middle stages, and eliciting basic responses in advanced stages of the disease. Music therapy is also employed at all levels of the disease to improve the quality of life for both patients and caregivers. This session will summarize previous research studies, focusing specifically on current investigations and findings related to music therapy and dementia, and present case study presentations through videotaped segments of clinical work with individuals at a variety of functioning levels. Future directions for research and clinical practice with this population will be discussed as well as ways that caregivers can employ music therapy activities in home or long-term care settings.

No. 90C
MUSIC THERAPY FOR SHORT-TERM INPATIENT PSYCHIATRIC TREATMENT

Carol L. Shultis, M.Ed., *Music Therapy, AUMC - Forbes, 500 Finley Street, Pittsburgh PA 15206*

SUMMARY:

The use of music therapy as an effective, experiential, psychotherapeutic intervention offers short-term inpatients a structured, contained environment to explore internal and external tensions and issues without the necessity of intellectual processing. Such processing may be useful in achieving goals from a psychoeducational model and may be counterproductive when working psychodynamically. The option for the patient to work on inner material through the creative process, bypassing the intellect, decreases the tendency for psychological regression, thus matching such intervention with the overall treatment goals in short-term psychiatric care. Cognitive problem solving after the musical experiences may lead to new life skills and improvement in the patient's ability to function in daily life.

This paper offers a review of current trends in the use of music therapy as a integral component of short-term inpatient psychiatric treatment for acute and chronically mentally ill persons. Considering the decrease in length of stay and concurrent demands for greater accountability and documentation of outcomes, the efficacy of music therapy as a treatment modality will be demonstrated. Exploring such questions as: What are the primary purposes and goals of music therapy interventions in short-term inpatient psychiatric treatment? What behavioral outcomes serve as observable measures of change? What attitudes and skills does the music therapist use to work in this short-term model? How does the music therapist include those patients who are on the unit for more than one session, perhaps even a week or more?

No. 90D
MUSIC-ASSISTED COGNITIVE-BEHAVIORAL INTERVENTIONS

Thomas H. Kerr, M.A., *Music Therapy, Dr. Peter Center, 2665 Carolina Street, Vancouver, BC V5T 3S9, Canada*

SUMMARY:

A large body of research documenting the efficacy of music therapy indicates that music can be used to promote positive cognitions, increase imagery vividness, and modify negative physiological and affective processes. These effects are integral to many of the principles of therapeutic change articulated by cognitive-behavioral theory. A number of recent studies have confirmed that music, when system-

atically selected and applied, can be used to enhance a variety of cognitive-behavioral interventions. Furthermore, because music offers an effective means of directly modifying the affective system, music can be especially useful when combined with cognitive techniques in the treatment of emotional disorders. This paper will discuss research on music-assisted cognitive-behavioral techniques, and provide descriptions of related applications in the treatment of anxiety.

No. 90E REIMBURSEMENT FOR MUSIC THERAPY SERVICES

Bryan C. Hunter, Ph.D., *Music Department, Nazareth College, 4245 East Avenue, Rochester NY 14450*

SUMMARY:

Credentialed music therapists have been providing service to children and adults with a wide range of mental and physical needs in public and private settings since approximately 1950. Funding for music therapy services has come from diverse sources, usually linked to the specific diagnoses of the persons served.

Too often the initial response to the question "Is music therapy reimbursable?" has been a premature, "no." Despite the constraints of the current managed care environment, music therapy continues to be funded and in some cases directly reimbursed by third-party payers. This paper will delineate a number of current sources available for reimbursement of music therapy services, including Medicare's partial hospitalization guidelines.

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2. Clair AA: Therapeutic uses of music with older adults. Baltimore: Health Professions Press, 1996.
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SYMPOSIUM 91—COMPUTER-ASSISTED PSYCHOTHERAPY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: summarize historical uses of computers in psychiatry, understand how computers can augment and enhance psychotherapy and psychiatric practice, and understand issues involved in multidisciplinary collaboration and development of computer applications in psychiatry.

No. 91A COMPUTER-ASSISTED TREATMENT OF DUAL-DIAGNOSIS PATIENTS

Robert J. Bischoff, Ph.D., *Box 1086, 10070 Pasadena Avenue, Cupertino CA 95015*

SUMMARY:

This presentation reports on the conception, development, and implementation of a knowledge base (KB 4.25) computerized system, based on DSM-IV criteria. This program is an original screening tool for the assessment of psychiatric disorders within the chemical dependency population. The program utilizes innovative programming techniques to investigate organic brain dysfunction, level of withdrawal symptoms, anxiety mood disorders, eating disorders, gambling, sexual trauma and deviations, suicide indicators, denial of disease, and personality disorders. The system, which has been in place at two Bay Area hospitals for seven years, provides differential Axis I diagnosis and dual diagnoses. The program also makes treatment recommendations in chemical dependency/recovery language and terms for the clinician. In addition, all patient responses are readily tracked for research and justification. In the course of the seven-year implementation, the KB 4.25 and its predecessors have been shown to provide requisite information without additional therapist time, provide characteristic protocols indicative of dual diagnoses, collect and and analyze relevant anamnestic data, and provide norms for differential diagnoses across local populations, as well as correlation with national samples as per standardized test scores.

No. 91B THERAPY PARTNER: A COMPUTER-ASSISTED PSYCHOTHERAPY PROGRAM

Robert A. Bailey, M.D., *Department of Psychiatry, Univ of New Mexico, 2400 Tucker NE, 4th Floor, Albuquerque NM 87131;* Edward M. Kovachy, Jr., M.D., Jerrold L. Shapiro, Ph.D., Alan Cooper, B.A., Arny Goldfien, Ph.D.

SUMMARY:

This presentation focuses on the development, description, and demonstration of Therapy Partner, an interactive, multimedia computer assistant for psychotherapy. Therapy Plus was motivated by patient desires for a tool to enhance their in-session focus and increase the impact of their psychotherapy without requiring additional sessions. Therapy Plus was jointly developed by a multidisciplinary team of psychiatrists, psychologists, and software engineers. The program includes a variety of modules adaptable to various psychotherapies. For example, Therapy Plus includes a 21-question, post-session patient interactive interview and a 25-question pre-session interview. The questions are a mix of qualitative and quantitative items. The program allows each patient to set specific goals for the therapy and to record and evaluate progress toward these goals. In addition to its evident therapeutic benefit, the program provides both outcome and process measures of therapeutic effectiveness and provides immediate graphical and statistical indices of progress. It requires no increase in therapist contact time. Unlike justification measures conform to the kinds of outcome and process data that are salient for clinicians and patients. The presentation will conclude with a demonstration of Therapy Partner.

No. 91C COMPUTER-ASSISTED PSYCHOTHERAPY FOR BRIEF TREATMENT GROUPS

Jerrold L. Shapiro, Ph.D., *Department of Psychology, Santa Clara University, 218 Bannan Hall, Santa Clara CA 95053*

SUMMARY:

Given the current, cost containment oriented economic environment, brief close-ended groups are increasingly likely to be employed in a host of clinical settings. Time-limited closed groups, when led by experienced professionals, alleviate symptoms and encourage

growth. Ample evidence of the efficacy of these brief treatment groups, geared to specific limited goals with a variety of populations, has been reported. A recent innovation, the twice-weekly use of a self-administered computer program to augment group therapy, is the core of this presentation. Therapy Partner: Groups is one of the Therapy Plus computer programs, specifically designed to help prepare group therapy patients for more effective sessions and to provide superior tracking of outcome. Thirty counseling psychology graduate students at Santa Clara University, in their mandatory 20-hour group training, used the Therapy Partner: Groups module. Results are matched with a control group of 26 students who used pencil and paper measures of group performance and outcome. Outcome data are further compared with an established database of 350 students in equivalent groups who completed paper and pencil outcome and videotape process measures. Finally, members' and leaders' subjective reactions to the program are explored and related to differences in impact and to specific group process stages.

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SYMPOSIUM 92—CURRENT PERSPECTIVES ON PSYCHIATRY AND RELIGION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants should be able to discuss current perspectives on psychiatry and religion that include cross-cultural and bioethical considerations, along with an awareness of recent research, training, and clinical advances at the psychiatry/religion interface.

No. 92A
A CROSS-CULTURAL PERSPECTIVE OF PSYCHIATRY AND RELIGION

Ronald M. Wintrob, M.D., *Department of Psychiatry, St. Elizabeth's Hospital, 736 Cambridge Street, Boston MA 02135;* Charles C. Hughes, Ph.D.

SUMMARY:

In their efforts to understand human suffering and distress, as well as in their approaches to relieving these painful life experiences, religion and psychiatry have both overlapping and contrasting approaches. This paper gives an overview of those similarities and differences by presenting a sampling of the issues drawn from the cross-cultural literature.

We begin by reviewing key shared concepts, with their widely differing meanings and implications for changing behavior concepts such as belief, faith, spirituality, spirit possession, and healing. We point out that in many cultures the healer is at one and the same time a religious leader in contact with the ancestors and the spirit world and a doctor concerned with healing the sick and disabled.

Case illustrations are included of spirit possession and spiritual healing from dramatically different cultural traditions, such as shamanism among Siberian Eskimos, priestly healing among the Navajo, faith healing among fundamentalist Christians in the U.S., and spirit possession and healing among the Yoruba people in Nigeria.

Syncretism—the blending of different religious and healing traditions—is described and illustrated by examples: Candomble in Brazil, Voodoo in the Caribbean, Muslim and Christian spiritual healing in West Africa.

The paper concludes with some guidelines for mental health clinicians working with culturally diverse populations.

No. 92B
CULTS AND NEW RELIGIOUS MOVEMENTS

Marc Galanter, M.D., *Department of Psychiatry, NY University Medical Center, 550 First Avenue, New York NY 10016*

SUMMARY:

In recent decades, cultic movements have regularly come to the fore as problems of major concern to both the general public and to psychiatric clinicians. On the basis of empirical research, this presentation will describe psychological and social forces that operate within these groups to allow them to influence the behaviors of their members. Among these are social cohesiveness, ideologic beliefs, and alterations in consciousness. Data will be drawn from movements such as the Unification Church and the Divine Light Mission, but these findings will be used to interpret behaviors observed in more recent cultic groups such as the Branch Davidians, Aum Shinrikyo, and Heavens Gate. Observations will also be used to illustrate issues arising in contemporary spiritually oriented healing movements.

No. 92C
RELIGION AND PSYCHIATRY: BIOETHICS AS ARBITER OF MUTUAL RESPECT

Laurence J. O'Connell, Ph.D., *STD, Park Ridge Center, 211 East Ontario, Chicago IL 60611*

SUMMARY:

The interest of religion and psychiatry intersect significantly. They provide vectors of insight and guidance as individuals strive to achieve and sustain meaningful, coherent, and morally consistent lives: As in the relationship between any two individuals, communities, or fields of endeavor, ethical concerns arise as competing moral claims come into play when psychiatric practice and religious life meet. The relatively new field of bioethics addresses these ethical quandaries and eases their resolution at points where religion and psychiatry cross. Bioethics offers a venue for adjudicating the competing, sometimes contradictory, moral claims of psychiatry and religion.

Concrete examples will be used to illustrate the mediating role of bioethics at the interface of religion and psychiatry. Drawing upon cases that are shaping the discussion of issues like assisted suicide and refusal of standard treatment, the author will describe how tension between psychiatry and religion is emerging and, further, how bioethics might be enlisted to resolve the potentially destructive consequences of such tension.

No. 92D
PSYCHIATRY AND RELIGION: CHANGES IN RESEARCH AND TRAINING

David B. Larson, M.D., *998 Farm Haven Drive, Rockville MD 20852-4213;* James L. Collins, M.D.

SUMMARY:

In the last few years psychiatry research has highlighted the neglect as well as the need to handle religious and spiritual issues in clinical care. In addition, generally following up on the published research, psychiatry has taken important clinical and training steps to better

address as well as respond to patients' spiritual issues in clinical education and care. This presentation will highlight the published mental health research as well as key recent steps taken by psychiatry. In addition, it will briefly summarize a recent model curriculum for residency training as well as the John Templeton Foundation-supported financial award program for the best pyschiatry residency programs educating residents about the clinical management of patients' spiritual and religious issues. Time will be available for those attending the symposium to discuss their own perspectives on the content and process of training and education initiatives at the interface of psychiatry and religion.

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SYMPOSIUM 93—PSYCHOTHERAPIES IN COMMUNITY PSYCHIATRY
Joint Session With the American Association of Community Psychiatrists

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) describe the range of psychosocial interventions that are useful in the treatment of individuals in community settings; (2) describe the specific psychotherapy needs of individuals with serious and persistent mental illness, and of individuals from cultural and racial minorities; (3) describe specific family interventions for individuals with mental illness, and the evidence supporting their effectiveness.

No. 93A
PSYCHOTHERAPIES IN COMMUNITY PSYCHIATRY

Clifton R. Tennison Jr., M.D., *1520 Cherokee Trail, Knoxville TN 37920–2205*

SUMMARY:

An AACP ad hoc Committee on Psychotherapy Issues recently defined the current challenges facing community and public sector psychotherapy practice. Responding to the APA's creation of a Commission on Psychotherapy by Psychiatrists, AACP outlined its position on access to psychotherapy services, which follows:

(1) Limits on the funding of psychotherapy require [a] advocacy for interventions common to community settings, [b] outcomes research on appropriate therapy and on withholding therapy, [c] study of restrictions induced by inadequate funding and precertification requirements, and [d] promotion of therapies for the most difficult disorders;

(2) A broad concept of psychotherapy acknowledging its place in all interventions includes [a] studying psychotherapy in the practice of pharmacotherapy, [b] promoting treatments for severe illness that include psychotherapy, and [c] promoting psychotherapy in alternative settings;

(3) The importance of patients having a primary clinician with comprehensive training requires [a] studying the impact of lesser credentialed lead clinicians, [b] determining when the psychiatrist should be the psychotherapist, [c] studying how medical necessity for psychotherapy is determined, and [d] supporting medical direction for treating populations at risk for increased intensity of services;

(4) Scholarly documents that psychiatrists can use to advocate, educate, and negotiate funding for psychotherapy services should be produced.

No. 93B
PSYCHOTHERAPIES AND PSYCHOSIS

Joel S. Feiner, M.D., *Mental Health Connections, 5959 Harry Hines Blvd, 9 South, Dallas TX 75235*

SUMMARY:

Despite significant advances in pharmacology and rehabilitation, psychotherapy continues to have a place in the treatment of persons with major mental illness. This section will discuss, with literature review and clinical examples, the following areas:

(1) As pharmacotherapeutic advances have contributed to the amelioration of both positive and negative symptoms, we are seeing the "awakening" phenomenon with atypical antipsychotic medication. The emergence of the ability to self-reflect and to develop active lives requires the support and, importantly, assistance with the realization of the losses of time and dreams, which may lead to suicidal potential. In addition, families must be helped to adjust to the changes in the identified patient.

(2) Resolution of psychotic symptomatology may unmask a personality disorder, which may require treatment in and of itself, which, if untreated, may interfere with psychotic recovery.

(3) Some families may organize inflexibly around its mentally ill member. Despite psychoeducational interventions, family therapy may be necessary to facilitate maximum function and quality of life.

(4) Cognitive interventions are receiving the most attention with this population because of the greater ease of developing standardized techniques. These interventions address such issues as adherence to medication, restoration of function, and symptom management.

No. 93C
PSYCHOTHERAPY FOR PEOPLE OF COLOR WITH SERIOUS MENTAL ILLNESS

Andres J. Pumariega, M.D., *Department of Psychiatry, William S. Hall Psych. Instit., POB 202, 1800 Colonial Drive, Jonson City TN 37614*

SUMMARY:

Serious mental illness occurs within the sociocultural context of the individual. Poverty, marginalization, and discrimination, associated with being a person of color, are often powerful precipitant and recurring stressors, which contribute to serious mental illness. Cultural values and beliefs influence the patients' presentation and symptomatology, their attribution for the illness, their defense/coping skills, as well as their help-seeking behaviors. Additionally, cultural differences between patient and therapist can serve as a barrier to the establishment of the therapeutic alliance, effective communication of distress and conflicts, and the negotiation of the therapeutic contract and expectations from treatment. This presentation focuses on attitudes, knowledge, and skills necessary for the culturally competent psychotherapy of people of color with serious mental illness. Some of these skills are oriented toward framing problem-oriented psychotherapy within the cultural values, beliefs, and unique stressors of the patient of color, while others address the power differential and barriers to communication that often derail such therapeutic

encounters. Given the great shortage of mental health professionals of color, it is imperative that mainstream culture providers develop the necessary skills toward culturally competent treatment.

No. 93D FAMILY PSYCHOEDUCATION: OUTCOME AND APPLICATION

William R. McFarlane, M.D., *Department of Psychiatry, Maine Medical Center, 22 Bramhall Street, Portland ME 04102*

SUMMARY:

Family intervention in the psychotic disorders, particularly schizophrenia and bipolar disorder, is not family therapy in the traditional sense. However, its impact on the course of those disorders has been far more profound than that of more traditional psychotherapies.

This paper will describe the key therapeutic techniques of family psychoeducational multiple family groups, review recent outcome studies in several diagnoses and populations with severe mental illness, and address questions about cost-effectiveness and feasibility in routine clinical practice. In particular the New York State Psychoeducation in Schizophrenia study and the NIMH Collaborative Treatment Strategies in Schizophrenia study will be described in detail. In those studies, over 400 patients at 11 highly diverse and representative sites were offered two years of treatment in multi-family groups, using experimental comparisons across treatment subtypes. Relapse rates averaged under 15% per year in both studies, while in the New York effort the cost-benefit ratio reached 1:34, suggesting that the multi-family group approach is the most cost-effective psychosocial treatment yet developed for schizophrenia.

The paper will also describe current U.S. and international efforts to disseminate these approaches, discussing the barriers to implementation and the alterations in treatment systems that may be necessary to realize these benefits. Implications for publicly funded managed care will also be addressed.

No. 93E BIOPSYCHOSOCIAL TREATMENTS FOR DEPRESSED PATIENTS

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

SUMMARY:

Objective: The objective of this study was to evaluate factors contributing to treatment outcome in severely depressed patients.

Method: A total of 121 patients hospitalized with severe major depression were assigned to four treatment groups: Pharmacotherapy only, Family + Pharmacotherapy, Cognitive+Pharmacotherapy, and Family, Cognitive+Pharmacotherapy. Patients were assigned to treatment conditions based on their family functioning, cognitive distortion, and other clinical factors. Patients were followed for a total of 19 months after discharge from hospital, six months while in the acute treatment phase of the study, and 13 months in maintenance.

Results: Overall 30% of the patients achieved HRSD scores of <7 by the six-month follow-up, while 42% of the patients' scores improved substantially (50% drop from index to six months). Dropout rates were 38.8% by month 6. Both improvement and attrition rates differed by treatment group; patients receiving Pharmacotherapy only tended to do worse than those in the other treatment groups. Logistic regression models suggested that treatment condition was an important factor in the patient's remaining in the study, while age of depression onset, perception of the family's functioning, severity of the illness, and suicidality were best at predicting lessening of a patient's symptoms.

Conclusion: Clinical, psychosocial, and treatment conditions are all contributing factors in the recovery of severely depressed patients.

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SYMPOSIUM 94—GENETICS OF PERSONALITY AND BEHAVIOR

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the latest thinking about the heritable nature of temperament, as a contributor to personality traits, behavioral styles, and personality disorders.

No. 94A GENETICS OF PERSONALITY AND BEHAVIOR

Kathleen R. Merikangas, Ph.D., *Department of Psychiatry, Yale University, Geru 40 Temple St, Lower Level, New Haven CT 06510;* Joel Swendsen, Ph.D., Martin Preisig, M.D.

SUMMARY:

Recent association studies of genetic markers have led to a renewed interest in the role of genetic factors in personality. The paradigms of genetic epidemiology comprise a major source of evidence regarding the mechanisms through which genetic and environmental factors may influence personality. This presentation will review the current evidence from family, twin, and adoption studies concerning the role of genetic factors in temperament, personality traits, and disorders. Key methodological and conceptual issues will be highlighted, with particular emphasis on the role of comorbid psychiatric syndromes and their impact on conclusions regarding genetic and familial factors. Finally, these issues will be illustrated through data from a large family study of personality and psychopathology, demonstrating links between personality, temperament, and psychiatric syndromes in adults and children.

No. 94B THE GENETIC STRUCTURE OF PERSONALITY DISORDER TRAITS

John Livesley, M.D., *Department of Psychiatry, University of British Columbia, 2255 Westbrook Mall, Vancouver, BC V6T 2A1, Canada;* Kerry L. Jang, Ph.D.

SUMMARY:

The evidence suggests that personality traits are hierarchically organized: higher order traits subdivide into lower order traits. In previous studies, the results of multivariate analyses of self-report questionnaires were used to describe the hierarchy in terms of four levels: items, specific traits (69 traits), basic level traits (18 traits), and higher order traits (four traits). Univariate genetic analyses indicate that traits at each level have a substantial genetic component.

This paper reports on the genetic structure underlying this hierarchy. Two questions will be addressed. First, are the lower order traits merely components of the higher order traits or are they separate entities with a distinct genetic etiology? Evidence will be presented based on data from approximately 700 volunteer twin pairs to show that many lower order traits at both the basic and specific levels have substantial residual heritable variance when the effects of the higher order factors are removed. This suggests that the phenotypic structure of personality is influenced by a relatively large number of specific genetic factors.

Second, what are the specific genetic components of personality disorder? Relatively few studies have explored the genetic structure underlying a large number of traits of either normal or disordered personality. The results of multivariate genetic analyses will be presented that were designed to identify the genetic architecture underlying the 69 traits that form the most specific level of the trait hierarchy. Particular attention will be paid to the genetic structure of emotional dysregulation, a higher order factor that resembles borderline personality disorder. These results suggest that the etiological structure of personality disorder is complex, consisting of a few general genetic factors and a large number of specific factors. The implications of these results for biological research will be discussed.

No. 94C
GENE MAPPING OF HUMAN PERSONALITY TRAITS

C. Robert Cloninger, M.D., *Department of Psychiatry, Washington Univ Medical School, 4940 Children's Place, Saint Louis MO 63110*

SUMMARY:

Recent advances in the quantitative assessment of human personality and gene mapping techniques have converged to allow mapping of genes for human personality. Four dimensions of temperament have been shown in twin and adoption studies to be moderately heritable (about 50%) and genetically independent of one another. These are measured by the Tridimensional Personality Questionnaire or Temperament and Character Inventory, which measure traits of harm avoidance, novelty seeking, reward dependence, and persistence, in addition to less heritable aspects of personality.

We have completed the first genome-wide scan between normal human personality traits and a set of 291 genetic markers at an average interval of 13 centimorgans (cM) in 758 pairs of siblings in 177 nuclear families of alcoholics. The work was done as part of the NIAAA Collaborative on Genetics of Alcoholism. We detected significant linkage between each temperament dimension and different sets of three to nine loci. Most of the heritable variation in each of the four personality traits was attributable to a different set of such epistatic loci. Candidate genes in the vicinity of each region of putative linkage are being examined with the goal of identifying molecular targets for therapy.

No. 94D
GENETICS OF ANTISOCIAL PERSONALITY DISORDER

Remi J. Cadoret, M.D., *Department of Psychiatry, University of Iowa, MEB 500 Newton Road, Iowa City IA 52242;* Kristin Caspers, Ph.D., Douglas R. Langbehn, M.D.

SUMMARY:

Adoption studies allow the separation of genetic from environmental factors, and, more importantly, are the most efficient way to study gene-environment interaction.

Recent adoption studies have shown that both genetic and environmental factors play a role in the genesis of adult antisocial behaviors. Of special interest because of their potential importance is the finding of significant gene-environment interaction: a biological background of antisocial personality in adoptees results in antisocial behaviors such as aggressivity, adolescent conduct disorder, and oppositional-defiant disorder in the presence of certain environmental factors in the adoptive family. The gene-environment interaction suggests that effective interventions could be devised for antisocial behaviors by manipulating the environment. For example, environmental factors found to interact with the genetic background are adoptive parenting styles, which should be amenable to change.

The findings also suggest that oppositional-defiant disorder not only has a genetic etiology but that it leads to adult antisocial personality disorder, a finding that has nosologic implications for criteria for adult antisocial personality disorder.

No. 94E
GENETICS OF SCHIZOTYPAL AND BPD

Larry J. Siever, M.D., *Department of Psychiatry, Mount Sinai School of Medicine, 1 Gustave L. Levy Place, New York NY 10029*

SUMMARY:

Schizotypal and borderline personality disorder are two of the best characterized personality disorders. For both, there is emerging evidence that genetic factors play a role in their pathogenesis. Schizotypal personality disorder was identified on the basis of a presumed genetic relationship to schizophrenia, which was confirmed in a re-examination of adoptive and family studies of schizophrenic patients. Schizotypal patients are more likely to have relatives with schizotypal personality disorder and schizotypal personality disorder may enhance the power of linkage studies of schizophrenia-related disorders, recently linked to a site on chromosome 6. Recent evidence from a Puerto Rican family pedigree links schizophrenia and schizotypal personality disorder to a locus on chromosome 5. New candidate gene data on schizotypal personality disorder will also be presented. Borderline personality disorder does not appear to be heritable by itself, but the dimensions of impulsivity and affective instability that underlie this disorder show greater concordance in monozygotic as compared with dizygotic twins. Since impulsivity has been linked to dysfunction of the serotonergic system, candidate gene studies exploring the role of serotonin related genes and impulsivity in borderline and related personality disorders suggest that the "L" allele of the tryptophan hydroxylase gene as well as an intronic allele of the serotonin transporter gene may be associated with measures of irritability and impulsivity. Such candidate gene approaches seem promising as a strategy to characterize the genetic foundations of the personality disordes.

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SYMPOSIUM 95—NEW TREATMENTS FOR HEROIN ADDICTION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should understand the demographic changes in heroin use over the last ten years, and understand several new treatments for heroin addiction. The symposium will focus on levo-α-acetylmethadol; methadyl acetate (LAAM), buprenorphine, "ultra-rapid opiate detoxification," and the peer-led group Methadone Anonymous.

No. 95A
CHANGES IN HEROIN ADDICTION

Laurence M. Westreich, M.D., *Department of Psychiatry, New York University, 40 Park Avenue, #1K, New York NY 10016*

SUMMARY:

Heroin use in the United States has shifted from a low-incidence endemic pattern to widely diffused and rapidly spreading epidemic proportions over the last six years. The popular media mold perceptions of this increase, most obviously in the "heroin chic" of high fashion models portrayed as hollow-eyed, strung-out junkies. But the rich and famous are not the only ones getting hooked on heroin. Since heroin is cheaper and purer, new addicts now include dabblers who unwittingly get caught by the drug, homeless people who in the past would have been unable to afford a heroin habit, and young people. According to the Drug Abuse Warning Network, the number of emergency department visits for heroin problems by persons in the age range 12–17, although relatively few, rose from 182 in 1990 to an estimated 504 in 1994, an increase of 277 percent. According to a yearly survey of high school seniors coordinated by the University of Michigan, the annual prevalence of heroin use, although small, doubled between 1990 and 1995. This paper will explain the mechanics of heroin use, describe the recent nationwide increase in use, and lay out treatment options for the addicted person.

No. 95B
LEVOMETHADYL ACETATE HYDROCHLORIDE (LAAM): OPIOID-SUBSTITUTION THERAPY

Paul P. Casadonte, M.D., *Department of Psychiatry, New York VAMC - NYU, 423 East 23rd Street, #116-A, New York NY 10010*

SUMMARY:

The New York VA Opiate Substitution Program initiated regular use of LAAM in October 1994. Patients entering treatment were offered methadone or LAAM until April 1995 when we offered all new patients LAAM only. Patients are rapidly titrated up from initial doses of 30–40 mg and are medicated three times a week. There is no differentiation between LAAM and methadone patients in terms of treatment approach: all attend the same treatment groups and are assigned to counselors without respect to maintenance medication. In April 1996 we evaluated the efficacy and acceptance of LAAM at the clinic by self-report questionnaires for patients enrolled longer than six months, including patients maintained on methadone (N=40) and individuals on LAAM who did (N=17) and did not have previous methadone maintenance experience (N=19). Patients maintained on methadone were concerned that they would be required to transfer to LAAM and indicated they would transfer out of the clinic rather than take LAAM. Patients on LAAM were satisfied with the medication, had discontinued opiate use at rates similar to methadone, were not disturbed by reduced clinic visits early in treatment, and believed that LAAM would not be a drug readily sold on the streets. We also surveyed eight clinic staff. Staff believed, as did LAAM patients, that the community would find LAAM more acceptable than methadone. After two years of clinical observation, in December 1996 we offered twice-weekly maintenance treatment with LAAM for stable patients. A June 1997 evaluation of 26 patients medicated twice weekly demonstrates that over 50% use no illicit drugs and 80% do not use heroin at any time. Individuals who lapse are returned to three times/week dosing. Overall LAAM is at least as effective as methadone, frees a patient from daily clinic visits and eliminates methadone diversion.

No. 95C
BUPRENORPHINE FOR OPIATE DEPENDENCE: CLINIC AND OFFICE-BASED PARADIGMS

Paul J. Fudala, Ph.D., *Department of Psychiatry, DVA Medical Center, Building 15, Philadelphia PA 19104*

SUMMARY:

Although many compounds have been evaluated for the treatment of opiate dependence, only three medications have been approved by the U.S. Food and Drug Administration for this condition: methadone, methadyl acetate (LAAM), and naltrexone. Buprenorphine is a mu-opiate partial agonist that is currently under active investigation as a treatment for opiate dependence, and is expected to be approved for this indication in the near future. Results from numerous studies have supported its therapeutic utility, and some have provided evidence for its abuse liability. A combination product containing both buprenorphine and the opiate antagonist naloxone is expected to be undesirable for parenteral abuse by opiate-dependent individuals. However, the product, when administered sublingually, is expected to be safe and efficacious for opiate-dependence treatment. This presentation will focus on providing clinicians with the most recent information regarding the rational and appropriate use of this medication, including that related to patient and dosage selection and therapeutic monitoring. Results from recently completed and ongoing studies involving both buprenorphine and buprenorphine/naloxone will be discussed.

No. 95D
METHADONE ANONYMOUS

Duncan McGonagle, R.N., *Department of Psychiatry, Bellvue Hospital, 1st Avenue & 21st Street, New York NY 10016*

SUMMARY:

Methadone Anonymous (MA) is a new 12-step program, modeled on the principles and tenets of Alcoholics Anonymous. Since its inception at Bellevue Hospital's Methadone Maintenance Treatment Program, MA has been a significant asset in the treatment paradigm of heroin/opiate addiction. MA has filled the void left by other 12-step programs that have historically rejected methadone-maintained heroin addicts.

There are currently seven meetings a week, Monday thru Saturday. Two meetings are held on Monday; one is a women-only meeting to discuss women's issues.

The counselor treatment staff have been enthusiastic about MA as they witness the change in patient attitude and subsequent engagement in treatment. Success has been demonstrated in clean urine

profiles with those attending MA. MA continues to grow within the MMTP treatment community on a daily basis. All practitioners working with the heroin/opiate addicted should be knowledgeable with this new peer-support referral program.

No. 95E
ULTRA-RAPID OPIATE DETOXIFICATION

Lance L. Gooberman, M.D., *1 South Center Street, Merchantville NJ 08109*

SUMMARY:

As the new heroin emerged in the early 1990's, the need for treating opiate-addicted patients became apparent. The challenge was to develop a treatment for heroin addiction with the following goals: (1) eliminate the fear of detoxification; (2) prevent premature termination of treatment; (3) prevent immediate relapse post detoxification; (4) avoid the delay in initiating naltrexone maintenance therapy; (5) prevent noncompliance with maintenance therapy; and (6) avoid the codependency associated with intense supervision.

The current abstinence-based treatment for heroin addiction has been 100 years in its development. It involves an opiate reversal under general anesthesia with immediate initiation of naltrexone maintenance therapy utilizing a depo-naltrexone preparation in association with 12-step recovery programs.

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SYMPOSIUM 96—BRAIN SIGNALING PATHWAYS IN PSYCHIATRIC SYNDROMES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To understand the pathophysiology of drug abuse and affective disorders.

No. 96A
BRAIN CIRCUITRY AND SIGNALING MECHANISMS OF COCAINE

Ronald P. Hammer, Ph.D., *Department of Psychiatry, Tufts-NEMC, 750 Washington St. Box 1007, Boston MA 02111*

SUMMARY:

The intense euphoria and psychostimulant properties induced by cocaine are mediated primarily by an increase of dopamine within the nucleus accumbens (NAc) located in the basal forebrain. The NAc also receives glutamatergic innervation from limbic and cortical brain regions, and the output of NAc neurons ultimately supplies a thalamocortical feedback circuit whose neurons contain GABA and several neuropeptide transmitters. Chronic cocaine use produces adaptive responses, reducing mesocortical dopamine efflux, which could underlie the augmented response of prefrontal cortical neurons in regions that innervate the NAc. Such activation of afferent projections to the NAc may contribute to behavioral sensitization or to the activation of limbic and cortical regions that are associated with craving induced by drug-related cues. Furthermore, chronic cocaine use gradually induces activation of limbic "striosomes," which are preferentially innervated by prefrontal neurons. Thus, chronic cocaine treatment selectively alters a heterogenous network of striatal neurons. Within this network, chronic treatment induces prodynorphin gene expression in the dorsal and ventral striatum via stimulation of dopamine D_1-like receptors. Thus, a compensatory response to excessive dopaminergic stimulation in neurons that are initially activated by cocaine treatment may contribute to dysphoric symptoms manifested during withdrawal.

Supported by USPHS Award DA09822.

No. 96B
BRAIN SIGNALING MECHANISMS IN OPIATE DEPENDENCE

Gary B. Kaplan, M.D., *Department of Psychiatry, Brown Univ./VAMC, 830 Chalkstone Avenue, Providence RI 02908*

SUMMARY:

Opiates mediate their reinforcing effects by binding to opioid receptors in mesocorticolimbic and mesostriatal regions. These receptors mediate their cellular effects via effectors such as adenylyl cyclase, potassium channels, and calcium channels via their coupling to signal transducing G proteins. Chronic opiate treatment produces homeostatic adaptations of multiple signaling elements including: neurotransmitters, opioid receptors, other G protein coupled-neurotransmitter receptors (e.g. dopamine receptors), G proteins, effectors, and other downstream cellular elements. Regulation of these cellular signals are important in the mediation of drug reinforcement, tolerance, dependence, and withdrawal. Acute opiate treatment produces euphoria and psychomotor stimulation that is associated with enhanced dopamine release in limbic and striatal regions. Opiate withdrawal produces dysphoria and craving that is associated with reduced dopamine efflux in these regions. Chronic opiate treatment produces adaptive upregulation of dopamine D_1 receptors and associated G protein-stimulated adenylyl cyclase in striatal regions. Cross-regulation of other neurotransmitter signaling systems, such as adenosine, has also been demonstrated. Dopamine-, opioid-, and adenosine-mediated signaling all represent therapeutic targets in the treatment of opiate withdrawal. Regulation of these selected neurotransmitter, receptor, G protein, and cAMP signaling systems are adaptive responses that oppose the effects of repeated opiate treatment and mediate aspects of tolerance, dependence, and withdrawal. These receptor and postreceptor elements are sites for therapeutic intervention in opiate abuse and dependence.

No. 96C
ABNORMAL INTRACELLULAR SIGNALING IN MOOD DISORDERS

Jerry J. Warsh, M.D., *Clarke Institute, 250 College St., Toronto, ONT M2H 1R7, Canada;* Peter P. Li,, Ph.D., L. Trevor Young, M.D.

SUMMARY:

Substantial evidence implicates disturbances in intracellular signaling in the pathophysiology of bipolar (BD) and major depressive (MDD) disorders. Levels and function of signal transducing proteins have been measured directly in BD postmortem brain. Increased levels and function of the stimulatory G protein α subunit, altered agonist-stimulated GTP binding to G proteins, and impaired cAMP dependent protein kinase (cAMPdPK) implicate hyperfunctional G

protein-mediated signaling in BD. Phosphoinositide signaling is blunted in postmortem BD occipital cortex, while it appears to be upregulated in platelets. Furthermore, increased mononuclear leukocyte and B lymphoblast intracellular calcium concentrations implicate calcium-signaling disturbances in BD. Crosstalk among the cAMP, phosphoinositide, and calcium signaling cascades may explain the pattern of signaling disturbances. Persistence of these abnormalities in euthymia or in B lymphoblasts and fibroblasts from BD patients suggest they are in part trait-dependent. The signal transduction disturbances in MDD differ from those observed in BD. Reduced basal cAMP levels, blunted agonist-stimulated G protein responses, elevated inhibitory G protein α subunit immunolabeling in peripheral blood cells and postmortem frontal cortex in MDD, and reduced cAMPdK activity in cultured fibroblasts are consonant with blunted postreceptor cAMP signaling in MDD. Together with evidence that mood-stabilizing and antidepressant drugs affect key loci in these transduction cascades, the above findings strongly support the relevance of altered signal transduction to the pathophysiology of mood disorders.

No. 96D
REGULATION OF TRANSMEMBRANE SIGNALING BY MOOD STABILIZERS

Husseini K. Manji, M.D., *Department of Psychiatry, Wayne State University, 4201 St. Antoine Dr. H5V, Detroit MI 48201*

SUMMARY:

Lithium, valproic acid, and carbamazepine are widely used in the treatment of manic-depressive illness, but the molecular mechanisms underlying their therapeutic actions have not fully been elucidated. In recent years it has become increasingly clear that rather than any single neurotransmitter system being responsible for depression or mania, multiple interacting and overlapping systems are involved in regulating mood, and that most effective drugs may exert their therapeutic efficacy by affecting the functional balance between interacting systems. In this context, we have found that in both rodents and man, chronic administration of these agents at therapeutically relevant concentrations produces significant effects on signal transduction pathways, in particular on G proteins, the protein kinase C isozymes, and the AP-1 family of transcription factors. Regulation of signal transduction within critical regions of the brain affects the intracellular signal generated by multiple neurotransmitter systems and may thus explain the efficacy of these agents in treating multiple aspects of manic-depressive illness. Given the key roles of these signaling cascades in the amplification and integration of signals in the CNS, these findings have clear implications not only for research into the etiology/pathophysiology of manic-depressive illness, but also for the development of innovative treatment strategies.

Supported by Stanley Foundation and Joseph Young Senior Awards

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SYMPOSIUM 97—PSYCHIATRY SERVICES RESEARCH IN PRACTICE AND POLICY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The participant should be able to identify major forms of services research relevant to quality of care assessment, early detection of illness, barriers to care, and serving high-risk populations. The participant will identify practical applications of health services research and gaps in translating research findings into policy or practice management.

No. 97A
DEPRESSION OUTCOMES: WHAT DO PATIENTS NEED AND WANT?

Junius J. Gonzales, M.D., *Suite #440, Georgetown University, 2233 Wisconsin Avenue, N.W., Washington DC 20007;* Kevin Weinfurt, Ph.D., Kamila Bajwa, B.A., Kevin Schulman, M.D.

SUMMARY:

Depression is widespread, and a 1990 estimate of its economic burden was $44 billion. While efficacious treatments are available, many people with depression go untreated, particularly in the general health care sector, and suffer significant decrements in well-being and functioning, even compared with those with other chronic medical illnesses. There is little research on what patients want, need, and think about depression and its treatments. Key elements surrounding a depressed person's needs and wants are not well delineated—elements that may directly affect the process of care, and hence patient outcomes.

This paper describes components of a research endeavor to examine what people think about, need, and want regarding depression and its treatments. The first component describes the use of state-of-the-art health services research methods to examine preferences for depression outcomes and how these preferences may reflect quality-of-life issues and/or trade-offs people consider in making treatment decisions. The second component highlights the relevance and importance of other rarely studied patient-centered constructs such as attitudes and expectations about depression and treatments. Finally, the relevance of these research methods, constructs, and preliminary findings to clinical practice, quality-of-life assessment, cost analyses, and policy formulations will be discussed.

No. 97B
HEALTH INSURANCE AND TREATMENT SEEKING FOR DEPRESSION

Shelly F. Greenfield, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont MA 02178;* Joelle M. Reizes, M.A., Larry Muenz, Ph.D., Barbara Kopans, B.A., Douglas G. Jacobs, M.D.

SUMMARY:

Objective: National Depression Screening Day (NDSD) is a voluntary, anonymous, community screening program. We conducted a telephone follow-up survey of participants in the 1996 NDSD to determine the effect of insurance status on whether participants followed the screening recommendation and the type of treatment they received.

Methods: We conducted a stratified random sample of NDSD attendees who agreed to participate in the follow-up study. Six months after screening, respondents were interviewed by trained interviewers using a structured questionnaire administered with a computer-assisted telephone interview (CATI) system.

Results: 1,502 telephone interviews were completed. Of these respondents, 918(62.5%) were told they had depression and should go for follow-up, and of these, 64.9% followed the recommendation. Those with insurance for mental health care were more likely to follow the screening recommendation than those without such insurance (74.6% vs. 55.3% p<.0001). Those with mental health insurance were three times as likely to see a psychiatrist and half as likely to discontinue treatment than were those without such insurance.

Conclusions: Among individuals participating in voluntary, community screening for depression who screen positive for depression, insurance status influences whether they follow the recommendation to obtain treatment as well as the type of provider they see for treatment.

No. 97C
MENTAL HEALTH CARE, EDUCATION SERVICES AND ADHD: WHO NEEDS TO PAY ATTENTION?

Regina Bussing, M.D., *Department of Psychiatry, University of Florida, Box 100234, UFHC, Gainesville FL 32610-0234;* Bonnie T. Zima, M.D.

SUMMARY:

This paper describes a conceptual framework for attention deficit/hyperactivity disorder (ADHD) recognition and help-seeking that takes into account the roles of family, school system, and health care providers, and that addresses the appropriateness of resulting care patterns. The policy contexts of ADHD identification and treatment for the health and education sectors are defined. The inherent challenges in selecting appropriate study designs, participants, and instruments are discussed, and steps in building cooperative relationships in nontraditional health service research settings are outlined. Findings from a school-district-wide study of detection and access to care for ADHD are presented, with special focus on the complementary uses of quantitative and qualitative research approaches. Study results indicated that significant numbers of children remained untreated, particularly females and children from minority backgrounds. School factors played an important role in prompting parental help-seeking in the medical sector and was seen as a source of ADHD interventions by many parents. Explanatory models of ADHD differed significantly by ethnicity. Primary care providers rendered the majority of ADHD treatment, almost exclusively using stimulants whose main effects occur during school hours. Yet contact between health providers and the child's school did not occur in one-half of the cases, even among the medicated children.

ADHD is an important treatable child psychiatric condition of relevance to the health and the education sector. Research evidence suggests that interventions in both sectors are currently poorly coordinated on the services level and not integrated at the policy level. Further studies are needed to provide guidance for policy makers in the health and education sector on service delivery models and approaches to service integration for this highly prevalent treatable child mental health condition.

No. 97D
IMPLEMENTING PRACTICE GUIDELINES FOR SCHIZOPHRENIA

Mark Olfson, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York NY 10032*

SUMMARY:

This presentation will describe the background, rationale, and development of a multisite, prospective, controlled study to evaluate an intensive guideline implementation intervention aimed at improving the short-term outcome of public sector patients with schizophrenia through a combination of (1) medication algorithms, (2) patient and family education, and (3) clinical support. The overall aim of this project is to evaluate whether an intervention that involves psychiatrist, patient, and family educational components improves the outcomes of patients with schizophrenia without increasing treatment costs. The project involves recruiting patient subjects from eight outpatient clinics operated by or affiliated with the New York State Office of Mental Health. The outpatient clinics will be matched in terms of the sociodemographic composition of the patients they treat and randomized by clinic to either the intervention or usual-care condition. The subjects will be independently evaluated four times over a 12-month period to assess psychiatric symptoms, side effects, adherence to prescribed medications, social and occupational functioning, quality of life, satisfaction with care, and mental health service utilization. Data will also be collected from service providers to estimate the direct costs of mental health service utilization of each group. Findings from this study will inform program planners and policy makers of the clinical effectiveness and financial costs of applying medication algorithms in combination with supportive and educational services to the treatment of schizophrenia.

No. 97E
IMPROVING TREATMENT RESOURCES FOR PRIMARY CARE DEPRESSED PATIENTS IN MANAGED CARE: THE PARTNERS IN CARE APPROACH

Kenneth B. Wells, M.D., *Department of Psychiatry, UCLA-NPI, 760 Westwood Plaza, Los Angeles CA 90024;* Lisa V. Rubenstein, M.D., Jurgen Unutzer, M.D., Jeanne Miranda, Ph.D., Maga Jackson, M.D.

SUMMARY:

Recent research has demonstrated that rates of appropriate care for depressive disorders are low in primary care, especially in managed care settings. These low rates of appropriate care may lower the cost-effectiveness of care relative to current practice guideline recommendations. This paper describes the interventions for improving care for depression developed for Partners in Care, a large randomized trial being conducted in seven managed care organizations in five U.S. sites. The interventions have the unique feature of being designed for implementation by practices themselves with minimal support from the development team. They involve basic quality improvement, consisting of provider education through expert practice leaders, and patient education and enhanced clinical assessments through depression nurse specialists; as well as intervention-specific resources, primarily a nurse case-management approach to facilitating medication management, and a method to implement rigorous cognitive behavioral therapy in usual managed care settings. The intervention protocols permit freedom of choice in treatment selection by patients and providers, and implementation emphasizes flexibility in adapting the basic clinical care models to resources and structure of managed care organizations. The interventions require substantial commitment of resources by participating organizations and acceptance of responsibility by an interdisciplinary clinical care team in the practices. Issues in designing and implementing the interventions will be discussed, and the first stages of the design and implementation of the five-year study will be reviewed. The approach will be compared with several other leading quality improvement approaches and evaluation designs, which tend to be more similar to a basic clinical efficacy research model or utilization-review-based quality improvement.

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SYMPOSIUM 98—21ST CENTURY PSYCHIATRY: INTERNET APPLICATIONS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To provide clinicians and researchers with a practical overview of resources currently available on the Internet. They will develop an understanding of how changes in computer technology are and will be impacting the field of psychiatry as we approach the 21st century.

No. 98A
RESOURCES FOR PSYCHIATRISTS ON THE INTERNET

Rima Styra, M.D., *Department of Psychiatry, The Toronto Hospital, 200 Elizabeth Street/EN8-235, Toronto, ONT M5G 2C4, Canada*

SUMMARY:

The Internet is the world's largest computer network providing access to over 50 million pages of information. It is revolutionizing the way that psychiatrists and health care professionals from around the world communicate and share information with each other. This medium will continue to grow as more and more information becomes converted from paper to digital form. The advantage of digital format as found on the Internet is that information can be accessed in a nonlinear manner through hyperlinks. This means that the user can use self-directed learning and focus on primary areas of interest using worldwide resources while saving time.

There are a growing number of resources that are relevant to psychiatrists on the Internet. These resources provide a variety of information on such topics as diagnosis and psychopharmacology, as well as access to Medline searches, journals, psychiatric associations, and clinical trials. This allows psychiatrists practicing in rural areas access to library systems similar to major university centers. Psychiatrists can access this information from their office or their homes at their convenience 24 hours per day, seven days per week. This presentation will provide a review of resources on the Internet that are relevant to psychiatrists as well as identify material that patients might be reading online.

No. 98B
PSYCHIATRY EMBRACING NEW TECHNOLOGY: TELE-NEURO-PSYCHIATRY

Turan M. Itil, M.D., *Div. Biological Psych, NY Institute, 150 White Plains Road, Tarrytown NY 10591-5521;* Kurt Z. Itil, Pierre Le Bars

SUMMARY:

Tele-neuro-psychiatry is the application of high technology communication systems to enhance diagnosis and treatment of rural area patients by using experts from remote expert centers. The system, which we originally developed for the research of the World Health Organization and is presently being used by the Memory Centers of America, includes the following components: *(1) Data collection in remote units:* Expensive and time-consuming differential diagnostic procedures, which are routinely required by the Food and Drug Administration, have been condensed, simplified, and put in clinically practical format to be used in remote outpatient units. *(2) Quality control in expert centers:* The objective (neuropsychological, cognitive, psychological, and electrophysiological [EEG, QEEG/brain mapping, evoked potential]) and subjective behavioral evaluation data collection in rural units are monitored and supervised for quality and reliability through the experts in the expert centers. *(3) Data transmission and analysis:* The collected raw data in remote units are transmitted via telemedicine procedures and/or Internet to expert centers. The data are analyzed, quantified, compared with database norms, and clinically relevant information is prepared in reports along with historical data. *(4) Expert opinions:* With comprehensive reports on subjective and objective data in hand, experts can interview patients and family and/or discuss with the treating physician, face to face, using a telepicture system. Expert opinion is provided on the diagnosis and treatment of the patients. In the absence of objective procedures to make a diagnosis in a variety of psychiatric disorders, expert clinicians are required, particularly for early diagnosis. Treatment is much more difficult when patients become chronic. Tele-neuro-psychiatry brings expert clinicians to the rural area patients in a most cost-effective manner.

No. 98C
EMERGING TRENDS IN NETWORKED PSYCHIATRY

Stephen Pogorski, Ph.D., *34 Rockcastle Drive, Etobicoke, ONT M9R 2V1, Canada*

SUMMARY:

Computer technology has been advancing at an astounding rate, with the power of computer chips doubling approximately every 18 months. This growth phenomenon has made it possible for psychiatrists and the population at large to access more information at increasingly affordable prices and from a larger, more global information base.

The goal of this presentation is to highlight the forces driving technological developments and to discuss the impact that these developments will have on psychiatrists. The presentation will move from a brief historical review to a scan of emerging technologies. Topics to be discussed will include advancements forecast in microprocessor technology; developments in intelligent software; the future of mass storage; network computing; new technologies that will impact connectivity and transmission of information on the Internet; as well as other exciting new technologies. The relevance of these technologies will be discussed with respect to issues that impact psychiatrists as they use the Internet today such as privacy, ease of use, speed of access, interactivity, shared databases, and push/pull technology.

No. 98D
PATIENTS' CONTACT WITH PSYCHIATRISTS VIA E-MAIL IN CLINICAL PRACTICE

Kenneth R. Silk, M.D., *Dept. of Pscyh. Bldg CFOB, Univ. of Michigan Med. Ctr., 1500 E Med. Ctr. Dr. Rm2954, Ann Arbor MI 48109-0704*

SUMMARY:

Electronic mail (e-mail) and e-mail addresses have become more readily available. Many of our patients now have the ability to access us through Internet Yellow Page postings, search engines, mental health Web sites, or simply because of the listing of an e-mail address on one's business card. Thus we can expect that our patients may begin to contact us between sessions via e-mail. The types of correspondence that our patients send to us via e-mail can be quite varied ranging from the need to change appointment times, notification of a need for medication renewal, or other information that some might consider to be reasonably factual and straightforward, to more complex messages such as reactions to previous sessions, pleas for a need for more or immediate contact with us, notification of a plan to terminate therapy, or other messages that could imply contamination of the boundaries around office visits or infringement on the psychiatrist's personal boundaries. While the response to any and all of these e-mail contacts will vary according to the theoretical approach of the psychiatrist as well as the diagnostic category of the patient, there needs to be a professional dialogue to explore the nature of these communications as well as how psychiatrists might or should respond. Some of the questions that might be considered include: Are e-mail communications part of the medical record? Since e-mail is not confidential, how might we protect patients' confidentiality while continuing to have dialogue via e-mail? What are the patient's expectations re the psychiatrist's response to receipt of an e-mail? This presentation will outline further issues related to e-mail contact between patient and therapist and will also present clinical examples from actual patient-psychiatrist e-mail communication that illustrate possible uses as well as limits to the use of e-mail in clinical practice.

No. 98E
CONTINUING EDUCATION IN PSYCHIATRY VIA THE INTERNET

Ivan L. Silver, M.D., *Department of Psychiatry, University of Toronto, 2075 Bayview Avenue FG21, Toronto ON M4N 3M5, Canada*

SUMMARY:

The Internet is changing the face of continuing medical education and psychiatry. No longer do clinicians need to leave their offices to attend a CME event; they can access information, contact an expert, and ask questions that are specifically relevant to their needs. The Internet has the potential for fulfilling all of the criteria for effective CME including teaching that is learner-centered, contextually relevant, interactive, longitudinal, and accessible to evaluation of outcome. Few university departments of psychiatry in North America have formally embraced the education potential of providing continuing education via the Internet. Industry and corporation sponsored sites on the Internet are now offering continuing education programs in various specialties in medicine or are replaying CME events that have already taken place.

Issues that few continuing education providers via the Internet have addressed include: using the Internet to conduct continuing education needs assessments with targeted audiences, using cases or problem-based learning formats, addressing the fee structure for courses and conferences via the Internet, and using the Internet to conduct outcome studies of CME interventions.

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SYMPOSIUM 99—PRACTICING EVIDENCE-BASED PSYCHIATRY: BIPOLAR DISORDER
APA Steering Committee on Practice Guidelines

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To integrate practice guidelines, assessment tools, and clinical data for the treatment of bipolar disorder. At the conclusion of this presentation, participants would be able to apply principles of evidence-based medicine to the treatment of patients with bipolar disorder.

No. 99A
USE OF FORMAL MEASURES IN CLINICAL CARE

Jacqueline Samson, Ph.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont MA 02178;* Kimberly A. Yonkers, M.D., Laurie McQueen, M.S.W.

SUMMARY:

The Handbook of Psychiatric Measures, being developed by the APA, is an evidenced-based guide to educate clinicians in evaluating, interpreting, and using measures. Envisioned as a "toolbox" with instructions for psychiatric measures, it will cover various domains of assessment including symptoms, function, and outcomes. The handbook's purpose is to provide clinicians in mental health settings with a guide to available measures that are useful in the clinical care of patients or for the interpretation of treatment and services research.

This project responds to challenges and opportunities presented by health care reform, managed care, and patient care needs. Public and private entities are developing new methods for measuring and reviewing psychiatric care that may not reflect good research or the perspective of clinicians. Mental health providers and patients are being held to "criteria" for the determination of access to services or for inclusion in care networks. Many clinical and policy issues are affected by the selection and application of measures: eligibility determinations, outcomes assessment, risk adjustment, quality assurance, utilization review, and practice guideline-related activities.

How to choose, use, and interpret measures for clinical use with bipolar disorder is the presentation's focus. Topics include goals of assessment, implementation issues, interpreting psychometric data, and the selection of measures of severity and screening for BPD.

No. 99B
CLINICAL PRACTICE GUIDELINES FOR TREATMENT

Robert M.A. Hirschfeld, M.D., *Department of Psychiatry, University of Texas, 1200 Graves Bldg. Rt. D-29, Galveston TX 77555-0429;* Harold Alan Pincus, M.D., Leslie Seigle

SUMMARY:

The American Psychiatric Association's practice guideline project is committed to the promotion of evidence-based psychiatry to improve patient care. APA practice guidelines are designed to result in documents that are both scientifically sound and clinically useful to psychiatrists by adhering to a development process that ensures clinical consensus, using standards from the Institute of Medicine and the American Medical Association. Well-constructed guidelines offer a critical review and synthesis of a rapidly expanding treatment literature; a framework for clinical decision making and, within it, recommendations for treating a "typical" patient with a given diagnosis; and consideration, in light of research data, of the implications of specific clinical features for treatment recommendations.

The bipolar disorder practice guideline was published in 1994. The guideline, which will be updated in 1998–1999, covers various treatment principles and alternatives. Pharmacological treatments (e.g., lithium and anticonvulsants) and psychotherapy (e.g., psychosocial and environmental approaches in manic episodes) are reviewed. The revised guideline will update the recommendations made in 1994 based on the literature now available.

No. 99C
WHAT'S REALLY GOING ON IN THE TREATMENT OF BIPOLAR DISORDER?

Ellen Leibenluft, M.D., *Psychobiology, NIMH, Bldg 10, Rm 4S239, 10 Center Drive, MSC 1390, Bethesda MD 20892;* Deborah A. Zarin, M.D., Ana P. Suarez, M.P.H., Harold Alan Pincus, M.D.

SUMMARY:

Practice-based data collected through APA's Practice Research Network (PRN) regarding the treatment of bipolar disorder will be presented. The APA PRN consists of 500 psychiatrists nationwide practicing in routine clinical practice settings who collaborate to conduct clinical and services research. Detailed information regarding the sociodemographic and clinical characteristics (e.g., co-occurring disorders, level of functioning) of patients with bipolar disorder seen by psychiatrists will be presented. Treatment practice patterns including history, services provided, medication usage (dosage and type), and future treatment plans will be highlighted. Factors that may impact the provision of care, such as health care financing issues (e.g., payment source, type of health plan, utilization management techniques) and psychiatrist characteristics, and clinical decision making will be examined. Comparisons of current psychiatric practice patterns for the treatment of bipolar disorder to external measures of quality, such as the APA practice guidelines, will be made.

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SYMPOSIUM 100—BIOLOGICAL RHYTHMS: DEPRESSION TREATMENT IMPLICATIONS
Joint Session With the Asher Depression Center/Feinberg Clinical Neuroscience Research Institute at Northwestern University

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium the participant should be able to understand the implications of newly emerging information about biological rhythms for the design of treatment programs for depressive disorders.

No. 100A
MODULATORY ROLE OF MELATONIN ON CIRCADIAN RESPONSES

Margarita L. Dubocovich, Ph.D., *Molecular Pharmacology, Northwestern University, 303 East Chicago Avenue, Chicago IL 60611*

SUMMARY:

Alterations in the light-dark cycle and the production of the hormone melatonin may lead to disruptions of the sleep/wake cycles and to depression. The goal of this presentation is to discuss the possible behavioral, molecular, and neurochemical mechanism(s) involved in the modulation of circadian rhythms by melatonin and its interaction with light. Activation of melatonin receptor(s) in retina and/or the hypothalamic suprachiasmatic nucleus by administration of exogenous melatonin to the C3H/HeN mouse, either advance (CT 10) or delay (CT 22) circadian activity rhythms. The phase advances by melatonin appear to be mediated through activation of specific melatonin receptors as this effect is antagonized by the melatonin receptor antagonist luzindole. The melatonin receptor subtypes (MEL_{1A} and/or MEL_{1B}) involved in mediating the phase shifts and the increases in the rate of reentrainment following a phase advance of the light-dark cycle are being studied using selective MEL_{1B} melatonin receptor antagonists (e.g., 4-P-PDOT). New findings on melatonin modulation of light-mediated phase shifts during subjective night as well as the neurochemical implications of this interaction for the treatment of circadian disturbances will be addressed and discussed in relation to their antidepressant potential.

Supported by NIMH 42922 and MH 52685.

No. 100B
DISRUPTION OF CIRCADIAN RHYTHMICITY: EFFECTS ON MOOD, PERFORMANCE AND SLEEP

Phyllis Zee, M.D., *Department of Neurology, Northwestern University, 222 East Erie, Room #500, Chicago IL 60611*

SUMMARY:

Human physiological, hormonal, and behavioral processes all exhibit circadian rhythmicity. One of the most prominent circadian rhythms is the daily cycles of sleep and wakefulness. Components of sleep, such as the total amounts of sleep, level of drowsiness, and alertness are also regulated by the circadian system. In addition to physiological variables, the circadian signal can cause human performance and mood to vary during the course of the 24-hour

day. Some psychological processes, including memory, subjective feelings of vigor, and mood, show circadian variation. Under normal conditions, levels of neuropsychological performance and mood reflect a combination of the influence of the central circadian clock and the sleep homeostatic process. When there is a disruption of circadian rhythmicity, physiological and psychological functioning are impaired. Therefore, it is not surprising that disrupted circadian rhythms have been associated with sleep and mood disorders, indicating the importance of an intact circadian system for the health of the individual.

The presentation will focus on recent advances in research and their implications for the clinical management of sleep and mood disorders that have been associated with circadian rhythms abnormalities. Some of the topics that will be covered include insomnia due to sleep-phase disorders, depression, seasonal affective disorder, and aging.

No. 100C
BIOLOGICAL RHYTHMS AND CLINICAL PSYCHOPHARMACOLOGY

James J. Stockard, M.D., *882 Forest Avenue, Evanston IL 60202-2402*

SUMMARY:

Few clinicans consider the mutual interactions of biological rhythms and psychopharmacological agents. Yet, commonly prescribed agents may significantly impact circadian rhythms. It has been suggested that lithium's efficacy in bipolar disorder may even be related to its effect upon biological rhythms. Many clinical questions remain to be addressed as chronobiological research progresses. What impact does time of day have upon the pharmacokinetics and pharmacodynamics of psychotropic medications? Might there be optimal times to dose individual psychotropic medications, as has been suggested for some forms of chemotherapy? What effect do psychotropic medications themselves have upon normal and abnormal biological rhythms? In the future may chronobiological measurements guide us in our treatment selection? Psychiatric clinicians working in biological rhythm research settings have a unique opportunity to collaborate with research colleagues in the search for answers to the above questions.

No. 100D
ANIMAL MODELS: LINKING CIRCADIAN RHYTHMS WITH AFFECTIVE DISORDER

Fred Turek, Ph.D., *Dept. of Neurobiology, 2153 Campus Drive, Evanston IL 60208*

SUMMARY:

Disturbances of circadian rhythmicity have been associated with adverse effects on both mental and physical health in humans. Indeed, there is now a large amount of evidence to indicate that one of the most common mental illnesses, depression, is associated with abnormalities in circadian timing. However, cause-and-effect relationships between such abnormalities and mood state have not been established. There are now a number of rodent animal models in which circadian rhythmicity can be disrupted, and these models may prove useful in determining the linkage between circadian abnormalities and depressed mood. Animal models to be discussed in this presentation include: (1) mice with single gene mutations that lead to dramatic changes in both the period and stability of circadian rhythmicity as well as the duration of sleep, (2) mice and rats with altered circadian rhythms and depressive-like symptoms due to chronic mild stress, to acute stress, or to acute prenatal stress, and (3) mice, rats, and hamsters in which antidepressive drugs are used to alter circadian rhythmicity. It is anticipated that these animal models will lead to a better understanding of the genetic and physiological bases for both normal and abnormal temporal organization, and that this such information will be useful in not only linking circadian abnormalities with alterations in mood, but also for developing countermeasures that could lead to the normalization of rhythmicity and mood.

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SYMPOSIUM 101—TREATING NICOTINE DEPENDENCE IN PSYCHIATRIC PATIENTS
Collaborative Session With the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

Utilize effective strategies to motivate psychiatric patients to attempt smoking cessation; treat nicotine dependence in patients with depressive disorders, schizophrenia, and comorbid alcohol and substance abuse/dependence; and utilize new pharmacotherapeutic approaches to treat patients who have failed nicotine patch and gum therapy.

No. 101A
MOTIVATING PSYCHIATRIC PATIENTS TO ATTEMPT SMOKING CESSATION

Michael G. Goldstein, M.D., *Department of Psychiatry, The Miriam Hospital, 164 Summit Avenue, Providence RI 02906*

SUMMARY:

Despite the health risks associated with smoking, more than 75% of smokers are not willing to commit to a quit attempt in the foreseeable future. Psychiatric patients appear to be even less likely to be motivated to quit than smokers without psychiatric disorders. Smokers who are not committed to quitting require interventions that are tailored to their level of motivation. Factors to consider in assessing motivation among smokers include patients' understanding of the harmful effects of smoking, their reasons for smoking (including their perceptions of the benefits of smoking), their fears and concerns about quitting, other barriers to quitting (e.g., lack of resources, lack of social support for quitting), and their past experience with quitting. Motivational approaches that have been demonstrated to be effective for increasing entrance into treatment among patients with alcohol dependence (by Miller and Rolnick and others) have also been applied to treating smokers, with promising results. The principles and strategies of motivational counseling will be discussed and applied to a specific case example.

No. 101B
SMOKING CESSATION IN PATIENTS WITH DEPRESSION

Alexander H. Glassman, M.D., *Clin. Psychopharmacology, NY State Psychiatric Institute, 722 West 168th Street, New York NY 10032–2603;* Lirio S. Covey, Ph.D.

SUMMARY:

In 1987 Hughes documented what many clinicians instinctively knew—that psychiatric patients are more likely to smoke than the general population. Two years later, we were able to show that this increased smoking applied not just to patients who were presently ill, but to anyone with a history of depression. What is more, when these individuals with a lifetime history of depression tried to stop, they were more likely to fail. To complicate the situation even further, it is now clear that when individuals with a history of depression successfully stop, they are at increased risk of a depressive relapse.

For these reasons, smoking cessation is a complex issue in a patient with a history of or present major depression. Probably any such smoker should try to quit on their own because some do succeed without difficulty. However, for those who are not presently on an antidepressant and become depressed when they try to stop, or those with a history of multiple depressive episodes, the best documented treatment is a combination of transdermal nicotine and bupropion.

No. 101C
TREATING NICOTINE DEPENDENCE IN SUBSTANCE-ABUSING PATIENTS

Raymond S. Niaura, Ph.D., *Department of Psychiatry, Miriam Hospital, 164 Summit Avenue, Providence RI 02906*

SUMMARY:

Most substance abusers, especially alcoholics, smoke. Smoking cessation in substance abusers has largely been ignored, with the focus placed on treatment of the other substance use disorder(s). However, most alcoholics and substance abusers, especially those who attain sobriety, are at increased risk of morbidity and mortality from smoking-related illnesses because they continue to smoke. Most substance abusers express a desire to quit smoking, although they are mixed in terms of when would be a good time to attempt to quit. Thus, timing of smoking cessation in the context of treatment for substance abuse is an unanswered question, but it appears imprudent to begin smoking cessation treatment prior to attaining sobriety. From the little available data, it appears that smoking cessation does not jeopardize sobriety from other substances. It is unclear that substance abusers would necessarily require different treatments for smoking cessation compared with non substance abusers. However, substance-abusing smokers tend to be more nicotine dependent and may, therefore, require more intensive treatment with conventional therapies such as nicotine replacement and behavioral therapy. Use of 12-step programs for nicotine dependence may have some appeal for subgroups of substance abusers. New antidepressant treatments for smoking cessation may be particularly efficacious for substance abusers with comorbid depressive disorders.

No. 101D
TREATING NICOTINE DEPENDENCE IN SCHIZOPHRENIA PATIENTS

Douglas M. Ziedonis, M.D., *Department of Psychiatry, Yale University, 34 Park Street, New Haven CT 06508*

SUMMARY:

Heavy nicotine use is common among individuals with schizophrenia and has become of increasing concern since the initiation of smoke-free units. Patients are often poorly motivated to quit smoking, and they drop out of the typical smoking cessation programs when more motivated. This presentation will review effective treatment strategies and differences from traditional smoking cessation programs based on clinical experience and research.

Our smoking cessation program is within a community mental health center, and treatment includes nicotine replacement and behavioral therapy. Pharmacotherapy strategies include switching to atypical neuroleptics, higher dose nicotine patch, combining nicotine replacements (i.e., gum and patch), and augmentation medication to nicotine replacement (i.e., buproprion or buspirone). The psychosocial therapy includes individual motivational enhancement therapy (MET) and group supportive, behavioral, and psychoeducation therapy modified for population. Tobacco smoking alters the blood level and effectiveness of many antipsychotic medications, may modify both positive and negative symptoms during chronic usage and withdrawal states, and is a clue for the presence of other substance abuse.

In our studies, higher intensity psychosocial treatment with MET and nicotine replacement improved outcomes. At six months, about 15% remained completely abstinent, and 50% reduced their usage and stayed in smoking-cessation treatment. Managing smoking on inpatient units will also be discussed in this presentation.

No. 101E
TREATING FIRST-LINE FAILURES

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

SUMMARY:

The APA Guideline on Nicotine Dependence recommends that smokers who have failed initial therapy with nicotine replacement and/or behavior therapy be assessed for their motivation to make another quit attempt, the adequacy of their prior therapy (if inadequate retreat with adequate therapy), psychiatric comorbidity (if present, then treatment), and cause of relapse. If the cause of relapse appears to be withdrawal related, the guideline recommends clonidine, nicotine patch + gum, nicotine nasal spray, or higher-dose nicotine patch therapy. In addition, bupropion and nicotine inhalers are now available as treatments. If the cause is due to nonwithdrawal stressors, it recommends more intensive behavior therapy. This presentation will focus on choosing among the different pharmacotherapies for treatment failures.

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SYMPOSIUM 102—BIPOLARITY AND COMORBIDITY: CLINICAL MANAGEMENT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: diagnose the entire spectrum of bipolarity, with its complex

comorbidies, and to develop a rational therapeutic plan that takes such comorbidity into consideration.

No. 102A
BIPOLAR DISORDERS: THE ANXIOUS CONNECTION

Susan L. McElroy, M.D., *Department of Psychiatry, Univ of Cincinnati Col of Med, 231 Bethesda Avenue, ML 559, Cincinnati OH 45267-0559*

SUMMARY:

Mounting clinical and epidemiological data suggest that there is a link between bipolar disorder and anxiety. First, anxiety may occur in mania and depression and is a common symptom of mixed states. Indeed, Kraepelin described the mood of mixed mania as "despairingly anxious." Second, anxiety disorders (e.g., panic disorder and obsessive-compulsive disorder) co-occur in persons with bipolar disorder more often than expected by chance alone and significantly more often than in persons with unipolar depressive disorders. However, little research has examined the effect of comorbid anxiety symptoms and disorders on the presentation, course, and treatment response of bipolar disorder. In this presentation, data on the overlap between bipolar and anxiety disorders will be summarized. Then the implications of this overlap on the presentation, course, and treatment of bipolar disorder will be discussed.

No. 102B
BIPOLAR II, RAPID CYCLING, MIXED STATES AND BORDERLINE PERSONALITY

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

SUMMARY:

There is increasing realization that classic bipolarity extends into a "softer" realm (bipolar II). When retarded depression and discrete hypomanic episodes alternate, the diagnosis is relatively easy; except when clinically depressed many of these patients are high functioning ("sunny" bipolars). There also exist bipolar II's who are cyclothymic between depressive episodes and therefore unstable; they often meet the criteria for borderline personality and are vulnerable to rapid-cycling. Although conventional wisdom suggests that pharmacotherapy may be relatively ineffective in affective patients with borderline personality—and this is certainly true if one has in mind TCA's and lithium—the skillful use of SSRI's, MAOI's, and anticonvulsants can considerably attenuate the emotional storms of these patients. There also exist highly irritable individuals with depressive episodes who are best considered as protracted mixed states. Although these dysphoric states could be similarly managed, antidepressants should be used sparingly. This literature comes primarily from clinical considerations, but sufficient data from controlled studies exist to support the use of specific mood stabilizers and avoidance of certain antidepressants. Borderline as a diagnostic label may be redundant in bipolar spectrum disorders. Indeed the pharmacological profile of borderline personality appears comparable to that of rapid-cycling and bipolar mixed forms.

No. 102C
BIPOLAR DISORDER AND SUBSTANCE ABUSE

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

SUMMARY:

Recent epidemiologic data indicate that bipolar disorder is the Axis I diagnosis with the highest odds ratio for co-occurrence with a substance use disorder. Data from this study also indicate that the substance use disorder often develops after the onset of bipolar disorder, indicating that early and aggressive intervention may be helpful. A number of studies also have shown that substance use adversely impacts the outcome and prognosis of bipolar disorder and is associated with medication noncompliance, suicidality, and hospitalization. Order of onset of affective disorder relative to the substance use disorder may have an impact on the treatment effectiveness and course of illness. Unfortunately, there are few data available concerning appropriate treatment interventions for individuals with comorbid bipolar disorder and substance use. In this presentation, recent data on prevalence and clinical course of bipolar disorder complicated by substance use disorders will be reviewed. Preliminary outcome data from a specific group therapy targeting comorbid bipolar disorder and polysubstance dependence will be presented. Data from a recent trial of carbamazepine in 170 cocaine-dependent individuals stratified for the presence or absence of affective disorder will also be presented. In that study, individuals with bipolar disorder had significantly less cocaine use when treated with carbamazepine compared with the placebo group.

No. 102D
JUVENILE MANIA: MIXED STATES IN ADHD

Joseph Biederman, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, ACC-725, Boston MA 02144*

SUMMARY:

Although considered rare in children, bipolar disorder (BPD) is one of the most impairing forms of child psychopathology. Its diagnosis has been controversial because of diagnostic uncertainties, especially its symptomatic overlap with attention deficit hyperactivity disorder (ADHD). In contrast to the severe mood instability that characterizes manic symptomatology, inattention, impulsivity, and hyperactivity are characteristic of both ADHD and BPD. Our group reported findings using systematic structured interview data that were collected from a sample of 262 consecutively referred preadolescent children (<12 years of age). This study found that: (1) 16% met full DSM-III-R diagnostic criteria for mania, (2) the clinical picture in these young manic children was characterized by severe irritability, their presentation was predominantly mixed, with symptoms of major depression and mania co-occurring, (3) the course was chronic, (4) manic children often met diagnostic criteria for ADHD, (5) manic children had severely impaired psychosocial functioning and high rates of psychiatric hospitalization (20%), and (6) excellent convergence was found between CBCL scales and the structured diagnostic interview derived diagnosis of mania and related conditions indicating that the structured diagnostic interview findings were not due to assessor bias. After removing overlapping symptoms, the majority of children continued to meet criteria for both ADHD and BPD. Considering that both ADHD and mania are familial disorders and that family aggregation studies are uniquely helpful in examining complex patterns of comorbidity, a family genetic study of our manic children was undertaken.

This family genetic study of first-degree relatives of children with BPD and ADHD found that (1) relatives of BPD+ADHD probands and ADHD probands were at significantly greater risk for ADHD than relatives of normal controls, (2) the two groups did not significantly differ from one another in their relatives' risk for ADHD, (3) an elevated risk for BPD was observed only among relatives when the proband child had BPD+ADHD but not when the proband had ADHD alone, (4) an elevated risk for major depression was found for relatives of both subgroups of ADHD probands, but the risk was greatest for relatives of probands with BPD+ADHD, (5) both ADHD

and BPD occurred in the same relatives more often than expected by chance alone (i.e., they cosegregated), and (6) no significant nonrandom mating between ADHD and BPD parents was found. These findings were fully replicated in another sample of children with ADHD who had comorbid BPD. Taken together these results supported the hypothesis that BPD+ADHD (or ADHD+BPD) is a familially distinct subtype of either BPD or ADHD. Finally, the occurrence of manic symptoms significantly predicted the subsequent prescription of mood stabilizers and mood stabilizers predicted decreases in manic symptoms.

No. 102E
NEUROLOGIC COMORBIDITY AND MANIA IN OLD AGE

Kenneth I. Shulman, M.D., *Dept. of Psychiatry, Sunnybrook Health Science Ctr, 2075 Bayview Ave, Toronto, ONT M4N 3M5, Canada*

SUMMARY:

Studies of elderly bipolar patients reveal a high prevalence of heterogeneous neurologic disorders including cerebrovascular lesions, head trauma, and brain tumors. The outcome of manic episodes in old age is associated with significant morbidity and mortality even when compared with age- and sex-matched elderly depressives. Many of these late-onset bipolar patients appear to meet criteria for secondary mania, hence the integration of data on the elderly with findings from the neurological literature is particularly relevant.

The neurological literature has examined disinhibition syndromes and cases of secondary mania in association with lesions lateralized to the right hemisphere of the brain and localized to the orbitofrontal and basal temporal cortex. These brain regions are functionally connected to the frontal and limbic systems as part of a functional circuit known as the orbito-frontal circuit (OFC). Thus the neurologic comorbidity found in elderly bipolars helps to form a framework for understanding mania in old age. The evidence suggests that an affective vulnerability in association with specific brain pathology involving the OFC may account for the late manifestation of mania. Findings of neurologic comorbidity in old age may help to elucidate the pathogenesis of bipolar disorders in younger patients.

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SYMPOSIUM 103—EATING DISORDERS: PATHOGENESIS, COURSE AND TREATMENT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

Participants will become acquainted with recent developments in eating disorders concerning pathogenesis, vulnerability factors, course and outcome of bulimia nervosa including new data on mortality, and revised recommendations for practice guidelines from the American Psychiatric Association.

No. 103A
THE FUNCTION OF LEPTIN IN ANOREXIA NERVOSA

Katherine A. Halmi, M.D., *Department of Psychiatry, Cornell Medical College, 21 Bloomingdale Road, White Plains NY 10605-1504;* Margherita Maffei, Ph.D., Hong Wang, B.A., Jeffrey R. Friedman, M.D., Claire Wiseman, Ph.D.

SUMMARY:

Leptin, the gene product of the ob gene is a 16-kilodatton protein that is present in mouse and human plasma and is highly correlated with body mass index (BMI = weight Kg/height m^2). Since leptin may have a role in regulating body weight, leptin dysregulation could influence the emaciation in anorexia nervosa (AN).

Anorectic-restrictors (AN-R) 21, anorectic-bulimics (AN-BP) 20, and normal-weight controls 15, were studied. Eighteen anorectics were tested pre/post treatment.

The mean leptin level in controls was 13.22 ng/ml ± SD 5.79. Pretreatment mean leptin level in the 43 anorectic patients was 5.61 ng/ml ± SD 8, with a range of 0–38 ng/ml. In the AN there was a significant correlation between BMI vs. leptin ($r = .678$, $p = .0001$). The mean change in leptin levels over treatment in 18 AN was 15.27 ng/ml with a mean change in BMI of 2.53. Both were highly significant (+ = 3.7, $p = .003$; + = 6.78, $p = .0001$, respectively) changes and were correlated ($r = .71$, $p = .006$).

The low leptin levels in AN are most likely due to decreased adipose tissue. These data indicate that AN is not the result of overexpression of leptin.

No. 103B
VULNERABILITIES CONTRIBUTING TO EATING DISORDERS

Walter H. Kaye, M.D., *Department of Psychiatry, Western Psycn. Institute & Cl., 3811 O'Hara Street, Pittsburgh PA 15232;* Lisa Lillerfelld, Ph.D., Kathleen R. Merikangas, Ph.D., Michael Strober, Ph.D., Katherine Plotnikov, Ph.D.

SUMMARY:

Only a small percentage of women exposed to psychosocial influences regarding weight and appearance develop anorexia nervosa (AN) or bulimia nervosa (BN). Underlying biological vulnerabilities may place someone at risk for these disorders. Research has suggested that increased serotonin activity may be inhibitory to feeding, stimulus reactivity, aggression, and sexual activity; that patients with BN and AN both have high levels of "harm-avoidance" (a personality trait hypothesized to be related to increased serotonin activity); both AN and BN respond to SSRI medication; and following recovery, women who have had AN and BN have similar levels of obsessive perfectionism and exactness, mild negative mood states, and elevated CSF levels of 5-HIAAA, the major serotonin metabolite. Therefore, trait-related disturbances in neuromodulation involving the metabolism of serotonin may contribute to vulnerability to eating disorders. We postulate that in spite of differences between them, a basal condition of restriction and behavioral inhibition may be common to AN and BN. In BN periodic disinhibition of eating may occur, but in AN the inhibition and behavioral overcontrol may be constant. This presentation will review related research and discuss potential implications for pathogenesis and treatment.

No. 103C
MORTALITY IN EATING DISORDERS

David B. Herzog, M.D., *Department of Psychiatry, Harvard Medical School, 15 Parkman Street, EDU 725-ACC, Boston MA 02146;* David J. Dorer, Ph.D., Ana Richards, A.B., Rebecca A. Burwell, B.A., Karin M. Nussbaum, B.A., Dara W. Greenwood, B.A., Andrea T. Flores, M.Ed., Mark A. Blais, PsyD.

SUMMARY:

Mortality for anorexia nervosa is among the highest of any psychiatric disorder, particularly compared with other disorders in young adult women. Mortality of 10% to 20% has been reported in some follow-up studies. In a recent meta-analysis, Sullivan et. al. reported a meta rate of 5.6% per decade. However, few longitudinal studies of anorexia nervosa have systematically evaluated mortality, and, to our knowledge, no long-term bulimia nervosa studies have systematically assessed mortality.

The MGH prospective naturalistic Longitudinal Study of Anorexia Nervosa and Bulimia Nervosa, now in its 10th year, has studied anorexia nervosa and bulimia nervosa in 250 treatment-seeking women through evaluations at frequent intervals. A preliminary survival analysis indicates a death rate of 0.50% per year (unadjusted) for this sample.

We will discuss mortality in this sample, including rates for anorexia nervosa and bulimia nervosa, causes of death, and factors that put the anorexic or bulimic patient at greater risk for death. We will discuss education of the public, treatment of patients with eating disorders, willingness of providers to treat these patients, and funding of eating disorders research.

No. 103D
LONG-TERM OUTCOME OF BULIMIA NERVOSA

James E. Mitchell, M.D., *Department of Psychiatry, Neuropsychiatric Research Ins., 700 First Avenue South/Bx 1415, Fargo ND 58107;* Pamela K. Keel, B.A., Scott Crow, M.D.

SUMMARY:

This paper will review the available literature on follow-up and outcome in naturalistic and treatment studies of patients with bulimia nervosa. Emphasis will be placed on predictors and correlates of outcome in various studies. Data from a 10–15-year follow-up study of individuals with bulimia nervosa seen for initial evaluation between 1981–1987 will also be presented. All subjects were screened using the SCID-I and Hamilton Depression Scale. All subjects also completed a number of self-report forms including the Eating Disorders Questionnaire, the Weissman Social Adjustment Scale, and the MPQ Impulsivity Scale. Of the 220 women in the sample, 200 (90.1%) were located and 179 (80.6%) agreed to participate. At long-term follow-up, 11% continued to meet full criteria for bulimia nervosa and 18% met criteria for EDNOS. Baseline treatment condition did not predict eating disorders outcome at long-term follow-up. Data on predictors of outcome and various correlates of outcome will be presented.

No. 103E
THE APA'S EATING DISORDER PRACTICE GUIDELINE: REVISED

Joel Yager, M.D., *Department of Psychiatry, University of NM School of Med, 2400 Tucker, NE, Albuquerque NM 87131;* Helen L. Egger, M.D., Deborah A. Zarin, M.D.

SUMMARY:

The Practice Guideline for Eating Disorders, the first of the American Psychiatric Association's practice guidelines to be written, was published in February 1992. As per plan, APA's practice guidelines are to have "minor" revision every three to five years and major revisions every 10 years. The revision of the Practice Guideline for Eating Disorders includes up-to-date reviews of data on the treatment of anorexia nervosa and bulimia nervosa, specifically highlighting additional information on epidemiology, osteopenia and osteoporosis, and medication and psychotherapy outcome studies. This presentation will focus on the major changes appearing in the revision with respect to recommendations for assessment and treatment. The revised guideline is based on and includes an updated literature review. To make the format more "reader friendly" tables and flow charts have been added, and management sections address specific commonly encountered comorbid conditions and special problems.

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SYMPOSIUM 104—DISSOCIATION AND TRAUMA: PSYCHIATRIC COMORBIDITY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of the symposium, participants should understand diagnostic criteria for dissociative disorders; the degree of comorbidity of dissociation with anxiety, depression, and other psychiatric disorders; and characteristics of individuals prone to these various symptom clusters in the aftermath of traumatic stressors.

No. 104A
FEATURES ASSOCIATED WITH DISSOCIATION IN AGING TRAUMA SURVIVORS

Rachel Yehuda, Ph.D., *Department of Psychiatry, Mt. Sinai School of Medicine, 130 West Kingsbridge Road, Bronx NY 10468;* Stacey Namm, Celia Perugganan, M.D.

SUMMARY:

Our group has been interested in the different types of psychological or other phenomena that are related to dissociative experiences. Indeed, although dissociation has been highly linked to traumatic experiences, not all trauma survivors show dissociation in response to a traumatic event, or subsequently. Furthermore, even among individuals who meet the diagnostic criteria for PTSD, there can be a wide range of dissociative experiences. We have previously reported that Holocaust survivors—even those with PTSD—show relatively less dissociation compared with survivors of other kinds of traumatic events. On the other hand, they tend to show more symptoms such as somatization and generalized anxiety. One issue that

has arisen regarding these data concerns whether trauma-related symptoms change over the course of an individual's life. Another question concerns whether certain types of symptoms, such as dissociation, are more prevalent among younger than older individuals. We will present data from a new study using the Dissociative Experience Questionnaire to evaluate the presence of dissociative experiences in Korean and World War II veterans. These findings will be compared with our previous studies of Holocaust survivors. Although this study is currently in progress, the findings to date indicate that both age at the time of evaluation and age of traumatization are important predictors of dissociation. Phenomenological data from aging trauma survivors also seem to suggest that while dissociative symptoms may become less prominent with time, other symptoms may become more central.

No. 104B
SOMATOFORM DISSOCIATION RELATED TO REPORTED TRAUMA

Richard Van Dyck, M.D., *Dept of Psychiatry, Vrije Universiteit, Valeriusplein 9, Amsterdam 1075BG, The Netherlands;* Ellert R. Nijenhuis, Ph.D., Lohan Vanderlinden, Ph.D., Philip Spinhoven, Ph.D., Onno Van der Hart, Ph.D.

SUMMARY:

In this study, the prevalence and severity of traumatic experiences as reported by patients with dissociative disorders and with other DSM-IV psychiatric diagnoses were compared. Furthermore, the predictive value of emotional, physical, and sexual trauma with respect to somatoform and psychological dissociation was analyzed. In contrast with comparison patients, dissociative disorder patients reported severe and multifaceted traumatization. Physical and sexual trauma predicted somatoform dissociation, and sexual trauma predicted psychological dissociation. According to the memories of the dissociative disorder patients, this abuse occurred in an emotionally neglectful and abusive social context. Pathological dissociation was best predicted by early onset of reported intense, chronic, and multiple traumatization. Methodological limitations restricting causal inferences between reported trauma and dissociation are discussed.

No. 104C
DISSOCIATION AND EMOTIONAL DISTRESS DURING TRAUMA

Charles R. Marmar, M.D., *Department of Psychiatry, VAMC (116-A), 4150 Clement Street, San Francisco CA 94143;* Daniel S. Weiss, Ph.D., Thomas J. Metzler, M.A., Kevin L. DeLucchi, Ph.D.

SUMMARY:

Recent studies of combat veterans and rape victims have reported a strong relationship between dissociation at the time of traumatic exposure and subsequent PTSD. These finding raise important theoretical questions. Does dissociation at the time of traumatic stress exposure protect against immediate overwhelming anxiety, or does catastrophic anxiety trigger entry into dissociative states at the time of trauma? Data from a three-group quasi-experimental design contrasting the responses of rescue workers at the 1989 Loma Prieta earthquake Interstate 880 freeway collapse (n = 198) with responses to the critical incident exposure of Bay Area controls (n = 140) and San Diego controls (n = 101) will be presented. Rescue workers were asked to rate their level of emotional distress at the time of critical incident exposure, overall threat appraisal at the time of exposure, and degree of peritraumatic dissociation. Results demonstrate strong positive correlations between peritraumatic dissociation and both emotional distress and threat appraisal. These findings support the view that dissociation during trauma is the product of extreme anxiety, terror, grief, shame, and guilt as experienced at the moment the trauma is unfolding. Peritraumatic dissociation reflects a breakdown in the capacity to modulate affect rather than an adaptive defense against perceived threat.

No. 104D
SOMATOFORM DISSOCIATION AS RELATED TO ANIMAL DEFENSE

Ellert R. Nijenhuis, Ph.D., *Department of Psychiatry, Vrije Universiteit, Amsterdam 1075BG, The Netherlands;* Philip Spinhoven, Ph.D., Lohan Vanderlinden, Ph.D., Richard Van Dyck, M.D., Onno Van der Hart, Ph.D.

SUMMARY:

We hypothesized that there would be a similarity between animal defensive responses to variable predatory imminence and injury, and certain somatoform dissociative symptoms of trauma-reporting dissociative disorder patients. As a first test of this hypothesis, 12 somatoform symptom clusters consisting of clinically observed somatoform dissociative phenomena were constructed. All clusters discriminated between patients with dissociative disorders (N-50) and patients with other psychiatric diagnoses (N=50). Those expressive of the hypothesized similarity—freezing, anesthesia/analgesia, and disturbed eating—belonged to the five most characteristic symptoms of dissociative disorder patients. Anesthesia/analgesia, urogenital pain, and freezing symptom clusters independently contributed to predicted caseness of dissociative disorder. Using an independent sample, it appeared that anesthesia/analgesia best predicted caseness after controlling for symptom severity. The results were largely consistent with the hypothesized similarity.

No. 104E
COMORBIDITY OF PTSD AND DISSOCIATIVE DISORDERS

J. Douglas Bremner, M.D., *Department of Psychiatry, Yale University, P.O. Box 208038 Yale Station, New Haven CT 06520*

SUMMARY:

There has been discussion about whether post-traumatic stress disorder (PTSD) and dissociative disorders (DD) are separate entities or really represent different aspects of one "trauma syndrome." To address this question, we looked at comorbidity for dissociative disorders in a PTSD population, and dissociative symptoms in patients with PTSD versus other psychiatric disorders. Patients with combat-related PTSD had a high level of comorbidity with DD as measured with the SCID for DSM-IV and the SCID for Dissociative Disorders. A total of 86% of 35 patients with PTSD met criteria for at least one DD. The most common was dissociative disorder NOS (51%), but others met criteria for depersonalization (40%), dissociative amnesia (40%), and dissociative identity disorder (DID) (3%). Patients with PTSD had higher rates of current dissociative symptom level as measured with the Clinician Administered Dissociative States Scale (CADSS) (mean = 19, SD = 11) vs. patients with schizophrenia (mean = 4, SD = 5), depression (mean = 8, SD = 10), panic disorder (mean = 1, SD = 3), healthy subjects (mean = 2, SD = 3), and traumatized nonPTSD subjects (mean = 1, SD = 4) (ANOVA: $F = 8.3$, $p < .001$). These findings support a close relationship between PTSD and DD, and specificity of high levels of dissociation to PTSD and DD. Biological and phenomenological models for a common pathogenesis of PTSD and DD will be discussed.

No. 104F
DISSOCIATIVE, PTSD AND ANXIETY SYMPTOMS AFTER INCEST

David Spiegel, M.D., *Department of Psychiatry, Stanford Medical School, 401 Quarry Road, Room 2325, Stanford CA 94305–5544;* Catherine Classen, Ph.D., Cheryl Koopman, Ph.D., Cheryl Gore-Felton, Ph.D., Bita Nouriani

SUMMARY:

Research has shown that symptoms of dissociation are significantly and positively correlated with measures of anxiety among people exposed to traumatic stressors. In our study of 154 survivors of the 1991 Oakland/Berkeley firestorm, dissociative and anxiety symptoms immediately after the disaster were significantly intercorrelated at baseline. Furthermore, dissociative symptoms at baseline were the strongest predictors of scores on the Impact of Event Scale (IES, Horowitz) given seven months later ($r = .44$ with the intrusion and .52 with the avoidance subscales; both p's $< .001$). This suggests that dissociation and anxiety may measure different but related aspects of peritraumatic distress. A consecutive sample of 32 women seeking psychotherapy for a history of sexual abuse were given two self-report measures of dissociative symptoms: the Dissociative Experiences Scale (Bernstein & Putnam) and Stanford Acute Stress Reaction Questionnaire (Koopman et al.). They also completed the State/Trait Anxiety Scale (Spielberger), the IES, and the Beck Depression Inventory. Dissociative symptoms were significantly correlated with trait anxiety (DES $r = .47$, $P < .01$; SASRQ dissociation $r = .39$, $p < .03$) but not with state anxiety or depression. SASRQ dissociation scores were also positively correlated with intrusion ($r = .46$, $p < .01$), avoidance ($r = .54$, $p < .003$), and hyperarousal ($r - .54$, $p < .002$) subscales. Thus studies of both acute and remote trauma suggest a positive association between dissociative and anxiety, but not depressive symptoms. Given the tendency of trauma victims with dissociative symptoms to have more re-exposure (self-endangering) experiences, it seems that dissociative symptoms may both modulate (leading to further trauma exposure) and exacerbate anxiety, leading to greater post-traumatic symptomatology.

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SYMPOSIUM 105—RESULTS OF THE NIDA COLLABORATIVE COCAINE TREATMENT STUDY
Collaborative Session With the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to demonstrate an understanding of the effectiveness of various psychosocial treatments for cocaine dependence in relation to drug use, secondary outcomes (e.g. psychological symptoms), and retention, as well as pretreatment and process predictors of outcome.

No. 105A
RATIONALE OF THE NIDA COLLABORATIVE COCAINE TREATMENT STUDY

Lynne Siqueland, Ph.D., *Department of Psychiatry, Univ. of Pennsylvania, 3600 Market Street, Rm. #705, Philadelphia PA 19104*

SUMMARY:

Objective: To provide background information and the rationale for the NIDA Collaborative Cocaine Treatment Study, a large, multisite psychotherapy clinical trial of 487 patients with DSM-IV cocaine dependence.

Method: Four research sites, in conjunction with the coordinating center, using an identical research protocol, examined the efficacy of two psychotherapies (cognitive-behavioral and psychodynamic supportive-expressive psychotherapy) and two drug counseling approaches (individual and group) in the treatment of cocaine dependence. In addition, the interaction of treatments with two patient-matching variables (psychiatric severity and coping style) were assessed.

Results: This presentation will provide information on rationale for the study design; a description of treatments, assessments, training of therapists, and evaluators; and the data analysis plan.

Conclusions: The results of this study will have a major impact on treatment planning, service delivery, and training of practitioners in the substance dependence field.

No. 105B
DRUG OUTCOME OF THE NIDA COLLABORATIVE COCAINE TREATMENT STUDY

Paul Crits-Christoph, Ph.D., *Department of Psychiatry, University of Pennsylvania, 3600 Market Street, Rm. #700, Philadelphia PA 19104*

SUMMARY:

Objective: To review acute phase and follow-up drug use outcome data from the NIDA Collaborative Cocaine Treatment Study.

Method: Four research sites, in conjunction with the coordinating center, using an identical research protocol, examined the efficacy of two psychotherapies (cognitive-behavioral and psychodynamic supportive-expressive psychotherapy) and two drug counseling approaches (individual and group) in the treatment of cocaine dependence. In addition, the interaction of treatments with two patient-matching variables (psychiatric severity and coping style) are assessed.

Results: This presentation will review longitudinal and cross-sectional drug use outcome using the Addiction Severity Index (ASI) drug composite score and ASI cocaine use in the last 30 days. Main treatment condition and interaction effects will be reviewed.

Preliminary analyses reveal a superiority for one treatment condition and no interaction effects.

Conclusions: Results have major implications for substance dependence treatment planning or treatment development.

No. 105C
SECONDARY OUTCOMES OF THE NIDA COLLABORATIVE COCAINE TREATMENT STUDY

Michael E. Thase, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh PA 15213*

SUMMARY:

Objective: To review acute phase and follow-up drug use outcome data from the NIDA Collaborative Cocaine Treatment Study.

Method: Four research sites, in conjunction with the coordinating center, using an identical research protocol, examined the efficacy of two psychotherapies (cognitive-behavioral and psychodynamic supportive-expressive psychotherapy) and two drug counseling approaches (individual and group) in the treatment of cocaine dependence. In addition, the interaction of treatments with two patient-matching variables (psychiatric severity and coping style) are assessed.

Results: This presentation will review longitudinal and cross-sectional outcome data on secondary measures (Addiction Severity Index composites (e.g., family/social functioning) and psychological symptoms (BDI, Hamilton scores, Brief Symptom Inventory) and other areas (motivation, self-help, attendance, etc). Main treatment condition and interaction effects will be reviewed. These data are still being analyzed.

Conclusions: Different treatments may have different effects on drug use compared with other secondary outcomes, which are important to consider when matching patient to treatment.

No. 105D
DROP-OUT IN THE NIDA COLLABORATIVE COCAINE TREATMENT STUDY

Arlene F. Frank, Ph.D., *NE Psychiatric, 29 Northwest Boulvard, Nashua NH 03063*

SUMMARY:

Objective: To review acute phase and follow-up drug use outcome data from the NIDA Collaborative Cocaine Treatment Study.

Method: Four research sites, in conjunction with the coordinating center, using an identical research protocol, examined the efficacy of two psychotherapies (cognitive-behavioral and psychodynamic supportive-expressive psychotherapy) and two drug counseling approaches (individual and group) in the treatment of cocaine dependence. In addition, the interaction of treatments with two patient-matching variables (psychiatric severity and coping style) were assessed.

Results: This presentation will review survival analysis of days to dropout and cross-sectional analyses of dropout at month 1, 3, and 6. Main treatment condition and interaction effects will be reviewed. Preliminary analyses reveal a treatment condition effects on time to dropout.

Conclusions: Substance dependence treatment always needs to take into account the relationship between retention in treatment and outcome.

No. 105E
PREDICTORS OF OUTCOME OF THE NIDA COLLABORATIVE COCAINE TREATMENT STUDY

Roger D. Weiss, M.D., *Proctor III, McLean Hospital, 115 Mill Street, Belmont MA 02178-1048*

SUMMARY:

Objective: To review acute phase and follow-up drug use outcome data from the NIDA Collaborative Cocaine Treatment Study.

Method: Four research sites, in conjunction with the Coordinating Center, using an identical research protocol, examined the efficacy of two psychotherapies (cognitive-behavioral and psychodynamic supportive-expressive psychotherapy) and two drug counseling approaches (individual and group) in the treatment of cocaine dependence. In addition, the interaction of treatments with two patient-matching variables (psychiatric severity and coping style) are assessed.

Results: This presentation will review patient predictors of outcome (demographic, intake drug and psychological severity, motivation, etc.) and treatment predictors of outcome (alliance, treatment attendance, etc.).

Conclusions: Results help to clarify which patients do best in treatment overall and provide clues on matching patients to treatment.

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SYMPOSIUM 106—PSYCHIATRISTS AS OWNERS AND MANAGERS OF DELIVERY SYSTEMS
APA Consultation Service Board

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To help psychiatrists seize the opportunity to regain control of their practices and their profession; to identify the essential clinical components of an integrated delivery system; to better understand how to manage and administer large systems of care.

No. 106A
THE PROFESSIONAL AFFILIATION GROUP MODEL

Benjamin Liptzin, M.D., *Department of Psychiatry, Baystate Medical Center, 140 High Street, Springfield MA 01199-0001*

SUMMARY:

Since 1992, the Professional Affiliation Group has evolved as a model of how community private practitioners can work together to manage clinical care of patients within a shared-risk program. This paper will describe the issues involved in putting together a functioning network and address the challenges.

No. 106B
FIRST YEAR OPERATING EXPERIENCE OF A DISTRICT BRANCH ORIGINATED IPA PRACTICE

Barton J. Blinder, M.D., *Department of Psychiatry, University of California, 400 Newport Center Dr Ste 706, Newport Beach CA 92660-7608*

SUMMARY:

The first-year experience of a District-Branch-generated, specialty-physician-owned psychiatric practice group will be reviewed. Special emphasis in the presentation will be description of operating a *psychiatrist gatekeeper model* with comprehensive psychiatric evaluation, adherence to APA practice guidelines, and use of appropriate subspecialty referrals. An analysis of outcome and cost-effectiveness will be presented along with a retroactive calculation of the range of capitation rates necessary to operate this model. Important issues related to confidentiality, collegial interaction, administration and management, interaction with local institutions, and maintaining the doctor-patient covenant will be reviewed.

No. 106C
MANAGED CARE: THE NEW COLONIALISM

Anthony M. D'Agostino, M.D., *Department of Psychiatry, Alexian Bros. Medical Center, 800 Biesterfield Road, Elk Grove Village IL 60007*

SUMMARY:

Psychiatry's opposition to cost-containment measures over the last 15 years has created a vacuum in the marketplace. This vacuum has been readily filled by insurance companies and psychiatric managed care carve-out companies. These large companies now control a significant percentage of psychiatric practice, creating a situation in which the "natural resources" of the various medical professions are now controlled and "mined" by these large new companies whose behavior resembles that of the colonial European powers during the 18th and 19th centuries in that the "indigenous peoples" (psychiatrists) no longer have any meaningful control over treatment or their profession.

This paper argues strongly for physician ownership and management of organized delivery systems and outlines a strategy for their development on a local and national level. Behavioral Health Systems, Inc. of Burr Ridge, Illinois, will be presented as a model.

No. 106D
NUTS AND BOLTS ISSUES IN PROVIDER OWNED DELIVERY SYSTEMS

Peter Benet, M.D., *Psychiatric Management, 60 Retreat Avenue, Hartford CT 06106-2526*

SUMMARY:

In order to regain control of the delivery system, 30 psychiatrists in Connecticut formed a company to manage behavioral health care. Raising capital, building an organization, negotiating two contracts for over 100,000 lives, and forming a clinical network and managing the business will be covered. Both the gratification and the pitfalls of such an undertaking will be discussed, with an emphasis on the conflicts encountered at each step of taking an active role in the allocation of reduced resources during a time of upheaval in our profession.

No. 106E
PROBLEMS IN PSYCHIATRIST OWNED AND MANAGED DELIVERY SYSTEMS

Ronnie S. Stangler, M.D., *1425 Western Avenue, Ste. #101, Seattle WA 98101-2036*

SUMMARY:

The extraordinary consolidation of managed behavioral health organizations into a handful of corporate giants only enhances the David and Goliath feel to the struggle of clinician-sponsored entities. Psychiatrists know all too well about the elements that render national proprietary companies formidable opponents: volume of "covered lives" and associated economies of scale, capital, sophisticated MIS, and business and marketing expertise. Yet psychiatrists do possess knowledge and skills that render us eminently qualified to deliver knowledge-based, ethical, and community-sensitive behavioral health care. What are the business, clinical, and personal ingredients necessary to compete and succeed? What are the problems and pitfalls along the way? Does David ever prevail? These issues will be discussed.

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1. Pomerantz JM, Liptzin B, Carter A, Perlman MS: Forming practice groups to deal with managed care: two views. J Pract Psychiatry Behav Health 1995;1:232–235.
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SYMPOSIUM 107—SPIRITUALITY AND HEALTH: STATE OF THE ART SCIENTIFIC AGENDA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To learn about new research on the relationship between religion and health, directions for future research, and possible clinical applications.

No. 107A
RELIGION, SPIRITUALITY AND PHYSICAL HEALTH

Harold G. Koenig, M.D., *Department of Psychiatry, Duke University Medical Center, Box 3400 Duke Univ. Med. Ctr., Durham NC 27710*

SUMMARY:

Religious activity and physical healing have long been connected, although the scientific basis for such connections has often been weak or nonexistent. Recent studies have examined the psychosocial and physiological mechanisms by which religious belief and practice might influence physical health. Following this model, studies have found that religiously active persons experience lower blood pressures (particularly diastolic pressures), stronger immune systems (assaying levels of interleukin-6 and other biological indicators of immune functioning), live healthier lifestyles (less smoking and alcohol use, safer sexual practices), have longer survival (25%–30% longer in two major longitudinal studies of thousands of adults at opposite ends of the United States), and use fewer health services (shorter hospitals stays, fewer hospitalizations). Other studies demonstrate conflicting results, with shorter survival (religious groups who avoid traditional medical care) and worse health outcomes (religious groups who avoid prenatal care or obstetrical care). This research has only scratched the surface of a potentially productive field of study that has been largely neglected. Prospective observational studies and randomized clinical trials are needed to better sort out the causal relationship between religious practices and physical health and to identify the mechanisms that underlie these effects.

No. 107B
RELIGION, SPIRITUALITY AND MENTAL HEALTH

Michael E. McCullough, Ph.D., *Department of Research, NIHR, 6110 Executive Blvd., Rockville MD 20852*

SUMMARY:

Spirituality and religiousness correlate with (1) higher degrees of subjective well-being, life satisfaction, and marital satisfaction, and (2) reductions in mental health problems, including depressive symptoms, suicide, delinquency, and alcohol and drug use. Although most of these findings are based on cross-sectional data, a small number of high-quality longitudinal studies have yielded similar findings. Several preliminary evaluations of psychotherapies with religious content show that they appear to be as effective as standard psychotherapies for depression and anxiety, particularly when used with religious patients. Randomized clinical trials are needed to evaluate the efficacy of spiritual and religious interventions for specific psychiatric disorders in clinical populations. Spirituality and religiousness variables should be included as factors in mental health services research studies in which efficacy and cost-effectiveness of treatments are being examined. While the majority of studies show that spirituality and religiousness are tied to greater well-being, others suggest that certain forms of spirituality and religiousness are tied to poorer functioning, greater emotional distress, and worse mental health outcomes. Thus, the negative as well as the positive consequences of spirituality and religiousness require further study.

No. 107C
RELIGION, SPIRITUALITY AND ADDICTIONS

David B. Larson, M.D., *998 Farm Haven Drive, Rockville MD 20852-4213*

SUMMARY:

There is strong evidence that (1) religious/spiritual involvement is associated with fewer alcohol/drug problems; (2) AA involvement predicts better outcomes after outpatient treatment; and (3) meditation-based interventions are associated with less alcohol/drug use and fewer problems. Moderate evidence exists that shows that (1) within denominations that take a strict stand against the use of alcohol, the risk of alcohol problems is significantly lower (although when present they tend to be more severe); (2) AA involvement is associated with better outcomes after inpatient treatment; and (3) clients treated in 12-step therapies do as well as those treated with other approaches. There is weak evidence that: (1) there are common motivations for drug use/abuse and spiritual pursuits; (2) spiritual/religious involvement is associated with higher success rates in smoking-cessation treatment; (3) religious involvement is low among people in treatment for substance abuse; and (4) following treatment for alcohol/drug problems, the personal sense of meaning in life increases. Finally, there is no persuasive evidence that (1) values change in the course of recovery; (2) intercessory prayer improves substance abuse treatment outcomes; (3) individuals in treatment for alcohol/drug problems report a low personal sense of meaning in life, relative to the general population; and (4) AA members often attribute their recovery to spiritual factors.

No. 107D
RELIGION, SPIRITUALITY AND THE NEUROSCIENCES

Frank H. Gawin, M.D., *Department of Psychiatry, University of California - LA, 612 Colorado Blvd. Suite 109, Santa Monica CA 90401*

SUMMARY:

Multiple studies in several research disciplines indicate that activation of specific central nervous system (CNS) regions correlate with spiritual experiences. Furthermore, various physiological responses can be affected by activation of these CNS regions, which, in turn, can affect health. These findings suggest that many intriguing avenues for the neuroscientific investigation of religion/spirituality may evolve from the existing literature. One such avenue involves studying certain psychopathological disorders, which have been associated in some individuals with intense spiritual experiences. It may also be fruitful to study some extreme forms of religious/spiritual experiences common in many "normal" cultures and religious traditions. These include hallucinations, visions, voices, and "speaking in tongues." Disorders caused by organic abnormities in the brain or brain injuries also can be associated with heightened and unusual spiritual experience and, thus, can be studied. A controversial source of spiritual experiences that also can be studied is drug-induced spiritual episodes. Some drugs are so adept at reproducibly inducing spiritual experiences that they have provided a foundation for some indigenous religious rituals. However, not all subjects given a specific psychoactive drug have attained spiritual experiences. This avenue of research, then, should be approached with extreme caution.

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SYMPOSIUM 108—AN INTEGRATIVE APPROACH TO PSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation participants should be able to describe an integrative approach to psychiatry and understand the theory underlying some of its component parts (the therapeutic use of self regulation and nontraditional therapies and acupuncture and the possibilities of viewing some psychological disturbance as a transformative process). Participants should be able to begin to use relaxation therapies, meditation, and herbal therapies in their lives and clinical practices.

No. 108A
TRANSFORMING PSYCHIATRIC PRACTICE

James S. Gordon, M.D., *2934 Macomb Street NW, Washington DC 20008*

SUMMARY:

Dr. Gordon will offer (an overview of a "new holistic psychiatry")which integrates ancient wisdom and modern science. He will describe the concepts of "the healing partnership" and "therapeutic transformation" and the corresponding shift from "treatment" to

"teaching" in psychiatric practice. He will present scientific evidence for the efficacy of such mind-body therapies as biofeedback, meditation, imagery, yoga, and Qi Gong and offer case histories of individual and group mind-body approaches to patients with psychiatric disorders.

No. 108B
WHEN PATIENTS PRESENT WITH PARAPSYCHOLOGICAL EXPERIENCES

Elisabeth F. Targ, M.D., *3853 22nd Street, San Francisco CA 94114-3203*

SUMMARY:

This presentation will review the current research literature on the prevalence of spontaneous parapsychological or "psi" and other spiritual and religious experiences and the concept of verdical psychic or parapsychological experience in the context of laboratory research in Remote Viewing. The presentation will focus on differential diagnosis and the assessment of the patient report in the context of psychiatric and psychosocial evaluation, with emphasis on normalizing and depathologizing the patient's experience for the purpose of reducing anxiety and helping the patient maintain and strengthen core social relationships and coping skills. The presentation will discuss both negative and positive sequelae of these experiences and ways in which the therapist can assist patients to observe these experiences without overidentifying with them.

No. 108C
THE USE OF ACUPUNCTURE IN PSYCHIATRIC TREATMENT

John M. Ackerman, M.D., *2417 Castillo Street, Santa Barbara CA 93105-4301*

SUMMARY:

Acupuncture affects multiple aspects of physiology including autonomic nervous system functioning, endorphins, and multiple neurotransmitters. It has been shown in numerous clinical studies to attenuate anxiety, agitation, violence, depression, and pain. It can be an extremely useful adjunct in detoxification and prevention in alcoholism and many other forms of addiction. It helps many women with hormonal imbalances and can help to decrease the dosage as well as many side effects of psychotropic medication. A case will be presented to illustrate how a special acupuncture diagnostic pulse technique can be utilized to assess what medical supplements and/ or medication have therapeutic potential for a particular patient.

No. 108D
NUTRITIONAL AND HERBAL THERAPIES IN PSYCHIATRIC TREATMENT

Georgelle Carpenter, M.D., *369 Montezuma, #356 Santa Fe, NM 87501*

SUMMARY:

This presentation will review some of the evidence for and against the role of diet in psychiatric disorders. It will discuss the studies that are used to substantiate the therapeutic ability of amino acids (phenylalamine, tryptophan, tyrosine) and of such herbs as St. John's wort, kava kava, chamomile, and ginkgo.

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SYMPOSIUM 109—CLINICAL PRACTICE GUIDELINES FOR PSYCHOTHERAPIES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To summarize the empirical literature regarding the effectiveness of the psychotherapies, to list the ethical guidelines pertinent to psychotherapy, to discuss the common features of the psychotherapies, to understand the benefits and liabilities of CPG's in clinical practice, to appreciate the central role of personality patterns in the practice of psychotherapy.

No. 109A
THE PRACTICE AND ROLE OF PSYCHOTHERAPIES IN PSYCHIATRY

Paul M. Cameron, M.D., *Ottawa General Hosp, 4422-501 Smyth Road, Ottawa, ONT K1H 8L6, Canada*

SUMMARY:

Skills in the psychotherapies are considered essential in the repertoire of a competent psychiatrist. This paper will explore the functions and roles of psychiatrists relevant to psychotherapy skills for general psychiatrists and subspecialists. In order to develop clinical practice guidelines, consensus must first be reached about effectiveness, efficacy, and cost-effectiveness. A survey of effectiveness of the major psychotherapeutic modalities will be presented to demonstrate the solid empirical base.

A process for writing clinical practice guidelines has been developed by the Canadian Medical Association. This model will be considered as it has influenced the development of a project titled Standards and Guidelines in the Psychotherapies. This paper forms the basis for the Canadian Psychiatric Association's position paper on the psychotherapies as well as the paper on clinical practice guidelines. Definition of the psychotherapies, gender issues, cultural factors, informed consent, and guidelines for record keeping will be reviewed.

In conclusion, this paper will present a glimpse of some of the broad issues that form a foundation for a proper construction of clinical practice guidelines across the major psychotherapeutic modalities.

No. 109B
CLINICAL PRACTICE GUIDELINES FOR THE PSYCHOTHERAPIES FROM THE CANADIAN PSYCHIATRIC ASSOCIATION

Molyn Leszcz, M.D., *Department of Psychiatry, Mount Sinai Hospital, 600 University Avenue, Toronto ON M5G 1X5;* K. Roy MacKenzie, M.D.

SUMMARY:

The Canadian Psychiatric Association (CPA) has recognized the professional responsibility to identify clinical practice guidelines (CPG) for the psychotherapies and has established a working group to draft CPG for the psychotherapies. The historic lack of clarity about appropriate practice has led, on occasion, to misuses, inefficiencies, misapplications, serious boundary crossings, and ethical and boundary violations. The chief objective of the CPG is to aid practitioners in clinical decision-making processes to improve the quality of care, effectiveness of treatment, and treatment efficiency. A first iteration was produced, and its key aspects will be reviewed to initiate a process of further debate, discussion, and consensus that will synthesize the empirical literature along with accepted clinical practice and expert opinion.

The CPG Document addresses core elements that are essential to all models of the psychotherapies, emphasizing factors common to all effective therapies and clinical issues that are relevant in virtually all psychotherapies. Intrinsic in this process is the recognition that the administration of psychotherapy involves clear indications, potential side effects and contraindications, and is a central component of comprehensive, integrative psychiatric care.

No. 109C
USE AND MISUSE OF CLINICAL PRACTICE GUIDELINES

Marcia K. Goin, M.D., *Department of Psychiatry, University of Southern CA, 1127 Wilshire Blvd, Ste 1115, Los Angeles CA 90017-4085*

SUMMARY:

For a number of years the American Psychiatric Association has been actively engaged in developing clinical practice guidelines. The treatment of major depression, eating disorders, substance abuse, bipolar illness, and schizophrenia are some of the Axis I disorders for which treatment guidelines have been developed. The guidelines are written by a panel of experts who work to pull together information about the current state of the art. Initial drafts are circulated to many of the APA membership and their reactions are responded to and revisions made when appropriate. Updates are planned for every five years. The goal is to provide recorded guidance for clinicians and to describe the current standard of practice. Currently the Canadian Psychiatric Association is drafting clinical practice guidelines for the psychotherapies.

The guidelines are valuable educational summaries of clinical information that provide guidance for clinical work but they are also measures by which clinical work will be judged.

This paper explores the value and usefulness of the clinical practice guidelines and also identifies potential vulnerabilities for misuse.

No. 109D
GUIDELINES FOR THERAPY OF PERSONALITY DISORDERS

John M. Oldham, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 722 West 168th Street, New York NY 10032*

SUMMARY:

Practice guidelines in psychiatry have been developed that are generally disorder-based, concentrating on major mental illnesses about which the most extensive research data exist. As a result, medication algorithms predominate since research studies on non-medication therapies are less numerous. In 1992, the American Psychiatric Association held a conference titled Challenges in Developing Psychiatric Practice Guidelines, at which time it was felt that it was premature to attempt practice guidelines for the personality disorders. Since that time, however, APA's Practice Research Network (PRN) has been established to aid in getting clinical consensus data about treatment of disorders commonly encountered in clinical practice but not easily researchable. A good example of such a disorder is borderline personality disorder (BPD). The PRN could now serve as a source of valuable information about treatment patterns for BPD, and in addition the entire area of Axis II has been increasingly prominent in the published clinical literature. Research studies are being funded on course, treatment, and outcome of the personality disorders, and BPD is most often singled out for focus. Interest is growing in developing treatment guidelines for BPD, and the Steering Committee for Practice Guidelines and the Board of Trustees of APA have now approved this project. Although it will be challenging to survey current research and clinical consensus on types of psychotherapy and pharmacotherapy for BPD, there is a strongly felt need for such BPD guidelines and a growing sense that such an effort is now timely. Preliminary thinking about practice guidelines for BPD by leading clinicians and researchers experienced in working with borderline patients will be presented.

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SYMPOSIUM 110—NEW ADVOCACY CHALLENGES FOR SOCIAL PSYCHIATRY
Joint Session With the American Association for Social Psychiatry

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To recognize new advocacy challenges for all age and minority groups that impact diagnosis and treatment protocols for these patients.

No. 110A
ADVOCACY IN SOCIAL PSYCHIATRY

Edward F. Foulks, M.D., *Department of Psychiatry, Tulane Medical Center, 1430 Tulane Avenue, New Orleans LA 70112-2699*

SUMMARY:

This paper will discuss a number of current approaches to advocacy in social psychiatry. During the past decade the social forces of stigma, health insurance trends, and "behavioral managed care" have seriously reduced access to care for most people who suffer from mental illness. Many now also suffer the abuses that accompany homelessness, poverty, and difficulties with the police and legal system. Families suffer the lost potentials of their afflicted members as well as a host of shocking indignities routinely encountered in committing and seeking treatment for them. Ironically, such experiences are occurring in the context of the astounding recent advancements in psychopharmacology.

Psychiatry has contributed greatly to designing caring, humane, and effective treatment for mental illness. There is much that we can do as psychiatrists to address social problems in order to obtain the quality of care and treatment that we all know is needed. Psychiatrists can learn from patients and family members about the difficulties in accessing adequate care. Psychiatrists can join with them to advocate a more user-friendly and consumer-oriented delivery system.

No. 110B
TRUE COMMUNITY/ACADEMIC PARTNERSHIPS

Carl C. Bell, M.D., *Community Mental Hlth Council, 8704 South Constance, Chicago IL 60617-2746*

SUMMARY:

"I am one who doesn't believe in deluding myself. I am not going to sit at your table and watch you eat, with nothing on my plate, and call myself a diner. Sitting at the table doesn't make you a diner. You must be eating some of what's on that table"—Malcolm X.

Community members are often invited to be on research project advisory boards, but this is like community members sitting at the research table and watching the academic researchers "eat" with nothing on the community member's plate. This presentation will highlight what researchers are obtaining from their community-based research projects. It will also outline what community members need to be able to consider themselves "diners" at the research table. The importance of relationship-building and empowerment will be stressed as a means to develop a true academic/community partnership. The Chicago HIV Prevention and Adolescent Mental Health Project (CHAMP) efforts to establish a collaborative board composed of parents, school staff, research staff, and a facilitator from a community mental health agency to help develop, implement, oversee, and interpret a five-year research project will be used as a best practice in establishing a true academic/community partnership. Barriers encountered in accomplishing such partnerships will be explained, and it will be shown how using tools of building a mission, group learning, personal leadership, ecology, and models helps facilitate such partnerships.

No. 110C
ADVOCACY IN CHILD AND ADOLESCENT PSYCHIATRY

Elizabeth B. Weller, M.D., *PA Child Guidance Center, 2 Children's Cntr/34th & Civic, Philadelphia PA 19104-4399;* Ronald A. Weller, M.D.

SUMMARY:

In this presentation a historical review of advocacy issues concerning children and adolescents will be presented dating back to the beginning of the child and adolescent psychiatry movement in this country. Observations of how issues of advocacy in children are promoted or hindered by sociocultural and political issues will be shared.

Current issues in promoting research in biological, psychological, and social arenas to better the lives of psychiatrically ill children and their families will be presented. This will be followed by describing the challenges of advocating for children and adolescents so they can get total health coverage rather than health coverage with mental health carved out to be provided by the least expensive providers.

No. 110D
ADVOCACY FOR THE ELDERLY

Kenneth M. Sakauye, M.D., *Psychiatry, LSU Medical School, 1542 Tulane Avenue #320, New Orleans LA 70112-2865*

SUMMARY:

Advocacy for the elderly involves issues of abuse, neglect, financial exploitation, lack of treatment, discrimination in services, and at times, deplorable living conditions. Psychiatrists often serve unique roles in advocating for the safety and rights of individuals in assessing competency and informed consent and providing leadership in developing systemwide services and fighting local battles against exclusion of coverage of psychiatric care.

This paper will focus on efforts of a university program to advocate for treatment of the mentally ill in nursing homes as an example of the importance of local advocacy that ultimately creates larger systemwide awareness and action. OBRA'87 (Omnibus Budget Reconciliation Act of 1987, which contained nursing home reform laws) and the OIG (Office of the Investigator General) report of 1995, which claimed that significant fraud and abuse in psychiatric care was occurring in target states, were important steps that in some states led to restrictions in psychiatric care instead of reform. Examples of local intermediary actions and counter actions taken both locally and within the APA and AAGP (American Association for Geriatric Psychiatry) will be highlighted.

No. 110E
ADVOCACY AND SUBSTANCE ABUSE

Joseph J. Westermeyer, M.D., *Department of Psychiatry, University of Minnesota, 1 Veterans Drive, Minneapolis MN 55417*

SUMMARY:

Advocacy on behalf of patients with substance related disorder (SRD) presents challenges to the psychiatrist who must participate actively in their care. Examples include negotiated "contingencies" and monitoring. Clinicians must promote short-term achievable objectives rather than long-term, permanent all-or-none, unrealistic goals. Advocacy can work to the detriment of psychiatrists and patients if carried to extremes. Psychiatrists must beware of "enabling" or "rescuing" the patient—a boundary that is often difficult to discern prospectively. Overinvolvement can harm psychiatrists, who may abandon SRD patients due to previous therapeutic failures. Today, third party payers, institutions, and community leaders want to shift the burden of SRD prevention and care elsewhere. As educators and community leaders, we must carry the basic SRD messages: treatment works; treatment is cost-effective; some patients are refractory to current treatment methods and require other approaches, etc. Numerous treatment approaches have been shown to be effective with selected cases. However, many of these therapies are not available in our hospitals, clinics, and communities. We must assure their availability. Finally, psychiatrists must link with community resources in public and private settings. Attempting to ameliorate SRD prevalence and misery solely in clinical settings is doomed to failure.

No. 110F
ADVOCATING FOR THEIR OWN: A CULTURAL DILEMMA

Silvia W. Olarte, M.D., *Department of Psychiatry, NY Medical College, 37 East 83rd Street, Apt 1, New York NY 10028*

SUMMARY:

Hispanics continue to be the fastest growing immigrant group in this country. Strong family ties and strong adherence to their cultural norms still define this migrant group. Both of these factors become a frequent source of conflict between the first and second generation immigrants, since the second generation becomes adapted to the host culture more readily, often rejecting their parents' culture of origin. If the first generation cannot communicate in English, this second generation often becomes the advocate for the first, with the ensuing role reversal and enhancement of already existing transcultural conflicts. The health care system can, due to lack of bilingual trained personnel, rely on the second and more adapted generation to the host culture for their communication with the family, enhancing even further the existing conflict and fostering a wider schism. Specific advocacy approaches sensitive to the original cultural frame of reference, the role reversal created by the migration, and the different levels of generational adaptation will be discussed.

No. 110G
ONGOING AND NEW GENDER ISSUES REQUIRING ADVOCACY

Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville, 323 Chestnut Street, Louisville KY 40202*

SUMMARY:

Gender issues requiring advocacy include gender equity in education, work, and sports, and personal and legal relationships for heterosexual, gay, lesbian, bisexual, and transgendered people across the life cycle. Racial, ethnic, socioeconomic, and regional gender factors also continue to impact women's and men's health.

Continuing and improved advocacy education and mechanisms to improve equity must be part of the willingness of all psychiatrists, other physicians, and health professionals to consider as affecting patients' diagnoses and treatment.

New gender issues requiring our advocacy include aspects of new reproductive technologies, adoption, end-of-life decisions, health and other insurance, and other benefits. Professionals must be aware of these issues because often our women and men patients are not yet aware of them, and their treatment and outcome are clearly affected.

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SYMPOSIUM 111—PSYCHODYNAMIC THERAPY RESEARCH IN THE NEW CENTURY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To understand new advances in brief and long-term psychodynamic psychotherapy as well as the methodologic challenges in conducting this research.

No. 111A
PSYCHODYNAMIC THERAPY FOR PANIC: AN OPEN CLINICAL TRIAL

Fredric N. Busch, M.D., *Department of Psychiatry, Cornell Univ. Medical College, 10 East 78th Street, Suite 5A, New York NY 10021;* Barbara L. Milrod, M.D.

SUMMARY:

Cognitive-behavioral and psychopharmacological treatment approaches to panic disorder have been demonstrated to have short-term efficacy. However, many patients have some level of persistent symptoms, and the longer-term efficacy of these treatments remains in doubt. To date, no prospective studies of psychodynamic treatment of panic disorder have been conducted, although multiple case reports suggest that it can be effective. This presentation will focus on an ongoing research study of a manualized psychodynamic psychotherapeutic treatment of panic disorder, developed by the authors. The process of operationalizing a psychodynamic treatment for the purposes of research will be elaborated. The treatment is a twice-weekly, 24-session, psychodynamic psychotherapy focused specifically on panic. The design of the study will be described, including the method for assessing adherence to treatment. Preliminary adherence and response data will be presented. The authors will describe the development of a randomized controlled trial.

No. 111B
OUTCOME IN LONG-TERM PSYCHODYNAMIC PSYCHOTHERAPY

Lisa A. Mellman, M.D., *Columbia University, NY State Psychiatric Institute, 722 West 168th Street, Box 63, New York NY 10032;* Edith M. Cooper, Ph.D., Roger Mackinnon, M.D., Andrew E. Skodol II, M.D.

SUMMARY:

Most psychotherapy research studies have investigated cognitive-behavioral or interpersonal approaches in short-term treatments. Long-term studies of psychodynamic psychotherapy are more difficult to conduct because of difficulties standardizing the treatment, designing control conditions, and funding the research. Consequently, fundamental research questions remain in psychodynamic psychotherapy regarding efficacy and correlations of treatment response with psychiatric diagnosis, symptoms, and internal change

(use of defenses, psychological capacities). A research study of 60 patients in a long-term, twice weekly, psychodynamic psychotherapy clinic is addressing these correlations. The study is evaluating whether (1) Axis I and II psychiatric diagnoses, determined by structured interview, correlate with improvement in symptoms and external functioning; (2) defenses and psychological capacities change; and (3) changes in defenses and psychological capacities correlate with treatment response. The design and preliminary data from this two-year study will be presented.

No. 111C
A SELF-REPORT MEASURE OF PSYCHOLOGICAL CAPACITIES

Edith M. Cooper, Ph.D., *Department of Psychology, NY State Psychiatric Institute, 722 West 168th Street, Box 63, New York NY 10032;* Lisa A. Mellman, M.D., Roger Mackinnon, M.D., Andrew E. Skodol II, M.D.

SUMMARY:

Measures of psychological capacities and ego defenses are important in assessing internal change during psychodynamic psychotherapy. Measures of ego defenses have previously been converted by other researchers into self-report forms. Thus far, all measures of psychological capacities have required structured interviews, which may limit their use in research studies. The present authors have converted the Scales of Psychological Capacities, developed by Robert Wallerstein and his colleagues, from a structured interview into self-report form. Psychological capacities assessed include concepts such as flexibility, trust, empathy, and impulse regulation. In this presentation, data from the development and validation of the self-report form will be discussed. The authors expect that a reliable and valid self-report instrument for measuring psychological capacities will facilitate psychodynamic research regarding internal change.

No. 111D
COMPUTERIZING RECORDS TO DETERMINE WHAT ACTUALLY WORKS FOR WHOM

Peter Graham, Ph.D., *Department of Psychology, The Menninger Clinic, 5800 SW 6th Ave, POB 829, Topeka KS 66601;* Paul Clifford, M.A.

SUMMARY:

The paper discusses a unique computerized recording system that generates standardized, operationally defined assessments of patients across multiple domains for the purpose of outcomes and protocols assessment. Using a novel data codification concept, this recording system makes it possible to store large amounts of assessment and care data on patients and to retrieve, analyze, and report on these data simply and quickly. Multiple source assessments, including from patient and therapist, across multiple domains of analysis, provide a comprehensive set of data relating to symptoms and also to levels of functioning; that is, patients' strengths and resources as well as problems. Comparisons of patient populations can then be made in terms of psychological, behavioral, interpersonal, historical, social circumstances, and care-actually-received factors. A uniform scale is used with several different qualifiers, including severity, risk, dependency, and duration, rather than using several separate scales. Such a methodology for collecting data on heterogeneous patient groups will allow us to look at actual practice in a rigorous, standardized manner across large numbers of patients and therapists, thereby potentially providing a complimentary insight to randomized control trials. The paper presents a model for multisite, multitherapist studies and discusses how this model of outcomes and treatment assessment compares and contrasts with previous treatment research models, such as the randomized control trial.

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SYMPOSIUM 112—NEW APPROACHES FOR OPIATE DETOXIFICATION
Collaborative Session With the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To treat opiate withdrawal more effectively and be aware of the strengths and weaknesses of new methods of opiate detoxification.

No. 112A
LOFEXIDINE FOR OPIATE DETOX: RECENT U.K. STUDIES

John Strang, M.D., *Addiction Sciences Bldg., National Addiction Center, 4 Windsor Walk, London SE5 8AF, United Kingdom*

SUMMARY:

Lofexidine is an α-2 adrenergic agonist, closely related to clonidine, which was originally developed as an antihypertensive but was subsequently dropped following clinical trials that demonstrated a lesser antihypertensive effect than existing medications such as clonidine. Its potential role in addictions treatment has recently been explored. Following approval of the drug in 1992 in the U.K., for opiate detoxification, lofexidine has been increasingly used to cover inpatient and outpatient detoxification. Results from randomized treatment trials in inpatient settings in the U.K. and elsewhere will be presented and include comparison of lofexidine versus methadone (n=86) (Bearn et al, 1996) and two separate comparisons of lofexidine versus clonidine (n=28 and n=80) (Kahn et al, 1997; Lin et al, in press). These trials give substantial support to the initial clinical impressions that lofexidine provides a therapeutic benefit equivalent to clonidine while being significantly less associated with hypotension. The more extensive use of lofexidine on an outpatient basis in the U.K. has not yet been studied systematically but will be described, since it is in this setting that the wider future utilization of lofexidine is expected to be seen.

No. 112B
CLONIDINE, NALTREXONE AND BUPRENORPHINE IN RAPID DETOX

Thomas R. Kosten, M.D., *Dept. of Psychiatry-116A, Yale University VA, 950 Cammpbell Avenue, Rm. 953M, West Haven CT 06516*

SUMMARY:

The treatment of opioid withdrawal has been enhanced by the use of clonidine to relieve symptoms and naltrexone to accelerate the process of detoxification from as long as two weeks to as little as one day. Symptom relief occurs through the cyclic AMP second messenger system linkage of the adrenergic and opioid receptors. This "intrinsic" mechanism can be augmented by an "extrinsic" mechanism via excitatory amino acid (EAA) transmission. Specific EAA agents such as dextromethorphan and cycloserine have been tested in humans. Resetting the opioid receptor system using naltrexone to accelerate detoxification can be enhanced using the partial agonist buprenorphine, which reduces the severity of withdrawal without extending its duration. Outpatient and inpatient trials using buprenorphine in combination with naltrexone and clonidine have found that successful detoxification can be completed in as little as one day with buprenorphine-stabilized patients, and that stabilization on buprenorphine is as rapid and successful as on methadone for heroin addicts. The overall success of outpatient detoxification using buprenorphine in combination with clonidine and naltrexone is better than using clonidine alone, with 85% of patients being transitioned to naltrexone. The cost savings for this new approach are substantial compared with methadone tapering.

No. 112C
ULTRA-RAPID DETOXIFICATION UNDER ANESTHESIA

Herbert D. Kleber, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 66, New York NY 10032*

SUMMARY:

Rapid opiate withdrawal using naltrexone and clonidine was developed in the 1980's and shortened withdrawal to two or three days. Ultra-rapid withdrawal in the 1990's attempted to overcome the rate limiting step of symptomatic discomfort of this earlier procedure by carrying out the naltrexone-precipitated detoxification either under heavy benzodiazepine sedation or general anesthesia. Withdrawal could thus in theory be shortened to five or six hours. The presentation will review the history of the technique, medications used, and what is known about the risk/benefit ratio. The procedure might be justified for a subset of opiate addicts if long-term results are better than with existing methods or if it is able to attract addicts otherwise unwilling to enter treatment—and if the risks are not substantial. As yet, no long-term controlled studies have been published.

No. 112D
THE USE OF ACUPUNCTURE IN OPIATE DETOXIFICATION

Janet Knoefal, Ph.D., *Department of Psychiatry, University of Miami School of Medicine, 1400 N.W. 10th Ave., Room 316, Miami, FL 33136*

SUMMARY:

Based on the original work of Wen in Hong Kong and the single-blind trial conducted by Washburn (1993), auricular acupuncture has been used for opiate detoxification in many clinical settings. A standard formula of four or five point locations on the external ear is used with patients in chairs in a group setting during the 45-minute treatment session. Acupuncture appears to relieve acute withdrawal symptoms and drug craving while preparing the patient to cooperate in psychosocial treatment. Acupuncture can be used alone or in conjunction with medications to manage withdrawal symptoms and can be given twice daily if necessary for symptom relief. In many states, auricular acupuncture for substance abuse can be administered by any clinician who has completed a 70-hour training program.

Thousands of addiction treatment staff members have been trained in the U.S. and Europe. More than 700 addiction treatment programs in the U.S and 40 other countries have added an acupuncture component to their protocol in the past several years. This development is based on the 20-year experience of Lincoln Hospital (Bronx, NY), which provides 150 acupuncture treatments per day as part of its comprehensive substance abuse program.

No. 112E
ENHANCING NALTREXONE TREATMENT AFTER DETOXIFICATION

Bruce J. Rounsaville, M.D., *Department of Psychiatry, Yale University, 34 Park Street, New Haven CT 06519;* Kathleen M. Carroll, Ph.D., Lisa R. Fenton, P.S.D.

SUMMARY:

Naltrexone, a long-acting opioid antagonist, has much to recommend it as a subsequent treatment to reduce the high relapse rates typically seen after a brief detoxification, since it has no psychotropic effects, no development of tolerance or withdrawal, and no complications regarding special licensing or diversion associated with opioid agonist treatments. Its major drawback is low acceptance and compliance due to side effects, lack of desired opioid agonist effects, and absence of withdrawal effects if treatment is discontinued.

We are conducting a clinical trial evaluating the strategy of enhancing naltrexone treatment with a psychosocial treatment designed to counteract the compliance issues. We have adapted elements of Higgings' Community Reinforcement Approach (CRA) for use with naltrexone-maintained opioid addicts and are comparing the efficacy of three treatment conditions: naltrexone with supportive therapy, naltrexone with contingency management (CM) + cognitive behavioral (CB) treatment, and naltrexone with CM, CB, and significant other(s)' involvement.

The CM condition entails providing vouchers of graduated value as reinforcement for compliance with naltrexone dosing. Vouchers are redeemable for goods or services consistent with treatment goals. SO involvement is included to provide additional incentive to comply with naltrexone treatment. Findings from the first 100 subjects in this trial will be presented.

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SYMPOSIUM 113—DEFICIT SYNDROME: RESEARCH AND TREATMENT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

Following this symposium, attendees will be able to describe (1) the differential diagnosis of negative symptoms in schizophrenia, (2) the neurobiologic correlates of deficit symptoms, (3) the prognostic implications of the deficit syndrome, and (4) pharmacologic and psychosocial approaches to the treatment of primary negative symptoms.

No. 113A DEFICIT SYNDROME: MARKER OF A SEPARATE DISEASE?

Brian Kirkpatrick, M.D., *MD Psychiatric Residential Ctr, PO Box 21247, Baltimore MD 21228-0747*

SUMMARY:

Patients with the deficit syndrome differ from other persons with chronic schizophrenia relative to the five dimensions that distinguish diseases. Compared with nondeficit patients, they are characterized by: (1) *signs and symptoms:* a lower level of function, less dysphoria, and a lesser severity of suspiciousness than nondeficit patients, in the absence of a greater severity of hallucinations, delusions, or formal thought disorder; (2) *course of illness:* poorer premorbid function as well as poorer function in early and later adult life, but a lesser frequency of suicidal thoughts; they may have a decreased risk of suicide; (3) *etiological and risk factors:* an excess of summer births and a greater familial prevalence of schizophrenia; (4) *biological correlates:* poorer neurocognitive function, especially in measures of attention and visuospatial information processing, despite more normal gross anatomy in some brain regions; (5) *treatment response:* the negative symptoms of deficit patients respond less well to typical and atypical neuroleptics, and tentative evidence suggests they may have a poorer response to psychosocial rehabilitation efforts.

The evidence further suggests they do not simply have a more severe form of the illness affecting others with schizophrenia. It is most parsimonious to interpret these findings as a categorical difference.

No. 113B A NATIONAL RESEARCH PROGRAM IN THE DEFICIT SYNDROME IN SCHIZOPHRENIA

Sonia Dollfus, M.D., *Department of Psychiatry, CHU Centre Esquirol, Cote De Nacre, Caen, France;* Michel Petit, M.D., Florence Thibaut, M.D., Dominique Campion, M.D., Jean Costentin, M.D., Jean Marc Constans, M.D., PHRC's Group

SUMMARY:

Objective: Because of the importance of the deficit syndrome in schizophrenia, France has launched a national research program aimed at better understanding the neurobiology of deficit symptoms. This report describes clinical and biological differences between deficit and nondeficit schizophrenia.

Methods: Inpatients and outpatients with DSM-IV schizophrenia were characterized into deficit and nondeficit subtypes using the Schedule for the Deficit Syndrome (SDS). Clinical rating scales, ocular motor tasks, neuropsychological tests, biochemical serum assays, and genetic variables were assessed blind to deficit and nondeficit characterization.

Results: Compared with nondeficit patients, patients with deficit schizophrenia demonstrated (1) a higher rate of neurological soft signs, (2) a lower rate and higher latency of antisaccades, (3) greater frontal impairment on neuropsychological tests, (4) lower mean pHVA with absent diurnal variation and higher mean pMHPG, (5) a slight excess of family history of schizophrenia and a significantly higher rate of alcoholism, and (6) no difference in Apo E allele frequency.

Conclusions: The data support a distinct neurobiologic process underlying deficit schizophrenia and support the validity of the deficit syndrome as a discrete subtype or domain of psychopathology.

No. 113C COURSE AND PROGNOSIS IN DEFICIT SCHIZOPHRENIA

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

SUMMARY:

Objective: The author will review data concerning the antecedents, symptom progression, and long-term outcome of patients diagnosed with the deficit syndrome, a putative domain of psychopathology and subtype of schizophrenia.

Method: Deficit and nondeficit patients in the Chestnut Lodge Followup Study are compared in relation to illness natural history, course, and long-term outcome.

Results: (1) Prior to illness onset, deficit patients are less likely to be married, but few other differences emerge; (2) Illness onset is often insidious for deficit patients and the illness is nearly always continuous and unreactive to life events; (3) Among deficit patients negative symptoms are often present at illness onset and progress in severity over the first five years of illness; (4) Patients with the deficit syndrome are at elevated risk of developing spontaneous motor disturbances, even in the absence of neuroleptic exposure; (5) Once established, the deficit syndrome is highly stable; (6) The deficit syndrome is associated with a very high risk of poor outcome and long-term disability; (7) Suicide may be rare in deficit patients.

Conclusions: The deficit syndrome as a subtype of schizophrenia has relatively distinct clinical correlates and natural history. An understanding of the differential diagnosis of the deficit syndrome informs the evaluation and treatment of negative symptoms.

No. 113D TREATMENT OF PRIMARY NEGATIVE SYMPTOMS

Robert R. Conley, M.D., *Department of Psychiatry, University of Maryland, Maple and Locust Streets, Baltimore MD 21228;* Deanna L. Kelly, Pharm. D., Carol A. Tamminga, M.D.

SUMMARY:

Persistent negative symptoms in people with schizophrenia are a vexing problem. A major hope for the novel antipsychotics is that they will provide a better treatment for negative symptoms than currently used drugs. Much of this therapeutic optimism stems from data showing improvement in negative symptoms in large populations of schizophrenic people treated with new antipsychotics. In this presentation we will carefully review these findings with particular emphasis on the differential diagnosis of negative symptoms. Many patients suffer greatly from secondary negative symptoms. It is clear that novel antipsychotics are frequently helpful in treating these symptoms. However, little evidence exists that primary negative symptoms respond as well to treatment. We have compared antipsychotic response of clozapine, remoxipride, risperidone, olanzapine, quetiapine, and sertindole with each other and with haloperidol in DSM-IV schizophrenic patients with primary and secondary negative

symptoms versus patients with secondary negative symptoms only. We will present data from these studies.

Patients had improvement in secondary negative symptoms but not primary negative symptoms. An effective strategy for improving the overall outcome of patients with negative symptom involves accurate diagnosis, thorough assessment of pharmacologic therapy, family support, and education. We will present this strategy at the meeting.

No. 113E
PSYCHOSOCIAL REHABILITATION FOR NEGATIVE SYMPTOMS

Robert K. Heinssen, Ph.D., *Research Institute, Chestnut Lodge, 500 W. Montgomery Avenue, Rockville MD 20850*

SUMMARY:

Objective: Care and treatment of patients with the deficit syndrome of schizophrenia demands the integration of biological and psychosocial interventions. A cognitive behavioral treatment model that offers a heuristic perspective for conceptualizing, implementing, and evaluating psychosocial treatments for negative syndrome patients is presented.

Methods: Clinical and quantitative data from a community-based rehabilitation program are presented to illustrate the utility of a cognitive-behavioral treatment model. A multidimensional assessment strategy which ascertains the patient's deficit/coping profile in information processing, social performance, and behavioral adaptation was developed. Once areas of impairment and residual functioning are catalogued, incremental treatment goals are specified for cognitive, affective, and interpersonal targets. Specific interventions (e.g., attention processing training, goal setting, social skills training) are then applied within "friendly" learning environments that are designed to be low in distracting stimuli, high in predictability, and consistent in expectations.

Results: Longitudinal assessment tests the efficacy of interventions and facilitates the maintenance of clinically responsive treatment plans. In the event that deficits preclude the acquisition of a new skill, environmental interventions are proposed for managing permanent cognitive and behavioral disabilities. Better patient care results when ongoing education and supervision allow treatment personnel to differentiate inability to function from unwillingness.

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SYMPOSIUM 114—TRAUMATIC BRAIN INJURY: PERSPECTIVES AND PEARLS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To (1) recognize, diagnose, and treat neuropsychiatric sequelae of traumatic brain injury (TBI); (2) understand risks of psychotropic medications in the acute setting; (3) better utilize the expertise of neuropsychologists in managing patients with TBI; and (4) enhance understanding of the patient's experience and the effect of TBI on the family.

No. 114A
THE CLINICIAN'S VIEW OF TRAUMATIC BRAIN INJURY

Kimberly A. Arlinghaus, M.D., *Department of Psychiatry, Baylor College of Medicine, One Baylor Plaza, Rm 625D, Houston TX 77030*

SUMMARY:

In this presentation, definitions of mild, moderate, and severe traumatic brain injury will be provided along with clinical pearls that will assist the clinician in recognizing TBI, taking an effective history, making correct diagnoses, and instituting appropriate treatments. Traumatic brain injury often mimics signs and symptoms of psychiatric disorders, such as depression, mania, anxiety, panic, psychosis, and personality disorders. Because neuropsychiatric conditions resulting from TBI require specific evaluation and treatment approaches, it is important to recognize the neurological cause of the disorder to ensure appropriate management. The DSM-IV will be canvassed for diagnostic categories applicable to neuropsychiatric conditions resulting from TBI, including delirium ("post-traumatic amnesia"), dementia, amnestic disorder, cognitive disorder ("post-concussive syndrome"), personality change ("dorsolateral frontal lobe syndrome", "orbitofrontal syndrome", etc.), psychotic/mood/anxiety disorders due to TBI, sexual dysfunction, and sleep disorders due to TBI. Psychotherapeutic and pharmacological treatments will also be overviewed with particular emphasis on those modalities unique to the brain-injured population. The information contained in this presentation will reinforce the importance of including TBI in the differential diagnosis of psychiatric symptoms and provide a foundation for evaluating and treating brain-injured patients.

No. 114B
THE PSYCHIATRIST'S VIEW OF TRAUMATIC BRAIN INJURY

Cindy B. Ivanhoe, M.D., *Phys Med and Rehab, Baylor College of Medicine, One Baylor Plaza, Rm 625D, Houston TX 77030*

SUMMARY:

Physiatrists specializing in traumatic brain injury combine their knowledge of physical medicine, rehabilitation, and neurology to restore optimal levels of pre-morbid functioning in the brain-injured patient. This presentation will describe effective approaches in the evaluation and treatment of TBI which may significantly impact the overall recovery of the patient as well as quality of care and length of stay. Because psychiatrists are often consulted to assist with the management of behavioral problems in brain-injured patients, it is important to recognize typical neurological findings produced by TBI, particularly in the acute care setting. For example, confabulation may be misinterpreted as delusional thought process, or aprosodia could be mistaken for depression. A psychiatrist who is unfamiliar with brain injury might approach an agitated patient in post-traumatic

amnesia in a more "traditional" fashion, prescribing haloperidol or lorazepam (rarely recommended by physiatrists due to the neurochemical ambience of the healing brain). This presentation will overview physiatric approaches to behavioral problems in TBI, illustrating the advantages of behavioral techniques, alternative concepts in pharmacological management and the role of the family. With this knowledge, psychiatrists may enhance the efficacy of interventions for brain-injured patients and their families.

No. 114C
THE NEUROPSYCHOLOGIST'S VIEW OF TRAUMATIC BRAIN INJURY

Corwin Boake, Ph.D., *Dept. of Neuropsychiatry, Inst. of Rehab Research, 1333 Moursund, Houston TX 77030*

SUMMARY:

This presentation will address three issues relevant to psychiatrists who interface with neuropsychologists in working with brain-injured patients: (1) How does one know if a psychologist performing neuropsychological evaluations has adequate training or credentials? This issue has grown in importance along with the role of neuropsychological expert testimony in personal injury litigation. (2) How does one know if a brain-injured patient has received an adequate neuropsychological evaluation? The patient's time post-injury and level of recovery indicate what tests are appropriate and how the results should be interpreted. Traditional neuropsychological batteries tend to under-assess recent memory and cognitive processing speed, the domains most sensitive to diffuse brain injury. Test scores must be statistically corrected for age and education, rather than classified as normal vs. impaired on the basis of uniform cutoff scores. (3) How can one distinguish between valid cognitive deficits and invalid responding associated with malingering and other non-TBI-related deficits? Techniques for detecting invalid responding on neuropsychological tests will be reviewed together with ethical issues in applying these techniques. The information provided in this presentation will offer the clinician helpful hints for assessing the validity of neuropsychological reports and utilizing the results to discern the origin of the patient's symptomatology.

No. 114D
THE PATIENT'S VIEW OF TRAUMATIC BRAIN INJURY

Phillip M. Colvard, *Department of Psychiatry, Houston VAMC, 2002 Holcombe Blvd., Houston TX 77030*

SUMMARY:

The speaker will present his experiences related to two traumatic brain injuries, one that rendered him comatose for approximately three weeks, and a second injury that produced significant emotional and cognitive setbacks. A video will be presented depicting the speaker in his acute stage of recovery after the first TBI as well as MRI's of the brain and illustrative case details from this injury. The importance of approaching survivors of TBI as individuals will be stressed throughout the presentation, reminding clinicians to tailor "the treatment to the patient" instead of "the patient to the treatment". Though common problems exist in survivors of TBI, the identity of the person ultimately shapes the recovery process and the outcome. The importance of maintaining hope and avoiding rigid, prognostic predictions will also be highlighted. By sharing experiences along a lengthy and arduous road of recovery, the speaker will deepen the participant's understanding of the devastating and life-changing forces often seen with traumatic brain injury. With this understanding, clinicians can design treatment programs for survivors of TBI (and their families) that embrace empathy for their challenging circumstances and respect for the individuality and strength of the survivor.

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SYMPOSIUM 115—IT'S NOT JUST AN EMERGENCY ROOM: URGENT CARE AND TRAINING IN AN ERA OF COST CONTAINMENT
Joint Session With the APA Consortium on Special Delivery Settings and the American Association for Emergency Psychiatry

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To (1) describe the spectrum of emergency services, (2) recognize the common elements of new emergency settings, (3) define psychiatric intensivism, (4) illustrate these concepts with examples, (5) articulate advantages and disadvantages of such services, (6) outline a complete emergency psychiatry training program, and (7) characterize the settings in which training occurs.

No. 115A
PSYCHIATRIC INTENSIVISM: A NEW ELEMENT IN EMERGENCY SERVICES

Michael H. Allen, M.D., *CPEP, NYU Bellevue Hospital Center, 462 First Avenue RM GS11, New York NY 10016*

SUMMARY:

Emergency psychiatry (EP) has undergone a radical transformation in recent years. Utilization of emergency services has been increasing while access to other services, particularly hospitalization, is declining. To some extent, resources have been reinvested in new crisis alternatives. This presentation will review the spectrum of crisis alternatives. The hallmarks of these new services are (1) acute, medically and psychiatrically complex presentations, (2) potential danger, (3) immediate, usually 24-hour, access and (4) brief, high-intensity care followed by transfer to a less-intensive setting. A new definition of EP encompassing these developments will be offered. This will be placed in the context of the evolution of emergency medicine and critical care specialists as the providers of immediate and/or intensive episodic care in a system generally favoring lower-cost continuity providers. Levels of psychiatric emergency services will be proposed that are analogous to the trauma system, with reference to the role of the psychiatrist at each level.

No. 115B
CRISIS ALTERNATIVES TO HOSPITALIZATION IN THE VA SYSTEM

Elie M. Francis, M.D., *Department of Psychiatry, 13000 Bruce B Downs Blvd, 116A, Tampa FL 33612*

SUMMARY:

In the last few years, the VA system started changing from an inpatient system to a primary care system with more emphasis on outpatient care and treatment. Finding alternatives to hospitalization became very important with renewed emphasis on accessible, high-quality, and efficient care. In psychiatry, we are presently using several alternatives.

In general psychiatry, we initially instituted 23-hour admission beds, which were then changed to overnight observation beds (outpatient), a daily crisis clinic, an intensive outpatient treatment program with a special track for patients with a history of multiple admissions and high utilization of ER services. We also now have a home health care service that follows these patients if they do not show up for their follow-up appointments.

In geriatric psychiatry, we instituted an interdisciplinary team that follows patients after they are discharged from the hospital to provide them with all the biopsychosocial services that they need as outpatients.

In substance abuse, the inpatient program was changed to a residential program with beds on contract in the community. In addition, we expanded our outpatient program to include various programs of multiple intensities, with a result of more patients receiving treatment and elimination of waiting times or assessments and waiting lists for admissions.

No. 115C
A FULLY MOBILE PSYCHIATRIC EMERGENCY SYSTEM

Joseph J. Zealberg, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425*

SUMMARY:

Traditionally, psychiatric emergency training and service delivery have occurred primarily in the emergency rooms of general hospitals. However, for the last 10 years, the Emergency Psychiatry Service/ Mobile Crisis Program of Charleston, South Carolina, has been providing clinical services in a completely mobile fashion; that is, the service responds to the patient in crisis, regardless of where the patient presents. Thus, the team responds to medical emergency rooms, clinics, or any other setting deemed necessary. Examples of other settings include homes, schools, nursing and residential facilities, malls, bridges, rooftops, homeless shelters, and street corners.

This public academic program is a collaboration between the Medical University of South Carolina and the Charleston Dorchester County Mental Health Center. A multidisciplinary approach is utilized, and close working relationships with law enforcement agencies have been established. In addition to conventional emergency evaluation and treatment, the program provides assistance in critical incidents such as barricaded, suicidal subjects and disaster relief coordination.

The presentation will focus on advantages and disadvantages of this approach. Discussion will address the delivery, coordination, continuity, and cost-effectiveness of the clinical services, education in this setting, and the impact on the community.

No. 115D
TEACHING EMERGENCY PSYCHIATRY: A MODEL CURRICULUM

Rachel L. Glick, M.D., *Department of Psychiatry, Univ. of Michigan Med Ctr., Box 0020, Ann Arbor MI 48109;* Jennifer S. Brasch, M.D., Jodi S. Lofchy, M.D., Janet S. Richmond, M.S.W., Victor G. Stiebel, M.D.

SUMMARY:

Psychiatric emergencies arise in all psychiatric and medical settings. All psychiatrists need the skills and knowledge to handle these crises. Although these skills are most likely acquired in residency, until now there have been no training standards for this broad and difficult field. With the increased awareness that residents must be prepared to handle emergencies safely and competently, the RRC recently added specific requirements for emergency training for all psychiatry residents. The American Association of Emergency Psychiatry (AAEP) is committed to leading in the development of educational programs in emergency psychiatry and has developed a model curriculum. This curriculum is designed to guide psychiatry residency programs in the teaching of crisis/emergency management and includes standards for emergency rotations, detailed learning objectives, suggested readings, and minimum didactic requirements. While it was created for residency training, it can easily be modified for medical students, fellows, and other mental health professionals. In this session, we will present and discuss our proposed curriculum. We will also describe the University of Toronto's innovative use of standardized patients in teaching emergency psychiatry to both residents and faculty. After attending this program, participants will be better able to both assess and design emergency psychiatry training programs.

No. 115E
A SURVEY OF TRAINING PROGRAMS IN EMERGENCY PSYCHIATRY

Jennifer S. Brasch, M.D., *Department of Psychiatry, St. Josephs Hospital, 50 Charlton Avenue East, Hamilton, ONT L8N 4A6, Canada*

SUMMARY:

Psychiatric residents need training in emergency psychiatry, a critical component of today's mental health services. Since shifts to community-based care and shortened hospital stays have increased the numbers of psychiatric emergencies seen in emergency rooms, it is crucial that residents become competent and confident at handling suicidal, violent, and other acutely ill psychiatric patients. The nature of the training residents currently receive and the types of emergency psychiatry services that offer training were not known until the American Association of Emergency Psychiatry's first survey of training programs in 1997. This presentation will review data from the 30 programs completing the survey, including the types of training environments, level of training offered, and elective available. In addition, different models of emergency psychiatric training will be presented. Participants will gain an understanding of current issues in emergency psychiatry training programs to assist them in planning and developing their own programs. Copies of The Directory of Training Opportunities in Emergency Psychiatry will be available to complement the presentation.

REFERENCES:

1. Allen MH: Definitive treatment in the psychiatric emergency service. Psychiatric Quarterly, 67:247–262, 1996.
2. Kizer KW: Prescription for unchange. The Guiding Principles and Stategic Objectives Underlying the Transformation of the

Veterans HealthCare System. March, 1996. U.S. Government Printing Office.
3. Gillig PM: The spectrum of mobile outreach and its role in the emergency service. New Directions in Mental Health Services 67:13–21, 1995.
4. Accreditation Council for Graduate Medical Education (ACGME): Essentials of Accredited Residencies. Directory of Graduate Medical Education Programs. Chicago, IL, American Medical Association, 1997, p. 266.
5. Thienhaus O: Academic issues in emergency psychiatry, in The Growth and Specialization of Emergency Psychiatry, Edited by Allen MH. Number 67, 1995, pp. 109–114.

SYMPOSIUM 116—INTRODUCTION TO PSYCHODERMATOLOGY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

Participants will have increased familiarity with psychodermatology; knowledge of representative cases with derm/psych diagnoses; knowledge of medications commonly utilized; and information to facilitate derm/psych working relationships.

No. 116A
PSYCHIATRIC TREATMENT OF STRESS-RELATED DERMATOSES

Iona H. Ginsburg, M.D., *Psychiatry, Columbia University, 55 E 86th St, New York NY 10028-1059*

SUMMARY:

The role of stress in triggering, exacerbating, and perpetuating skin disorders has been debated and studied over many years, often with anecdotal clinical reports. In general, there has been resistance among some dermatologists to accepting this relationship as having causal significance rather than being coincidental. Several recent studies will be briefly reviewed: these demonstrate links between the central nervous system and the skin, which suggest a potential pathway by which anxiety and depression resulting from stressful life events and/or intrapsychic distress might impact the pathophysiology of the skin. Two patients, one with psoriasis and one with atopic dermatitis, will be presented in relation to the treatment with psychotherapy and psychotropic medication of their stress-driven disease.

No. 116B
BODY DYSMORPHIC DISORDER IN DERMATOLOGY PRACTICE

Caroline S. Koblenzer, M.D., *Psychiatry & Dermatology, University of PA, 1812 Delancey Place, Philadelphia PA 19103*

SUMMARY:

Evidence suggests that more patients with body dysmorphic disorder consult dermatologists than physicians in any other medical specialty. Dermatologists find these patients confusing and difficult management problems. This presentation will describe, with clinical illustrations, common dermatologic manifestations of the disorder. Treatment options will be discussed, with emphasis on the education of the dermatologist and cooperation between the dermatologist and psychiatrist.

No. 116C
PSYCHOPHARMACOLOGICAL TREATMENT OF PSYCHODERMATOLOGICAL DISORDERS

John Y. Koo, M.D., *Dermatology, UCSF Medical Center, 515 Spruce Street, San Francisco CA 94118*

SUMMARY:

The psychological issues range from patients experiencing exacerbation of skin disorders like eczema or psoriasis when under stress, to the development of depression, social phobia, and even paranoia as a consequence of disfigurement and the manifestation of psychopathologies through the skin (e.g., neurotic excoriations, trichotillomania, factitial dermatitis, etc.). Theoretically, any antianxiety agent, antidepressant, antiobsessive-compulsive agent, or antipsychotic can be helpful in the treatment of psychodermatological cases, depending on the nature of the underlying psychopathology. However, certain psychopharmacological agents, such as doxepin, are known to be especially efficacious in this population. In addition to being an antidepressant, doxepin is a powerful antipruritic (i.e., anti-itch) agent, as well as the most powerful antihistamine available. In fact, doxepin is now used by dermatologists, not only as an oral medication, but also in the form of a prescription cream for pruritus. Pimozide is an antipsychotic agent with powerful antiformication properties; it greatly reduces the crawling and biting sensations frequently seen in psychodermatological patients, including those with delusions of parasitosis. In this presentation, a selected list of psychopharmacological agents that are known to be most useful in the treatment of psychodermatological cases will be discussed in detail.

No. 116D
THE INTERFACE BETWEEN DERMATOLOGY AND PSYCHIATRY

Thomas M. Gragg, M.D., *Psychiatry & Dermatology, Stanford University, 701 Welch Road #221, Palo Alto CA 94304-1704*

SUMMARY:

A model for the interface between dermatology and psychiatry will be presented with visual representations. An actual case, involving cutaneous excoriations and obsession/depression, treated by the author at the dermatology-psychiatry outpatient clinic at Stanford University Medical School, illustrates this interface. Possible variations and outcomes are included, with descriptions of the resulting impact on case treatment. Additional facets of dermatology-psychiatry interface are explored including: (1) mutual obligations and contributions by two physicians treating the same case; (2) patient response to treatment by two physicians from different specialties; (3) departmental involvement and sanction; and (4) organizational representation of dermatology and psychiatry. In conclusion, psychiatrists and mental health workers are encouraged to become more actively involved in this interesting area of medicine.

No. 116E
PITFALLS IN PSYCHOSOMATIC DIAGNOSIS: A CAUTIONARY TALE

Peter J. Koblenzer, M.D., *1812 Delancey Place, Philadelphia PA 19103*

SUMMARY:

There are two situations in the field of psychocutaneous medicine where psychiatric insight is particularly critical in directing the patient toward appropriate therapy. Each is characterized by a dramatic, manifest physical disorder. One is wrongly referred to the psychiatrist, when aggressive medical or surgical treatment is what is needed.

In the other, a psychiatrist is needed to protect the patient from harmful surgical intervention or endless medical investigations.

Illustrative clinical examples of each situation will be given, and the importance of cooperation between the dermatologist and the psychiatrist will be stressed.

REFERENCES:

1. Koblenzer CS: Stress and the skin: significance of emotional factors in dermatology. Stress Medicine, 4:21–26, 1988.
2. Phillips KA. Body Dysmorphic Disorder; Diagnosis and Treatment of Imagined Ugliness. J Clin Psychiatry. 57 Suppl 8:61–64, 1996. Discussion 65.
3. Cotterill JA. Body Dysmorphic Disorder. Dermatology Clinics 1996 Jul. 14:457–463.
4. Koo J: Psychodermatology: a practical manual for clinicians. Current Problems in Dermatology 7(6):199–234, 1995.
5. Gould W, Gragg T: A dermatology-psychiatry liaison clinic. J Am Acad Dermatol 9:73–77, 1983.
6. Koblenzer PJ, Koblenzer CS: Psychogenic purpura: a most distressing case. CUTIS, 45:60–61, 1990.

SYMPOSIUM 117—DRUGS AND PSYCHOTHERAPY IN ANXIETY DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To understand the methodological conditions under which clinical trials combining/contrasting drugs and psychotherapy in anxiety disorders can lead to meaningful results that can be generalized.

No. 117A
BEHAVIORAL THERAPY VERSUS CLOMIPRAMINE FOR OCD: METHODOLOGICAL ISSUES

Michael J. Kozak, Ph.D., *Department of Psychiatry, Allegheny University, 3300 Henry Avenue, Philadelphia PA 19129;* Edna B. Foa, Ph.D., Michael R. Liebowitz, M.D.

SUMMARY:

Methodological issues for pharmacotherapy-psychotherapy comparisons are considered in the context of an ongoing NIMH-sponsored, multicenter, controlled comparison of the efficacy of clomipramine, cognitive behavior therapy, and their combination, for obsessive-compulsive disorder. The study design, procedures, and analytic plan are described and related methodological considerations are explained. These include determination of treatment and control conditions, selection of a between-subjects simultaneous-treatment design, patient recruitment and the resultant sample, standardization of assessment and treatment procedures, preserving the independence of assessors, and choice of outcome analyses. Preliminary results are described, and methodological implications for their interpretation are discussed.

No. 117B
DRUGS AND PSYCHOTHERAPY IN PANIC DISORDER: METHODOLOGICAL ISSUES

Heinz Katschnig, M.D., *Department of Psychiatry, University of Vienna, Waehringerguertel 18-20, Vienna A1090, Austria;* Peter Berger, M.D., Gabriele Sachs, M.D., Michaela Amering, M.D., Anita Holzinger, M.D., Dagmar Maierhofer, M.D., Bettina Bankier, M.D.

SUMMARY:

In a controlled clinical trial 100 DSM-III-R panic disorder patients were randomized to either paroxetine alone or in combination with a specific form of group psychotherapy containing elements of both cognitive-behavioral therapy (CBT) and interpersonal psychotherapy (IPT). The study has a 24-week treatment phase and a 52-week follow-up phase. The latter was planned in order to detect differences between the treatment groups in terms of persistence of improvement and possible sleeper effects. Results of the 24-week treatment phase will be presented. Methodological problems encountered in planning and conducting the study will be discussed. These include selection and randomization problems (given the different attitudes of patients to drugs and psychotherapy), different speeds of onset of different treatments, and drop-out issues in relation to different study durations.

No. 117C
DRUGS AND PSYCHOTHERAPY IN SOCIAL PHOBIA: METHODOLOGICAL ISSUES

Michael R. Liebowitz, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 722 West 168th Street/MB #120, New York NY 10032-2603;* Richard G. Heimberg, Ph.D., Frank R. Schneier, M.D.

SUMMARY:

For many years pharmacotherapy and psychotherapy investigators made competing claims concerning treatment efficacy in social phobia without adequate data to resolve differences of opinion. Studies comparing medication and psychosocial treatment emanating from a single center did not greatly clarify the situation because such studies were seen as possibly biased by the center's treatment ideology and did not reflect the state of the art of both modalities. To improve this situation, a collaboration was initiated in which phenelzine, the medication with the best-documented efficacy in social phobia, was compared with cognitive behavioral group therapy (CBGT), a well-studied psychosocial approach for this disorder. The study was carried out at two sites, one expert in medication, the other in CBGT, with both active treatments as well as the control treatment carried out at both sites. This study went a long way toward resolving the problems besetting previous attempts to compare medication and psychotherapy in the anxiety disorders and helped create a new investigate model for the field. The results of this study and the design of a subsequent investigation aimed at answering a number of remaining questions will be presented. Research issues that remain unresolved will also be discussed.

REFERENCES:

1. Kozak MJ, Liebowitz MR, Foa EB: Cognitive-behavior therapy and pharmacotherapy for OCD: the NIMH-sponsored collaborative study. In W.K. Goodman, M. Rudorfer, and J. Maser (Eds.) Treatment-Refractory Obsessive-Compulsive Disorder, Mahwah, N.J.: Lawrence Erlbaum, in press.
2. Katschnig H, Amering M, Stolk JM, et al: Long-term follow-up after a drug trial for panic disorder. Brit. J. Psychiat. 167:487–494, 1995.
3. Heimberg RG, Liebowitz MR, Hope DA, Schneier FR: Social Phobia: Diagnosis, Assessment, and Treatment. New York: Guilford Press, 1995.

SYMPOSIUM 118—CLINICAL UPDATE ON PREMENSTRUAL DYSPHORIC DISORDER

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To understand the diagnostic, epidemiologic, and pathophysiologic aspects of PMDD as well as the clinical approach to the treatment of this disorder.

No. 118A
PREMENSTRUAL DYSPHORIA: DIAGNOSIS, EPIDEMIOLOGY AND COMORBIDITY

Jean Endicott, Ph.D., *Department of Psychiatry, NY State Psych Institute, 722 W 168th Street Unit 123, New York NY 10032*

SUMMARY:

The availability of specified criteria for premenstrual dysphoric disorder has been of great value to investigators with an interest in differential diagnosis, epidemiology, and comorbidity of changes in mood and behavior along the menstrual cycle. Recent studies have helped clarify the nature of other conditions most likely to be present in women seeking treatment for premenstrual dysphoria. Differentiating other conditions from episodic premenstrual dysphoric disorder is important given the increasing use of episodic dosing of medications that are effective in the treatment of premenstrual dysphoria. Careful diagnosis has also led to better estimates of lifetime comorbidity with other mental disorders, the rates generally found to be somewhat lower than was the case when less stringent criteria were applied. The use of the DSM-IV criteria in epidemiological studies has also resulted in more informative data regarding the rates of the disorder in community samples. Interestingly, the rates are within the range of those noted in DSM-IV. An overview of the results of recent studies will be presented and the clinical and research implications of the newer findings will be discussed.

No. 118B
CHRONOBIOLOGY OF PREMENSTRUAL DYSPHORIC DISORDER

Barbara L. Parry, M.D., *Department of Psychiatry, University of California, 9500 Gilman Drive, La Jolla CA 92093;* Richard L. Hauger, M.D., J. Christian Gillin, M.D., Jeffrey Elliott, Ph.D.

SUMMARY:

Multiple etiologies and treatments have been proposed for premenstrual dysphoric disorder (PMDD). Our laboratory has been investigating chronobiological hypotheses which predict that changing levels of reproductive hormones during the menstrual cycle precipitate a desynchronization of underlying circadian rhythms (such as melatonin and sleep) in relation to the external environment. To test these hypotheses, we have conducted sleep, melatonin and light studies in women with PMDD versus normal control subjects. Sleep studies indicate increased awakenings in the premenstrual phase and lighter sleep in patients compared with controls. Sleep deprivation studies point to the therapeutic efficacy of sleep deprivation (both early and late) in this disorder. Melatonin studies suggest a blunted circadian rhythm of melatonin at all menstrual cycle phases in PMDD women. Light treatment, designed to enhance the melatonin rhythm, improves mood compared with baseline but the different types of light treatment (morning bright light, evening bright light and dim evening light) do not show statistically significant differences from each other in follow-up studies. Recent work suggests that PMDD patients in the symptomatic luteal, but not asymtomatic follicular phase, have a blunted response to bright morning light. This effect might account for their decreased melatonin profiles and desynchronized rhythms, possibly contributing to mood disturbances.

No. 118C
SERTRALINE VERSUS DESIPRAMINE IN PMS TREATMENT

Ellen W. Freeman, Ph.D., *Dept. of OBGYN/Psychiatry, University of Pennsylvania, 3400 Spruce St. 2Dulles, Philadelphia PA 19104;* Karl Rickels, M.D., Steven J. Sondheimer, M.D.

SUMMARY:

Objective: Studies show that selective serotonin reuptake inhibitors are effective for premenstrual symptoms (PMS). This study compares the serotonergic antidepressant sertraline with a noradrenergic antidepressant, desipramine, to determine whether efficacy for PMS is a general effect of antidepressant medications or a specific effect of serotonin reuptake inhibitors. Preliminary results are reported.

Method: Subjects were randomized to three months of double-blind treatment after a three-month screening period. The total premenstrual scores from the daily symptom reports (DSR) were analyzed using ANCOVA with baseline scores as a covariate.

Results: Of 88 randomized subjects, 22 discontinued before completing the three-month treatment phase: two of 30 (7%) in the sertraline group, 13 of 27 (48%) in the desipramine group, and seven of 31 (23%) in the placebo group (chi square = 13.2/2 df, $p < 0.01$). In endpoint analysis, improvement differed significantly among the three treatment groups ($p < 0.009$, $p < 0.009$, $p < 0.04$ in the three treatment cycles, respectively). Sertraline was significantly better than desipramine or placebo in each cycle; desipramine did not differ from placebo. A history of major depression did not alter the treatment results. Defining improvement as ≥ 50% decrease in DSR scores from baseline, 66% (20/30), 41% (11/27), and 42% (13/31) improved in the sertraline, desipramine, and placebo groups, respectively. When only continuers were examined, improvement with desipramine increased but still did not significantly exceed placebo.

Conclusions: The results show that the serotonergic antidepressant is effective for the total symptoms of PMS. The efficacy of desipramine is not greater than placebo, in part because fewer PMS patients tolerated the medication.

No. 118D
AN ALGORITHM FOR THE TREATMENT OF PREMENSTRUAL DYSPHORIC DISORDER

Stephanie Klein-Stern, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, One Gustave L. Levy Pl. 1228, Bronx NY 10029;* James J. Strain, M.D.

SUMMARY:

Objectives: We attempted to construct an evidence-based algorithm for the treatment of premenstrual dysphoric disorder (PMDD) based on a comprehensive review of psychopharmacologic and psychotherapeutic controlled studies of late luteal phase dysphoric disorder (LLPDD) and PMDD.

Design and Methods: A Medline and Psychlit search covering the period 1987–1997 identified over 100 related double-blind, controlled-treatment trials. Four main methodological considerations were applied: (1) Controlled trial(s) demonstrated superiority of the active agent (AA) over placebo; (2) Controlled trial(s) demonstrated superiority of one AA over a second AA; (3) Where possible, to resolve the discrepancy between contradictory studies, their data were pooled and meta-analyzed; (4) Sequential order of treatments

was also determined based on assessments of relative degree of utility.

Results: Across controlled trials the placebo response rate was considerable. SSRI's and ovulation suppressants were consistently superior to placebo. While controlled, head-to-head comparison trials between SSRI's and ovulation suppressants were not found; for typical cases, utility computations favored the SSRI's. The algorithm relied on effect size computations and relative degree of utility for subsequent choices after treatment failure.

Conclusions: Only a few branches of the algorithm could be derived from strictly evidence-based data. Further studies using structured diagnostic assessments and standardized outcome measures to compare proven AA's are essential.

REFERENCES:

1. Gehlert S, Hartlage S: A design for studying the DSM-IV research criteria of premenstrual dysphoric disorder. J Psychosom Obstet Gynaecol 18:36–44, 1997.
2. Parry BL, et al: Blunted phase-shift responses to morning bright light. J Biological Rhythms, 122:443–456, 1997.
3. Freeman EW: Premenstrual syndrome: current perspectives on treatment and etiology. Curr Opin Obstet Gynecol 9:147–153, 1997.
4. Nelson JC, Docherty JP, Henschen GM, et al: Algorithms for the treatment of subtypes of unipolar major depression. Psychopharmacol Bull 31(3):475–482, 1995.

Component Workshop 1
MALPRACTICE AND LITIGATION IN PSYCHIATRIC RESIDENCY
APA New York State Psychiatric Association's Committee of Members-in-Training

Chairpersons: Cletus S. Carvalho, M.D., *Department of Psychiatry, St. Vincent's Hospital, 101 West 15th Street, #3-OS, New York NY 10011-6745*
Participants: Paul S. Appelbaum, M.D., Martin G. Tracy, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to understand the malpractice and litigation risks that psychiatric residents are exposed to and strategies to aid in the reduction and management of such risks.

SUMMARY:

Every psychiatric physician involved in patient care is exposed to situations that could lead to litigation. For the psychiatric resident this is a complex issue since patient care that is dispensed is usually carried out under order of an attending or supervising psychiatrist. In such instances the need to clearly define where one's responsibility begins and ends is not appreciated until the issue of probable malpractice arises and medical records are more closely looked at. This is also important for faculty involved in training psychiatric residents.

This workshop will address malpractice and litigation risk in psychiatric residency training. Speakers will discuss aspects relevant to psychiatric residents and to psychiatrists involved in teaching residents. Issues surrounding the occurrence, management, and prevention of malpractice and litigation will be examined; further, strategies to incorporate these into residency curricula will also be looked at. Input provided will be from a clinician's and an attorney's perspective in an effort to ensure that all areas are properly covered. Most importantly, active participation from the audience will be encouraged during a discussion that will affect psychiatrists in residency and academia.

REFERENCES:

1. The mock trial in psychiatric staff education. Bull Am Acad Psychiatry Law, 1994; 22:127–132.
2. Malpractice litigation against child and adolescent psychiatry residency programs, 1981–1991. J Am Acad Child Adoles Psychiatry, 1993; 32:462–465.

Component Workshop 2
NURSING HOME PSYCHIATRY: PROBLEMS AND SOLUTIONS
APA New Jersey Psychiatric Association

Chairperson: Marc I. Rothman, M.D., *Department of Psychiatry, Hampton Hospital, 650 Rancocas Road, Westampton NJ 08060*
Participants: Istvan J.E. Boksay, M.D., Patricia A.J. Kay, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to improve geropsychiatric care skills of nursing home staff, effectively utilize psychotropic medicines in the nursing home within federal guidelines, manage marital and intimacy issues of nursing home residents, and intervene with families experiencing a crisis due to the nursing home experience.

SUMMARY:

The workshop will address difficult challenges commonly encountered by psychiatrists working in nursing home settings. These are: (1) enhancing the psychiatric assessment and management skills of all levels of personnel interacting with nursing home residents to increase problem prevention and make psychiatric consultation efforts more effective; (2) understanding how to optimize use of psychotropic medicines while practicing in accordance with federal "OBRA 87" prescribing guidelines; (3) reconciling issues of privacy, safety, and autonomy in working with both married couples in nursing homes and intimate behaviors between nonmarried residents; and (4) assisting family members through the emotional and behavioral crises that they and their elderly relatives in the nursing home often experience. Each problem area will be introduced with a vignette designed to elicit approaches from the audience. The audience's comments and responses will be integrated into the discussion of potential approaches and solutions by each workshop presenter. In addition, related topics and concerns of the audience will be discussed.

REFERENCES:

1. Streim JE, Katz IR: Federal regulations and the care of patients with dementia in the nursing home. Med Clin North Am. 1994; 78:895–909.
2. Reichman WE, Katz IR: Psychiatric Care in the Nursing Home New York: Oxford University Press, 1996.

Component Workshop 3
HOW YOUR PATIENTS' DISABLEMENT WILL BE EVALUATED
APA Committee on Psychiatric Diagnosis and Assessment

Co-Chairpersons: Frederick G. Guggenheim, M.D., *UAMS, 4301 West Markham, Slot 554, Little Rock AR 72205-7101,* Bedirhan Ustun, M.D., *World Health Organization, Geneva 1211, Switzerland*
Participants: Cille Kennedy, Ph.D., Dale N. Cox, B.S., Laura Lee Hall

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will have a basic understanding of the scope of ICIDM and its applications to the seriously mentally ill regarding their disability benefits. Participants will see how the evaluation works and why the Social Security Administration and private insurers have such a keen interest in ICIDM.

SUMMARY:

This workshop will focus on the new "Manual of Dimensions of Disablement and Functioning," the WHO-sponsored International Classification of Impairments, Activities, and Participation. It is now in beta testing for the new second version. Within the next three years, the Social Security Administration, disability insurance companies, and managed care corporations may begin testing this function-relevant rating system as a complement to symptom-related schemas such as DSM-IV or ICD-10. As parity for funding of psychiatric disorders gathers momentum, a widely accepted rating of function will put disabilities from all causes on a level playing field. Whether the condition is brain disease with stroke or brain disease with schizophrenia, individuals afflicted with either of these conditions have restrictions of activities and limitations of participation. The availability and integration of the manual into routine clinical practice will have implications for economic support, policy, and research.

The overall aim of ICIDM-2 classifications is to provide a uniform and standard language to serve as a frame of reference for the "consequences of health conditions." It is an attempt to capture the integration of the various dimensions of disablement into a biopsychosocial approach.

REFERENCES:

1. Wiersma D: Psychological impairments and social disabilities and the applicability of ICIDM to psychiatry. International Rehabilitation Medicine, 1986; 8:3–7.
2. Badley EM: An introduction to the concepts and classifieds of the international classification of impairment, disabilities and handicaps. Disability and Rehabilitation, 1993; 15:161–178.

Component Workshop 4
POLITICAL VIOLENCE IN THE POST-COLD WAR ERA
APA Task Force on National and International Terrorism and Violence

Chairperson: Jerrold M. Post, M.D., *Political Psychology, George Washington University, 2013 G Street, NW, Ste 202A, Washington DC 20052,*
Participants: Stevan M. Weine, M.D., David A. Rothstein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the psychology of political violence.

SUMMARY:

The end of the cold war has been destabilizing, with major changes in the phenomenon of political terrorism and a rise in ethnic/nationalist tensions, which at its extreme has resulted in genocidal violence. In this workshop, which will be didactic with audience participation, we will explore political violence in the post-cold-war era. We will consider collective memory and the intergenerational transmission of trauma. The psychological foundations of ethnic conflict will be explored, which can express itself both in genocidal conflict as well as nationalist terrorism. And we will explore the changing face of terrorism, emphasizing that the threshold of mass casualty violence has been crossed, describing new forms of terrorism that can be expressed in weapons of mass destruction.

REFERENCES:

1. Robins R, Post J: Political Paranoia: The Psychopolitics of Hatred. New Haven: Yale Univ. Press, 1997.
2. Post J: The loss of enemies, fragmenting identities, and the resurgence of ethnic/nationalist hatred and antisemitism in Eastern Europe J. For the Psychoanalysis of Culture and Society 1996; Vol 1, #2.

Component Workshop 5
NEW AND ALTERNATIVE TREATMENTS IN HIV CARE
APA Commission on AIDS

Chairperson: Francisco Fernandez, M.D., *Department of Psychiatry, Loyola University, 2160 South First Avenue, Maywoodn IL 60153,*
Participants: Francine Cournos, M.D., John H. O'Donnell, M.D., Karl Goodkin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to review new and alternative therapies for the management and treatment of AIDS and disease.

SUMMARY:

There is great optimism shared by many in the clinical community that for the first time we have a real chance to transform HIV disease from an inexorably fatal condition to a chronic, manageable viral infection. Protease inhibitors, in particular, have generated renewed hope for the treatment of HIV infection. The field is also seeing a growing interest in alternative therapies for managing HIV disease. Alternative therapies can refer to all types of interventions against disease that are not part of the Western medical tradition. This represents a considerable range of treatments including acupuncture, yoga, herbal medicines, visualization, and megavitamins. Many alternative therapies report tremendous success, while others offer little more than inflated promises.

In this session panelists will examine both new and alternative treatment therapies, discuss the problems and potential benefits of various therapies, and provide practical guidelines for counseling patients on treatment options. The session will also include a consumer's perspective on combining new and alternative treatment strategies. Audience members will be asked to participate in the discussion, invited to ask questions, and encouraged to share their own clinical experience.

REFERENCES:

1. Gordon J: Manifesto for a New Medicine. Addison-Wesley, 1996.
2. Moyle G, Gazzard B: Current knowledge and future prospects for the use of HIV protease inhibitors. Drugs 1996; 51(5):701–712.

Component Workshop 6
GUIDELINES FOR COLLABORATIVE TREATMENT IN PSYCHIATRY
APA Consortium on Treatment Issues

Chairperson: Jerome A. Collins, M.D., *P.O. Box 1040, Kennebunk ME 04043-1040*
Participants: Michelle Riba, M.D., Joseph J. Westermeyer, M.D., Richard J. Kessler, D.O., Lawrence C. Sack, M.D.

EDUCATIONAL OBJECTIVES:

At the conclution of this workshop the participants should be able to recognize some of the legal, ethical, and therapeutic pitfalls of collaborative psychiatric treatment, and should have concepts and guidelines for addressing them.

SUMMARY:

Although collaborative treatment between psychiatrists and mental health professionals is a treatment approach with deep historical roots, the practice in recent years has been complicated by the advent of managed care. The panel, a subcommittee of the APA Consortium on Treatment Issues, has been at work on the development of guidelines for the therapeutic collaboration between psychiatrists and mental health professionals that will fit the legal, ethical, and caregiving needs of the new clinical task environment. The core task in collaborative treatment is how to provide the patient with an integrated therapeutic product; one that is intelligible to the patient, one that is therapeutic and cost-effective, and one that keeps the boundaries of mutual responsibility and obligation as clear as possible. The panel will present some of the current pitfalls of this practice and tentative clinical guidelines that aim to avoid them. It will seek active dialogue with the audience to add to and flesh out this work in progress.

REFERENCES:

1. Weiner H, Riba M: Medication backup: attitudes and practices of psychiatrists and residents. Psychiatric Services, 1997; vol. 48, no. 4
2. Krupnick JL, et al: The role of therapeutic alliance in psychotherapy and pharmacotherapy outcome: findings in the National Insti-

tute of Mental Health Treatment of Depression Collaborative Research Program. J Consult Clin. Psychol. 1996; 5:32–39.

Component Workshop 7
DEALING WITH VIOLENCE IN SCHOOLS
APA Committee on Psychiatry and Mental Health in the Schools and APA Task Force on Psychiatric Aspects of Violence

Chairperson: Lois T. Flaherty, M.D., *770 Lantern Lane, Blue Bell PA 19422-1612*
Participants: Carl C. Bell, M.D., Paul Jay Fink, M.D., Joan Evelyn Kinlan, M.D., Joseph J. Palombi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate knowledge of the epidemiology of school-related violence, describe programs used to help alleviate violence in schools, list factors in school environments that tend to be associated with violence, and identify factors associated with violence in schools.

SUMMARY:

Violence presents a challenge for today's educators and poses major concerns for parents and students. Every day 160,000 students stay out of school because of fears of violence. Violence in communities impacts on the school, but violent incidents in schools also occur with alarming frequency. School systems are being pressured to implement programs to deal with violence rapidly. These range from installing metal detectors to organizing peer mediation programs. Many of these programs are untested or of questionable value. Psychiatrists who work as consultants to school systems should be aware of the knowledge base related to violence and violence prevention. Each of the presenters has implemented and/or evaluated programs for violence among school students. They will summarize the current knowledge about risk and protective factors and efficacy of violence prevention and postvention programs. Ample time during the workshop will be reserved for audience questions and discussions.

REFERENCES:

1. Resnick MD, Bearman PS, Blum RW, et al: Protecting adolescents from harm: findings for the National Longitudinal Study on Adolescent Health. JAMA, 1997; 278: 823–832.
2. Sheras PL, Cornell DG, Bostain DS: The Virginia Youth Violence Project: transmitting psychological knowledge on youth violence to schools and communities. Professional Psychology. Research and Practice 1996; 27:401–406.
3. Koop CE: Violence in America: a public health emergency. Professional Psychology-Research and Practice. JAMA 1992; 267:3075–3076.

Component Workshop 8
HANDS-ON WEB WORK: PART I
APA Committee on Information Systems

Chairperson: Bertram Warren, M.D., *86 North Martine Avenue, Fanwood NJ 07023-1330*
Participants: Cheryl A. Chessick, M.D., Ivan Goldberg, M.D., Sol Herman, M.D., Ronnie S. Stangler, M.D.

EDUCATIONAL OBJECTIVES:

By the conclusion of this workshop participants will be able to use a keyboard and mouse in a windows environment, will be able to navigate the Web using a standard browser, will know how to use Internet technology to meet individual needs, and will understand the basic format and structure of the APA web site.

SUMMARY:

With the three-room format, there will be an attempt to segment the participants into beginner, intermediate, and more advanced users. Presentations and materials will include introduction to Windows technology, Web history and design, and navigation of the Web, including specifically APA's site. Information will be presented in a hands-on format and will include: how to use the Windows environment; exercises to become familiar with a mouse (for the beginning sections); how to use the Web navigation tools; and how to find the information you want when you don't know exactly who or what you are looking for. Skill development will include: how to familiarize yourself with the Web environment; how to find useful sites, using search engines; how to find a site again that you like; how to handle searches that are taking too long; how to respond when you get error messages (e.g., can't find this server); how to set preferences; how to download and print from the Web.

Component Workshop 9
IMPROVING MANAGED CARE IN THE PUBLIC SECTOR
APA Committee on Managed Care and APA Committee of Black Psychiatrists

Chairperson: Altha J. Stewart, M.D., *Amoore Health Systems, 7150 Crittenden Street, Philadelphia PA 19119*
Participants: Gloria Pitts, D.O., Ivan C.A. Walks, M.D.

SUMMARY:

As more states move Medicaid recipients into managed care programs, policymakers are discovering that many practices developed by managed care organizations working with commercial populations are not easily generalized to more vulnerable and impaired populations. Issues such as little experience in treating public patients and lack of linkages with essential community support agencies frequently result in little to no effectiveness in treating the public sector patient population. The challenge of providing more carefully managed, clinically appropriate, and cost-effective care will require increased collaboration between the "public" and "private" systems. Government payers must understand how to design managed systems of care that maintain the traditional "safety net" while achieving the desired cost savings. They must be sensitive to the special needs of the patients they serve and design and implement managed care programs to meet these needs. Through contracts with managed care organizations, well-intentioned but inexperienced or poorly trained government workers will develop and implement the systems for delivery, management, payment, and measurement of the quality of service provided to Medicaid populations.

A discussion of a set of guidelines being developed to assist state government decisionmakers in developing appropriate service delivery systems will be an integral part of the workshop presentation. Optimal public-private integration strategies will be described. Workshop participants will also hear updates on the status of initiatives in some of the states currently implementing mental health managed care programs, such as Massachusetts, Iowa, Tennessee, and Pennsylvania. Presenters will discuss these changes from both the public- and private-sector perspectives.

Component Workshop 10
USE OF CULTURE IN INTERVENTIONS FOR YOUNG CHILDREN
APA Committee on Pre-School Children

Chairperson: Harry H. Wright, M.D., *Neuropsychiatry, University of South Carolina, 3555 Harden Str. Ext. Ste #104, Columbia SC 29203*
Participants: Robert N. Emde, M.D., Irene Chatoor, M.D., David S. Rue, M.D., William Arroyo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the issues and the importance of cultural considerations in working with young children and their families, and to apply principles of cultural competence to psychiatric practice.

SUMMARY:

By 2010 approximately 42% of the nation's children will come from ethnic minority families, more than half of the children under age 6 will come from these families. These demographics emphasize the importance of developing culturally competent systems and individuals for the care of young children and their families. To intervene effectively with young children, psychiatrists must deal with numerous developmental issues within a broader ecological context that emphasizes a cultural framework. Both developmental and cultural competence are essential for effective assessment, diagnosis, and treatment of young children and their families. The workshop will begin with a brief summary of the principles of culturally competent care and describe a model for delivery of such care. Clinical vignettes will be utilized to demonstrate culture-related issues in work with young children. Psychiatrists skilled in cultural interventions will respond to the vignettes and initiate the audience's participation in the discussion. The focus will be on practical application of the knowledge and skills necessary to develop culturally competent systems and clinicians.

REFERENCES:

1. Vargas LA, Koss-Chioino JD: Working with Culture. San Francisco: Jossey-Bass Publishers, 1992.
2. Canino IA, Spurlock J: Culturally Diverse Children and Adolescents. New York: Guilford Press, 1994.

Component Workshop 11
LOVE LETTERS: SHORT DRAMA WITH ANALYTICAL INTERPRETATION AND DISCUSSION
APA Auxiliary

Co-Chairpersons: Catherine Kirschner, *3421 Garrison Street, N.W., Washington DC 20008*, Elizabeth A. Reade, M.D., *RR 5, 150 Delhi Street, Guelph, ONT N1E 6K9, Canada*
Participants: Venie B. Palasota, Pete C. Palasota, M.D.

EDUCATIONAL OBJECTIVES:

Using a dramatic tool (a short, two-character play) followed by analytical discussion and audience participation, those attending will be able to recognize, diagnose, and better understand the many variables of interpersonal relationships.

SUMMARY:

''Love Letters,'' a nationally acclaimed play, has been described as a tender and often hilarious story told through letters exchanged over a lifetime between two people who grew up together and then went their separate ways. They continue to share confidences, love, joy, anger, ambition, and heartaches along the way. The presentation will be done in dramatic format with two actors and a simple set—one table and two chairs—and will be followed by analytical interpretation by a psychiatrist. The audience will participate in the discussion with educational and anecdotal material from their own experiences and from those of their patients. This program should enhance the therapist's knowledge of and abilities to better understand and work with patients who have similar problems.

Sought after by well-known actors, the play has been performed over the U.S. by many great artists such as Colleen Dewhurst and E.G. Marshall, Alan Alda and Carol Burnett, and Charlton Heston and his spouse. The Palasotas' performance of ''Love Letters'' has been very well received. This play has it all—love, anger, ambition, parental and alcohol abuse, frustration—all tempered with humor.

REFERENCES:

1. Gurney AR: Love Letters (a play).

Component Workshop 12
SOLVING PROBLEMS IN PSYCHIATRIC ADMINISTRATION
APA Council on Medical Education and Career Development

Co-Chairpersons: W. Walter Menninger, M.D., *Menninger Clinic, 5800 South West 6th Street, Topeka KS 66606*, Philip E. Veenhuis, M.D., *Medical Director, Division of MH/DD/SAS, 325 North Salisbury, Raleigh NC 27603*
Participant: William H. Reid, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize and more effectively address common problems in psychiatric administration.

SUMMARY:

Members of the APA Committee on Psychiatric Administration and Management from both the private and public sectors will discuss common problems in organizational practice. Audience participation will be encouraged in sharing problems and identifying solutions.

REFERENCES:

1. Keill SL, Arce AA, Mallott DB: Strategies for organizational change, in Textbook of Administrative Psychiatry. Edited by Talbott JA, Hales RE, Keill SL. Washington, DC: APPI, 1992
2. Fauman MA: Quality assurance monitoring in psychiatry. Am J Psychiatry 1989; 146:1121–1130

Component Workshop 13
BEYOND COMING OUT
APA Committee on Gay, Lesbian and Bisexual Issues

Chairperson: Lowell D. Tong, M.D., *Department of Psychiatry, San Francisco VAMC 116N, 4001 Parnassus, Box ACC-0348, San Francisco CA 94143*
Participants: Steven J. Lee, M.D., Howard C. Rubin, M.D., Karine J. Igartua, M.D., Diana C. Miller, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to treat patients who happen to be gay/lesbian/bisexual or whose lives are connected to those who are gay/lesbian/bisexual with greater efficacy because of a wider appreciation of the many contemporary coming out issues, which go far beyond self-disclosure.

SUMMARY:

''Coming out'' today goes far beyond the initial models that dealt primarily with self-awareness or self-disclosure of one's sexual orientation. This workshop comprises four presentations, each lasting approximately 10 minutes, plus ample discussion time when the audience will be encouraged to ask questions, give clinical examples, and contribute ideas.

There will be four presentations: ''Coming Out Issues for Today's Youth'' will discuss how more people are able to come out at earlier ages, such as during high school, and will examine the different challenges for this group compared with those who come out as young adults; ''Transference and Countertransference Issues for Patients who are Coming Out'' will use clinical examples to explore

the impact of feelings and attitudes of patients and psychiatrists engaged in psychotherapy; "Coming Out as Parents of Gay/Lesbian/Bisexual Children" will address concerns of parents in this era of greater visibility and disclosure of sexual orientations; and "Coming Out as a Partner in a Gay Couple" will explore the issues that couples face in social, family, and workplace environments.

REFERENCES:

1. Martin H: The coming out process for homosexuals, Hospital and Community Psychiatry, 1991; 42:158–162.
2. Textbook of Homosexuality and Mental Health. Edited by Cabaj R, Stein T. Washington, DC: American Psychiatric Press, Inc., 1996.

Component Workshop 14
LIFE AFTER RESIDENCY: MAKING A CAREER CHOICE
APA Assembly's Committee of Area Member-in-Training Representatives

Chairperson: Judythe S. McKay, M.D., *Department of Psychiatry, W.S. Hall Psych. Institute, 1800 Colonial Drive, Box 202, Columbia SC 29202*
Participants: Allan Tasman, M.D., Suzhanna M. Elam, M.D., George A. Fouras, M.D., Mary Kay Smith, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to list two positive and two negative aspects of choosing a career in private, public, or academic psychiatry; to name three guidelines to help choose a specific career in psychiatry; to recognize there are creative ways to set up a practice; and to recognize that career development is as important as choosing the first career.

SUMMARY:

As residents prepare to leave the safety net of residency and embark on a career in psychiatry, they face many questions. These questions have different answers depending on the particular resident's style, interests, personality, and family concerns. This workshop is designed to provide a format for residents to interact with four psychiatrists from different areas of psychiatry: private, public, and academic. The presenters are men and women in different stages of their careers who found both traditional and creative ways to put together a practice. They have had to struggle with the challenges of choosing a career, balancing career and family, and continuing the development of their career. The presenters will talk briefly about the type of practice they chose, why they chose it, what they like and dislike about their choice and, if applicable, how their original decision led them to other types of careers. Then participants will discuss with the panel members any questions and concerns they have regarding the selection of specific areas of psychiatry. The workshop is designed to raise awareness of issues surrounding choosing a career and to provide an informal atmosphere in which the participants can engage in an open and honest dialogue.

REFERENCES:

1. Yager J: The many quests of psychiatrists: how well can we fulfill them? Academic Psychiatry 1990; 14:44–53.
2. Review of Psychiatry Vol 15 (Sec V). Edited by Dickstein LJ, Riba Michelle B, Oldham John M. Washington D.C.: American Psychiatric Press, Inc., 1996.

Component Workshop 15
HANDS-ON WEB WORK: PART II
APA Committee on Information Systems

Chairperson: Thomas A.M. Kramer, M.D. *Mail Slot 766, VAMS Psychiatric Clinic, 4301 W. Markham, Little Rock, AR 72205-7101*
Participants: David F. McMahon, M.D., James L. Day, M.D., Norman E. Alessi, M.D., Bertram Warren, M.D.

EDUCATIONAL OBJECTIVES:

By the conclusion of this workshop participants will be able to use a keyboard and mouse in a Windows environment; will be able to navigate the Web using a standard browser; will know how to use Internet technology to meet individual needs; will understand the basic format and structure of the APA web site.

SUMMARY:

With the three-room format, there will be an attempt to segment the participants into beginner, intermediate, and more advanced users. Presentations and materials will include introduction to Windows technology, Web history and design, and navigation of the Web, including specifically APA's site. Information will be presented in a hands-on format and will include: how to use the Windows environment; exercises to become familiar with using a mouse (for the beginning sections); how to use the Web navigation tools; and how to find the information you want when you don't know exactly who or what you are looking for. Skill development will include: how to familiarize yourself with the Web environment; how to find useful sites, using search engines; how to find a site again that you like; how to handle searches that are taking too long; how to respond when you get error messages (e.g., can't find this server); how to set preferences; how to download and print from the Web.

Component Workshop 16
HANDS-ON COMPUTER LEARNING: USING CLINICAL APPLICATIONS/DEMONSTRATIONS
APA Committee on Information Systems

Chairperson: Steven E. Hyler, M.D., *Unit 112, WHCS, NY Psychiatric Institute, 722 West 168th Street, New York NY 10032*
Participants: Daniel A. Deutschman, M.D., Stuart Gitlow, M.D., Carlyle Hung-Lun Chan, M.D., Robert S. Kennedy, M.A.

EDUCATIONAL OBJECTIVES:

In a laboratory experience participants will learn how to navigate through a basic Windows environment; how to use a mouse; how to access applications that are relevant to the practice of psychiatry.

SUMMARY:

Faculty members and mentors will assist individuals who are wary of using computers, teaching them how to use computers in the most basic way and to give them exercises and access to applications that relate to psychiatry. Psychiatrists who have software that relates to psychiatry have been and are being invited to demonstrate their programs at this laboratory experience. These applications have mostly been demonstrated by psychiatrists at the AADPRT and APA Institute meetings over the past two years in hands-on computer workshops. Examples of software and demonstrations will include: cognitive therapy and multimedia learning programs; psychopharmacology software; programs for research and reference in psychiatry

and mental health; databases for community psychiatry programs; computerized health enhancement support system; APA Electronic Library; how to use the Web to find resources for psychiatrists.

REFERENCES:

This will be provided at a later time.

Component Workshop 17
PRODUCING A WEB PAGE: INTRODUCTION
APA Committee on Information Systems

Chairperson: Robert C. Hsiung, M.D., *Department of Psychiatry, University of Chicago, 5737 South University Avenue, Chicago IL 60637*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should: (1) know what is required to publish on the World-Wide Web, (2) be able to use a Web page editor, and (3) have turned an idea for a Web page into an actual file ready to be published on the Web.

SUMMARY:

The World Wide Web has literally millions of users and offers countless opportunities to those who publish Web pages. In the area of mental health, these might focus on oneself, the services or products one offers, the conditions or treatments one studies, etc.

This hands-on workshop takes participants from ideas for Web pages to actual files ready to be published on the Web. Participants should have some familiarity with the Web and some ideas for Web pages. They should bring their own Macintosh or IBM-compatible laptops and are encouraged also to bring specific text and graphics files.

An introduction covers what the Web is, what Web pages are, and how to view and to publish Web pages. The class learns how to use a Web page editor to create a Web page that includes different text styles, lists, tables, color, graphics, links, and e-mail. This approach obviates the learning of HyperText Markup Language (HTML). The presenter's home page serves as an on-line example. Participants then apply the above to their own ideas. Pages created by the class function as case studies for further discussion.

For detailed information on required software and ancillary files, participants should see http://uhs.bsd.uchicago.edu/dr-bob/presentations/apa98intro.html.

Component Workshop 18
THE NEW SOCIAL SECURITY INCOME RULE FOR CHILDREN: PRACTICAL ISSUES
APA Committee on Chronically Ill and Emotionally Handicapped Children

Chairperson: Graeme Hanson, M.D., *Dept. Child & Adol Psych., Langley Porter UCSF, 401 Parnassus Avenue, San Francisco CA 94143-0984*
Participants: Deborah A. Zarin, M.D., Joseph R. Mawhinney, M.D., Duncan S. Wallace, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: (1) demonstrate knowledge of the new SSI regulations, (2) conduct an adequate evaluation for SSI determination, and (3) discuss current controversies regarding the new regulations.

SUMMARY:

SSI regulations have recently undergone significant changes that affect more than 250,000 children and adolescents. The new regulations raise the threshold for eligibility, which will eliminate many children from receiving benefits. This workshop will be presented by experts with different backgrounds and experiences in SSI evaluation. The new SSI regulations will be presented and current controversies will be discussed.

Members of the audience will be encouraged to present particular clinical dilemmas, ethical conflicts, and the social policy implications of these changes. The role of the psychiatrist as advocate at the individual patient level, the professional organizational level, and in the political arena, will also be discussed.

REFERENCES:

1. Supplemental Security Income; Determining Disability for a child under 18; Interim Final Rules with Request for Comments, Social Security Administration 20 CFR Parts 404 and 416. Federal Register, Feb. 11, 1997.
2. American Academy of Child & Adolescent Psychiatry: Guidelines for Reviewing SSI Disability Benefits for Children and Adolescents with Mental Disorders. Dept Govt Affairs Am Acad Child & Adol Psychiatry, Sept 1997.

Component Workshop 19
RECRUITMENT AND RETENTION
APA Membership Committee

Chairperson: Bernard A. Katz, M.D., *22 Rosalie Road, Newton Centre MA 02159-3131,*
Participants: Rodrigo A. Muñoz, M.D., Harold Alan Pincus, M.D., R. Dale Walker, M.D.

SUMMARY:

Technology, rising medical costs, limited resources, and expanding consumer expectations are just a few of the reasons medical associations are facing challenges in retaining and recruiting members. The American Psychiatric Association and its district branches are no different. In today's marketplace, customers have immediate access to exceptional services at competitive prices. They expect the same kind of value and benefits from their memberships in professional associations. Representatives from your district branch are invited to attend and to find out what current and prospective members really want from us. Innovative strategic plans and opportunities for partnerships will be shared with participants.

Component Workshop 20
ADVANCES IN VETERANS AFFAIRS SCHIZOPHRENIA RESEARCH
APA Consortium on Organized Service Systems

Co-Chairpersons: Laurent S. Lehmann, M.D., *Mental Hlth & Behav Scien, (111C) VA Central Office, 810 Vermont Avenue, NW, Washington DC 20420-0002,* Frederick G. Guggenheim, M.D., *UAMS, 4301 West Markham, Slot 554, Little Rock AR 72205-7101*
Participants: Robert Freedman, M.D., Robert W. McCarley, M.D., Dennis S. Charney, M.D., Paul Hoffman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to discuss recent neuroimaging and electrophysiological findings in schizophrenia as well as the correlation of genetic markers to physiological abnormalities. They will be able to identify the latest methodology in schizophrenia research.

SUMMARY:

Robert W. McCarley, M.D., Director of the Brockton/West Roxbury Schizophrenia Biological Research Center will discuss MRI and electrophysiological studies of individuals in their first psychotic episode, showing differences between those with schizophrenia and those with affective psychoses. He will also review in vitro cellular

and computer modeling studies exploring the possibility of post-developmental neurodegenerative changes in the medial temporal lobe of schizophrenic patients.

The Denver Center is concerned with genetic factors in schizophrenia. Center director Robert Freedman, M.D., will discuss studies of physiologic abnormalities in schizophrenic patients and their relatives used to identify possible genetic deficits such as alterations in the functions of nicotinic receptors.

Dennis Charney, M.D., director of the West Haven Center, will discuss neuroimaging studies of dopamine release and dopamine receptors, neuropharmacological studies of the role of the NMDA receptor system, and treatment studies of clozapine and other new generation antipsychotic drugs.

Our discussant will be Paul Hoffman, M.D., VA's Chief of Medical Research. The program co-chairs will be Dr. Fred Guggenheim, professor and chair of psychiatry at the University of Arkansas School of Medicine Department of Psychiatry, and myself. There will be time for questions after each presentation and a final question period.

REFERENCES:

1. McCarley RW, et al: Neuroimaging and the cognitive neuroscience of schizophrenia. Schiz Bull 1996; 22:703–726.
2. Freedman, R, et al: Linkage of a neurophysiological deficit in schizophrenia to a chromosome 15 locus. Proc Natl Acad Sci 1997; 94:587–592.

Component Workshop 21
CERTIFICATION IN PSYCHIATRIC ADMINISTRATION
APA Committee on Psychiatric Administration and Management

Co-Chairpersons: William H. Reid, M.D., *P.O. Box 4015, Horseshoe Bay TX 78657,* Carmel A. Foley, M.D., *Schneider Children's Hospital, Hospital LIJ Medical Center, New Hyde Park NY 10042*
Participants: Dave M. Davis, M.D., W. Walter Menninger, M.D., Philip E. Veenhuis, M.D., Paul A. Rodenhauser, M.D., Horace G. Whittington, M.D.

SUMMARY:

The APA Committee on Psychiatric Administration and Management will describe the purpose and process of APA certification, as well as the knowledge candidates are expected to possess in four main areas of mental health system management: administrative theory and human resources, law and ethics, budget and fiscal management, and psychiatric care management.

Component Workshop 22
ACCESS TO PATIENTS: ARE RESIDENTS BEING CARVED OUT?
APA Glaxo Wellcome Fellows

Chairperson: Diana R. Sanderson, M.D., *Department of Psychiatry, Erie County Medical Center, 462 Grider Street, Buffalo NY 14215*
Participants: James H. Scully, Jr., M.D., John H. Lloyd, M.D., Steven P. Hamilton, M.D., Sukhmani K. Gill, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will understand the impact of HCFA changes and managed care restrictions as regards residency psychotherapy education, the psychotherapy types taught, the decline in available outpatients for treatment, and the potential solutions.

SUMMARY:

The impact of managed care restrictions and HCFA cutbacks especially with Medicare have been great on residency training in general. In particular the education and availability of patients and the practice of psychotherapy have been greatly altered in response to these changes. This has raised great debate among hospital administration program directors, and residents themselves. We ask to what extent these changes are having an effect on residency programs and to what degree education in psychotherapy is affected.

This workshop will explore these changes through vignettes of residents' experiences and through discussion of the various aspects financial reductions have on psychotherapy training and residents' patient experience. Results from a survey of residents and program directors will be presented that include data on residency programs' current means of teaching psychotherapy, attitudes on the appropriateness of types of psychotherapy taught, rating of whether residents are provided with good and diverse number and types of patients, and areas of perceived conflict on these issues within the training programs.

Workshop participants are encouraged to share their experience. Our discussant, Dr. James Scully, will contribute his perspective as a present and preeminent educator. Together, this input and survey data will help explore the various changes taking place and hopefully potential solutions or compromises for problematic issues. Residents and directors may find these useful in designing future policies to achieve the best psychotherapy training possible.

REFERENCES:

1. Tasman A: The future of residency training in psychiatry. Bulletin of the Menniger Clinic. Fall; 58(4): 475–85, 1994.
2. Yager J, Docherty JP: Preparing psychiatric residents for managed care: values, proficiencies, curriculum, and implications for psychotherapy training. J of Psychotherapy Practice and Research 1997 Spring; 6(2):108–122.

Component Workshop 23
CURRENT ISSUES IN MEDICAL STUDENT EDUCATION
APA Committee on Medical Student Education

Co-Chairpersons: Michael J. Vergare, M.D., *Department of Psychiatry, Albert Einstein Med. School, 5501 Old York Road, Hirsch Bld, Philadelphia PA 19141,* Ronald L. Martin, M.D., *Department of Psychiatry, University of KS SM-Wichita, 1010 North Kansas Street, Wichita KS 67214-3124*
Participants: Carlyle Hung-Lun Chan, M.D., Christopher M. Palmer, M.D., Larry Maayan, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) describe the role of a director of medical student education, (2) understand the important role residents play in medical student education and how they can develop their skills as teachers during their residency, and (3) learn more about the interplay of departmental and university demands and how they affect medical student education.

SUMMARY:

The role of director of medical student education is critical to how medical students first learn about psychiatry. For many future physicians, the didactic and clinical work in psychiatry covered in a few weeks of medical school will be their only exposure to our field. As more and more academic departments come under pressure to generate revenue and economize, there is danger that the importance of having a dedicated and skilled educator for students will be underestimated. Workshop discussion will begin with the views of an educator who serves as president of ADMSEP. Also included

will be discussion of the essential skills, the activities, and responsibilities commonly performed, and the time required of an educator. There will follow discussion of the views of a residency training director who relies on residents to train medical students. Joining in this will be a resident panelist and a medical student, each of whom will discuss their views of how to improve medical student education in psychiatry. A department chairperson will discuss the pressures that departments currently face in trying to do a good job of introducing medical students to the field of psychiatry. There will be ample time for audience presentation of their views.

REFERENCES:

1. Psychiatric Residents as Teachers. American Psychiatric Association, March 1988.
2. Beasley BBW, Wright SM: Promotion criteria for clinician-educators in the United States and Canada. A survey of promotion committee chairpersons. JAMA. September 3, 1997; Vol. 278, No. 9.

Component Workshop 24
SUCCESSFUL PRACTICE IN LONG-TERM CARE
APA Committee on Long-Term Care and Treatment for the Elderly

Co-Chairpersons: George Dyck, M.D., *Department of Psychiatry, University of Kansas, 1010 N Kansas St, Wichita KS 67214-3124,* Gary S. Moak, M.D., *21 Longmeadow Road, Westborough MA 01581*
Participants: James A. Greene, M.D., J. Pierre Loebel, M.D., Jeanne M. Jackson, M.D., David K. Conn, M.B.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to develop a consultation practice in a long-term care facility, taking into consideration the needs of the patient family, primary care physician, and nursing staff.

SUMMARY:

This workshop will summarize the special knowledge and skills needed to engage in consultation work in a nursing home setting.

Dr. Greene will present an overview of the work psychiatrists are currently performing in nursing homes and the kind of contractual agreements being used.

Dr. Loebel will discuss the nature and severity of mental illness found within long-term care facilities, and reasons given for requesting psychiatric consultation. He will outline some of the types of clinical responses that can be made, problems of residents, and ways to improve the general environment of the nursing home.

Dr. Moak will discuss the impact of the federal nursing home standards known as "OBRA '87," and what knowledge is required on the part of the psychiatrist to assist the nursing home in meeting these standards.

Dr. Jackson will talk about managed care as it affects practice in long-term care settings, and the practice models and patterns that are emerging.

Dr. Conn, a geriatric psychiatrist working in Toronto will discuss the outstanding features of work in Canadian nursing homes, and how this differs from the United States experience.

The workshop participants will have the opportunity to ask questions and make comments after the brief individual presentations.

REFERENCES:

1. Goldstein, MZ et. al: Selected Models of Practice in Geriatric Psychiatry. American Psychiatric Associations, 1993.
2. Birkett DP: Psychiatry in the Nursing Home. The Haworth Press, Inc, New York 1991.

Component Workshop 25
THE HISTORY OF MANAGED CARE IN PSYCHIATRY
APA Committee on History and Library

Co-Chairpersons: Etham S. Rofman, M.D., *Mass. Behavioral Health, 150 Federal Street, 3rd Floor, Boxton MA 02110,* Dilip Ramchandani, M.D., *241 Merion Road, Merion PA 19066*
Participants: Miles F. Shore, M.D., Ronald I. Dozoretz, M.D., Kenneth A. Kessler, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the historical factors that led to the development of managed care in American psychiatry.

SUMMARY:

This workshop will present a discussion of the historical events and societal forces that influenced and shaped the changes in the delivery of psychiatric care over time in the context of the broader transformation affecting American medicine.

Over the past 30 years medicine and psychiatry have witnessed a radical change in the methods of payment and the degree of control that payers exert on clinical practice. This change accelerated rapidly after the passage of the HMO Act of 1973. During the 1980's managed care extended beyond the HMO's. New companies were developed that separated mental health from medical benefits and challenged the existing fee-for-service system by seeking to integrate financing and management with delivery of psychiatric services. The panel will focus on the specific factors that promoted the establishment of these managed care companies in the 1980's and their evolving impact on access, quality, and effectiveness of psychiatric care. After these presentations, the audience will be invited to participate in a discussion of the lessons to be learned from history as psychiatrists attempt to respond to the professional challenges and ethical dilemmas associated with the managed care environment.

REFERENCES:

1. Shore MF, Beigel A: The challenges posed by managed behavioral health care. New England Journal of Medicine Jan 1996; Vol 334(2) 116–118.
2. English J, Kritzler ZA, Scherl DJ: Historical trends in the financing of psychiatric services. Psychiatric Annals 1984; 14(5) 321–331.

Component Workshop 26
WOMEN PSYCHIATRISTS: THEIR TRIUMPHS AND TRAGEDIES
APA Committee of Asian-American Psychiatrists, APA Committee on Women, and APA Committee on Religion and Psychiatry

Co-Chairpersons: Geetha Jayaram, M.D., *Department of Psychiatry, Johns Hopkins Univ Sch. of Med, 600 North Wolf Street, M-101, Baltimore MD 21287,* C. Deborah Cross, M.D., *Department of Psychiatry, Albany Medical College, 47 New Scotland Avenue (A-164), Albany NY 12208*
Participants: Cecilia Tang, M.D., Patel Alpha, M.D., Nalini V. Juthani, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, participants should be able to (1) identify biological and sociocultural factors influencing differ-

ences in identify formation and gender role behavior; (2) recognize phase-of-life conflicts related to early, mid, and late career issues; (3) gain insights and find solutions to conflicts, leading to autonomous decision making.

SUMMARY:

Gender roles and career identities in women crystallize during their residency training. Sociocultural and societal expectations as well as environmental influences and support play a role solidifying them, or in causing role diffusion. Also, nurturing relationships with males or females as significant others, and key figures in the identity/career development process help develop autonomy and fulfillment. Simultaneously, problem identification, education of faculty, women's networks, and mentoring are important factors in the intervention process. Career issues will be categorized for the purpose of the workshop as early, mid, and late career issues. Ways to identify difficulties and formulate solutions will be discussed.

The audience will be encouraged to express opinions and these will be structured to organize solutions. Time will be devoted to address concerns unique to ethnic minorities.

REFERENCES:

1. Spielvogel A, Dickstein L, Robinson GE: A Psychiatric Residency Curriculum About Gender and Women's Issues. American Psychiatric Press, Inc. 1995.
2. Fried IP, Francomano CA, et al: Career development for women in academic medicine. Journal of the American Medical Association, September 18, 1996; Vol 276, No 11.

Component Workshop 27
MEDICAL MANPOWER ISSUES: ARE IMGS SCAPEGOATS?
APA Committee on International Medical Graduates

Chairperson: Jambur V. Ananth, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center, 1000 West Carson St. Bldg 1 St, Tirrabce CA 90509*
Participants: Richard Balon, M.D., Nyapati R. Rao, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to appreciate the problems that American medicine is facing, and that IMG's are neither the cause of nor solution to these problems.

SUMMARY:

The medical manpower issue has become the focus of politicians and the profession as a result of many causes, including technological advances, increased longevity, the cost of medical care, and the public perception that every ailment needs to be cured. Medical manpower needs have been determined not by the quality of care but by imaginative head count techniques, which do not have any validity. While IMG's did not create the problems medicine is facing now, all the envisioned solutions impinge upon IMG's. Cutting down residency positions and not allowing IMG's into the country have been suggested. These solutions scapegoat IMG's and do not address the causes. While these quick fixes have short-term appeal, they produce irreparable damage to American medicine for two reasons: (1) The problems that have caused the current crisis in medicine go unaddressed, and (2) America has incorporated the best in every profession in the world. The globalization and global trade treaties on one hand, and restrictions on the IMG's on the other, are contradictory and un-American. Scapegoating the IMG's who have significantly contributed to American medicine will not alleviate the problem.

REFERENCES:

1. Kindig DA, Libby DL: Domestic production vs international immigration options for the physician work force. JAMA 1996; 276:978–982.
2. Kassirer JP: The next transformation in the delivery of health care. N Engl J M 1994; 332:52–53.

Component Workshop 28
OCD: SPANISH PERSPECTIVE
APA Committee of Hispanic Psychiatrists

Chairperson: Silvia W. Olarte, M.D., *Department of Psychiatry, NY Medical College, 37 East 83rd Street, Apt 1, New York NY 10028*
Participants: Angela Pedraza, M.D., Jesus De La Gandara, M.D., Julio Vallejo, M.D., Julio Bobes, M.D., Jose Manuel Menchon, M.D., Roberto A. Dominguez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have an outlook of OCD as experienced by Spanish psychiatrists including the approach to the diagnosis and treatment of this disorder using current research and clinical data.

SUMMARY:

Psychiatrists in the U.S. are becoming increasingly aware of the significance of the cultural background as an important factor to be considered in the psychiatric evaluation. Indeed, gaining an understanding of psychiatric disorders as it presents in different ethnic, racial, and cultural groups will facilitate the diagnosis and treatment of the different groups. In this workshop, a group of leading Spanish psychiatrist clinicians and researchers will present an overview of the research and clinical data in OCD. The presentation will focus on data and experience obtained from a relatively culturally homogeneous population. The epidemiology, social impact, and quality of life of patients suffering from OCD in Spain will be presented. A review of the clinical characteristics and manifestations of OCD including subgroups of patients studied by researchers throughout Spain and the treatment modalities and results of current therapeutic research will be presented including the most significant findings in the treatment of OCD in that country.

REFERENCES:

1. De La Gandara JJ, et al: Serotonina y psiquiatria: aspectos clinicos y terapeuticos. Cadis; Ingrasa, 1994; pp 57–77.
2. Vallejo J: Estados Obsessivos. Barcelona: Salvat, 1987.

Component Workshop 29
PROMISES AND PROBLEMS WITH NEW TREATMENTS FOR HIV
APA New York County District Branch's AIDS Committee

Co-Chairpersons: Elizabeth V. Getter, M.D., *Village AIDS Day TX, 1133 West 20th Street, New York NY 10011,* John A. Sahs, M.D., *158 West 81st Street, #34, New York NY 10024-5956*
Participants: Stephen J. Ferrando, M.D., John A.R. Grimaldi, Jr., M.D., Kyle S. Kato, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be more informed about the complex issues related to the potent new treatments for HIV, including medication adherence, changed perception of HIV risk, and life adjustments to successful or unsuccessful treatment.

SUMMARY:

Introduction: The past two years have witnessed the widespread use of the HIV protease inhibitors, which are unsurpassed in antiviral potency. Many, but not all patients are experiencing dramatic improvements in physical and psychological well-being. With the treatment improvements, patients, their doctors, and the general public increasingly view HIV as a chronic, manageable illness. Mental health professionals working with HIV-impacted individuals during this exciting time are encountering new clinical and ethical challenges.

Method: The panel will introduce several critical clinical issues in which mental health professionals are often involved, including assessment of patient "readiness" to adhere to complex combination therapy regimens, intervening to enhance adherence once the therapies are prescribed, evaluating changed perception of HIV transmission risk and intervening to prevent or reduce risky behaviors, helping patients manage the "crises" associated with an extended life, and assisting those who do not benefit from the new treatments. Panelists will briefly review relevant literature and will present case material from their own work as a means of facilitating discussion. Workshop participants will be invited to share their ideas and clinical experiences.

Conclusions: On the frontier of new and expanding therapeutic options for HIV infection, mental health professionals face exciting new challenges. Because many of these are complex and fraught with ambiguity, it is critical to promote ongoing discussion as a means of support and of enriching our work with patients.

REFERENCES:

1. Rabkin JG, Ferrando S: A "second life" agenda: policy and research issues raised by protease inhibitor treatment for people with HIV/AIDS. Archives of General Psychiatry 1997; 54(11), in press.
2. Dilley JW, Woods WW, McFarland W: Are advances in treatment changing views about high-risk sex? New England Journal of Medicine 1997; 337:501–2.

Component Workshop 30
PSYCHIATRY FELLOWSHIPS: RESIDENT TO RESIDENT
APA New York County District Branch's Residents' Committee

Chairperson: Evaristo O. Akerele, M.D., *Harlem Hospital, 506 Lennox Avenue, New York NY 10037*

EDUCATIONAL OBJECTIVES:

At the end of this workshop residents will become fully aware of fellowships and research possibilities available to them. They will also become cognizant of some of the less obvious requirements such as state license, research activity, and visa status.

SUMMARY:

I am currently serving as chair of the New York county Residents' committee. During my term as vice chair I became painfully aware of the extent of ignorance among my colleagues with regard to the availability of fellowships and research opportunities. The committee worked ceaselessly to rectify this. As part of our efforts a fellowship manual was produced. As a final year resident myself I have gained a significant amount of knowledge in my personal search for a research fellowship. At this workshop fellows and senior residents will share their knowledge and experience with junior residents. The latter group will be able to ask questions about fellowships in general and their place in the future of psychiatric practice. In essence this will be a resident-to-resident perspective on the relevance of fellowships and the best approach to them.

REFERENCES:

1. New York County district branch of the APA fellowship manual.
2. Directory of Psychiatry Residency Training Programs, Sixth Edition.

Component Workshop 31
FILM CLUBS: HOW TO HAVE FUN WHILE LEARNING PSYCHIATRY
APA Media Subcommittee

Co-Chairperson: Francis G. Lu, M.D., *Department of Psychiatry, University of CA at SF, 1001 Potrero Avenue, San Francisco CA 94131,* Steven E. Hyler, M.D., *Unit 112, WHCS, NY Psychiatric Institute, 722 West 168th Street, New York NY 10032*
Participant: Tal Burt, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the value of film clubs in teaching psychiatry to medical students and residents, and to understand film programs on themes of suicide, mental disorders, psychiatrists, healing, and cultural issues.

SUMMARY:

This workshop will discuss how to enliven the learning of psychiatry through films and videotapes organized as film clubs in residency programs and district branch activities. The rationale, benefits, and organizational logistics of film clubs will be reviewed. Suggested film programs for specific themes discussed will include suicide, psychopathology and psychiatric diagnosis, depiction of psychiatrists, therapy and healing, cultural competence and diversity, and stigma. Video clips from films will be shown to illustrate these topics.

This workshop would be useful to medical students, residents, training directors, and others interested in the use of film to learn psychiatry.

REFERENCES:

1. Hyler S, Moore J: Teaching psychiatry? Let Hollywood help! Academic Psychiatry 1996; 20:212–219
2. Fidler DC: The dilemma of unavoidable videotapes for psychiatric education. Academic Psychiatry 1993; 17:171–173

Component Workshop 32
PATIENTS' RIGHTS: AN INTERNATIONAL PERSPECTIVE
APA Committee on International Abuse of Psychiatry and Psychiatrists

Chairperson: Alan L. Gordon, M.D., *Department of Psychiatry, Brown University, 345 Blackstone Blvd, Providence RI 02906-4861*
Participants: Valery N. Krasnov, M.D., Abraham L. Halpern, M.D., Lars Jacobson, M.D., Atalay Alem, Roger M. Montenegro, M.D., Paul S. Appelbaum, M.D., Diane Froggatt, B.Ed.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate an increased awareness of issues related to patients' rights in organized settings around the world, and, in particular, from countries such as Sweden, Ethiopia, Argentina, and Russia.

SUMMARY:

Respect for patient rights in psychiatric settings is a fundamental human right that has been neglected in many parts of the world, and at times flagrantly abused. The United States and many other westernized countries have a strong tradition of giving attention to

patient rights. In the United States, there is a large body of legislation that protects these rights and the public has developed sophisticated support and advocacy groups. This is a period of "democratization" in many parts of the world, and with these changes a much greater emphasis placed on the individual's rights. The Committee on International Abuse of Psychiatry and Psychiatrists will bring attention to the problems and prospects of advancing patient rights in psychiatric settings, while obtaining an international perspective. The panelists, representing different continents of the world, will describe the state of public awareness and professional practice patterns in their respective countries, as well as public policy and legislative initiatives that relate to the rights of the mentally ill. The status of grassroots patient advocacy movements and the role they (might) play in promoting awareness will also be considered.

REFERENCES:

1. Bloom JD, Williams MH: Management and Treatment of Insanity Acquittees: A Model for the 1990s. APPI, 1993.
2. Beck JC: Confidentiality Versus the Duty to Protect. APPI, 1990.
3. Lindstrom E, Wallsten T, Palmstierna T, von Knorring L: The need for compulsory care in schizophrenia. European Journal of Psychiatry, April/June, 1997 Vol. 11, No. 2.

Component Workshop 33
PSYCHIATRY AND THE PHARMACEUTICAL INDUSTRY
APA Joint Commission on Public Affairs

Chairperson: Nada L. Stotland, M.D., *Department of Psychiatry, Illinois Masonic, 5511 South Kenwood Avenue, Chicago IL 60637*
Participants: Freda C. Lewis-Hall, M.D., Laurie M. Flynn, M.A., Michael Faenza, M.S.W., Stephen M. Goldfinger, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to recognize public affairs aspects of the relationship between psychiatry and the pharmaceutical industry through discussions between industry, psychiatric, and advocacy group leaders.

SUMMARY:

Thanks to research advances over the past 40 years, psychoactive medications have become an indispensable tool in the psychiatrist's treatment armamentarium. As medications increase in category and number, the industry is playing an increasingly important and visible role in funding of research, publications, meetings, and other activities. Industry annual meetings exhibits are extensive, attractive, and informative, but to some, overwhelming. Industry-supported symposia are increasingly numerous, well-attended, and draw high marks from members. The companies, at APA's request, also support receptions, transportation, and make other valuable contributions. APA and other organizations have developed firm guidelines to ensure that these activities serve the best interests of psychiatrists and patients. Interactive discussions between panelists and participants will focus on these guidelines and the public affairs aspects of pharmaceutical and psychiatric relationships.

Component Workshop 34
CHANGING PSYCHIATRIC COMPENSATION
APA Committee on Psychiatric Administration and Management

Co-Chairpersons: Carmel A. Foley, M.D., *Schneider Children's Hospital, Hospital LIJ Medical Center, New Hyde Park NY 10042,* Philip E. Veenhuis, M.D., *Medical Director, Division of MH/DD/SAS, 325 North Salisbury, Raleigh NC 27603*
Participant: W. Walter Menninger, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to appreciate the current status of changing physician compensation strategies across diverse mental health care settings.

SUMMARY:

A historical overview of compensation methods and their strategic underpinnings will be presented.

The implementation of a system of variable compensation for physicians, which replaced fixed salaries in a private sector mental health setting, will provide a stimulus for audience participation.

Changing compensation in a state mental health system without a merit pay structure and the attendant changes at the level of the systems in many community mental health clinics will also be discussed. Extensive audience participation will be encouraged through dialogue with the panel about the pros and cons of different physician compensation strategies across the country.

REFERENCES:

1. Physician Compensation and Health Care Compensation: Strategic Planning. Timothy J. Colter, Compensation Architecture, Division of Hartstein Assoc., Inc. Independence, KY.
2. Human Resource Management, 7th ed. Gary Dessler, Prentice Hall, 1997.

Component Workshop 35
HOT OFF THE PRESS: NEW GUIDELINES FOR JAILS AND PRISONS
APA Task Force to Revise the APA Report on Jails and Prisons

Chairperson: Henry C. Weinstein, M.D., *Department of Psychiatry, New York University, 125 East 87th Street, New York NY 10128-1124*
Participants: Kathryn A. Burns, M.D., Joel A. Dvoskin, Ph.D., Cassandra F. Newkirk, M.D., John S. Zil, M.D., J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop participants should be able to identify the essential mental health services that must be provided in jails and prisons and be familiar with the special application of these guidelines to such special populations in correctional facilities as youth in adult correctional facilities, the geriatric population, women, those inmates with co-occurring disorders, and the mentally retarded.

SUMMARY:

The APA Guidelines on Psychiatric Services in Jails and Prisons have been the most influential guidelines on mental health services in jails and prisons that have ever been written. Since the APA Guidelines were published in 1989 American jails and prisons have changed in many ways. In response to these changes, the APA is currently revising these guidelines. In this interactive workshop, the members of the Task Force to Revise the APA Report on Psychiatric Services in Jails and Prisons will present the proposed revisions, including an entirely new section on "Special Applications of the Principles and Guidelines" to particular groups. After an introduction to the overall structure and salient feature of the APA Guidelines on Psychiatric Services in Jails and Prisons, the faculty members of the task force will present brief discussions of particular populations that are the focus of the new edition of these guidelines. These groups include women in correctional institutions, youth in adult facilities, geriatric population inmates with co-occurring disorders of mental illness and substance abuse, and the mentally retarded. The audience will be asked to make suggestions and comment on these changes and revisions and react to the proposed special section on issues of screening and evaluation, crisis intervention, and treat-

ment and discharge planning for these and other groups of patients in jails and prisons.

REFERENCES:

1. Task Force on Psychiatric Service in Jails and Prisons, Report 29, Psychiatric Services in Jails and Prisons. Washington, DC, American Psychiatric Association, 1989.
2. Metzner JL, Cohen F, Grossman LS, Wettstein, RM: Treatment in Jails and Prisons, in Treatment of the Mentally Disordered Offender. Edited by Wettstein RM. Guilford Press, 1998.

Component Workshop 36
EFFECTIVE PSYCHIATRIC WORK IN THE JUVENILE JUSTICE SYSTEM
APA Committee on Juvenile Justice Issues

Chairperson: Wade C. Myers, M.D., *Department of Psychiatry, University of Florida, PO Box 100256/JHMHC, Gainesville FL 32610-0256*
Participants: Patrice A. Harris, M.D., Diane E. Heisel, M.D., Ledro Justice, M.D., Debra K. DePrato, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate an understanding of: (1) strategies for becoming involved as a psychiatrist in different areas of the juvenile justice system, (2) the fundamental components of a juvenile offender psychiatric evaluation, (3) the basics of writing a forensic report, and (4) the type of treatments that have been shown to decrease recidivism in juvenile offenders.

SUMMARY:

This workshop is being sponsored by the APA Juvenile Justice Issues Component. Presentations will be limited to 14 minutes so that ample audience participation, including questions and clinical experiences, can be accomplished. Juvenile delinquency continues to be a major social problem in the United States. Dr. Harris will present models that bridge the gap between psychiatrists' skills and the mental health needs of the juvenile justice system. Dr. Justice will address the unique challenges and needs that arise in doing psychiatric evaluations of juvenile offenders. Special attention will be given to the issues of culture/countertransference. Dr. Heisel will cover the basics of writing a forensic report. The psychiatrist's well-constructed, thoughtful forensic report will serve as an effective instrument to identify mental health treatment needs and placement recommendations for juvenile offenders. The basic framework and detail necessary for such a document will be presented along with suggestions for effective communication. Dr. DePrato will review the types of treatment interventions that decrease the rate of recidivism in juvenile offenders. Identification of risk and protective factors for chronic juvenile delinquency will also be covered.

REFERENCES:

1. APA Workgroup on Psychiatric Practice in the Juvenile Court: Handbook of Psychiatric Practice in the Juvenile Court. Washington DC, American Psychiatric Press, 1992.
2. Schetky DH, Benedek EP: Clinical Handbook of Child Psychiatry and the Law. Baltimore, Williams and Wilkins, 1992.

Component Workshop 37
NAVAJO PSYCHOLOGY
APA Committee of American Indian/Alaskan Native and Native Hawaiian Psychiatrists and APA Council on National Affairs

Co-Chairpersons: Mary H. Roessel, M.D., *HWY 666 N. Box 160, Shiprock NM 87420,* Edward J. Neidhardt, M.D., *HWY 666 N. Box 160, Shiprock NM 87420*
Participant: Ruth Roessel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize Navajo methods of treating mental disorders and have an overview of Navajo psychology; to understand the range of therapeutic endeavors utilized by Navajo practitioners and be able to compare it with psychiatric practice; and to appreciate the psychotherapeutic sophistication of Navajo healers.

SUMMARY:

A Navajo psychiatrist and a general psychiatrist practicing on the Navajo Reservation have been working with traditional healers to define a body of knowledge that might be considered as Navajo psychology. This information, along with the healing practices used by traditional practitioners to treat mental disorders, will be explored. This workshop will examine the underlying premises that form the basis of Navajo practice within the framework of Navajo philosophy. Comparisons with Western medicine and the perspectives of other cultures will be discussed with workshop participants. The traditional practices of ceremony, prayer, molding, bathing, sandpainting, teaching, counseling, education, and the role of kinship will be introduced. The Enemy Way Ceremony for the treatment of PTSD will be reviewed in more depth. Methods of therapeutic technique will be shared to give workshop participants some knowledge of the psychotherapeutic sophistication of the Navajo practitioners, including empathy and the part it plays in the effectiveness of prayer. The audience will be expected to discuss implications of this knowledge, apply it to their cultural perspectives, and have an opportunity to participate in some traditional practices.

REFERENCES:

1. Sandler DJ: Navajo Symbols of Healing. Harcourt Brace Jovanovich, 1979.
2. Wyman LC: Blessingway. University of Arizona Press, 1970.

Component Workshop 38
CODING CHANGES AND NEW DOCUMENTATION REQUIREMENTS
APA Work Group on Codes and Reimbursements and APA Work Group on Harvard Resource-Based Relative Value Scale Study

Chairperson: Chester W. Schmidt Jr., M.D., *Department of Psychiatry, Hopkins-Bayview, 4940 Eastern Avenue, Baltimore MD 21224-2735*
Participants: Tracy R. Gordy, M.D., Donald J. Scherl, M.D., Edward Gordon, M.D., Melodie Morgan-Minott, M.D., Frank T. Rafferty, Jr., M.D., Ronald A. Shellow, M.D., Shelley Stewart, Eugene Cassel, Katherine Moore, Jay B. Cutler, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant will be knowledgeable about the conversion of the G-codes for psychotherapy in CPT codes; the elements of a single-system psychiatric examination; and the new documentation guidelines for evaluation and management codes.

SUMMARY:

During the past year three major changes have taken place in the CPT coding system. HCFA introduced the G-codes for psychotherapy, CPT incorporated those codes in the November 1997 edition of CPT, and the AMA and HCFA jointly published documentation guidelines for Evaluation and Management codes (July 1997). The goals of the combined workshop (Work Groups on RBRVS Study and on Codes/Reimbursements) are to familiarize practitioners with these changes and to discuss the implications for practice procedures including documentation and billing. Presentations and handouts will

provide specific recommendations for model notes (documentation) and guidelines for selecting service/procedure codes (billing).

REFERENCES:

1. Schmidt CW, Jr: CPT Handbook for Psychiatrists. Washington DC: American Psychiatric Press, Inc., 1993.

Component Workshop 39
PHYSICIANS UNDER FIRE: UNDERSTANDING AND HELP
APA Committee on Physician Health, Illness and Impairment

Co-Chairpersons: Stephen L. Dilts, M.D., *16850 Wild Plum Circle, Morrison CO 80465-2137,* Malkah T. Notman, M.D., *Department of Psychiatry, Cambridge Hospital, 54 Clark Road, Brookline MA 02146*
Participants: Richard F. Limoges, M.D., Michael F. Myers, M.D., Patti Tighe, M.D., Carmen T. Webb, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to familiarize participants with problems of stress involved in the treatment of physicians both as presented by the doctors as patients and in the attitudes of the treating physicians; to improve recognition of stress in administrative situations and treatment-encounter skills.

SUMMARY:

The psychiatric treatment of another physician by a psychiatrist presents special problems. Identification with the colleague and reluctance to see him or her as sick, impaired, or having a disability is echoed by the physician patient who often denies illness, substance abuse, addiction, or psychological problems.

Recent changes in medical practice have resulted in new stresses due to managed care and other regulations, eroding physician autonomy, control, and status-determinants for many physicians of their choice of medical careers. This has resulted in depression, loss of professional goals and satisfaction, and disability claims.

This workshop will discuss some of the problems confronting physicians, particularly psychiatrists treating other physicians, and problems of the physician as a patient who has to acknowledge disability and stress. Dr. Notman will discuss emotional responses in patient and treater. Dr. Limoges will describe dilemmas rising from recent trends in physician disability claims. Dr. Myers will summarize the impact on the family, and Dr. Tighe will present the role of hospital committees. Dr. Webb will describe medical student learning by abuse and ideas for how to live in the system.

REFERENCES:

1. The Impaired Physician. Edited by Scheiber S, Doyle B. Washington DC: APPI, 1982.
2. Fromson J: Substance abuse among health care professionals. Edited by Hyman S, Friedman L, et al: Substance Abuse Handbook. Baltimore: Williams and Wilkins, 1996.

Component Workshop 40
THE EXPERIENCE OF COMING OUT IN PSYCHIATRY
APA Southern California Psychiatric Society's Committee on Gay, Lesbian and Bisexual Issues

Chairperson: Nick M. Gutierrez, M.D., *Department of Psychiatry, UCLA-NPI, 1549 N. Poinsettia Place Apt 2, Los Angeles CA 90046-3662*
Participants: William Arroyo, M.D., Robert Dasher, M.D., William E. Callahan, Jr., M.D., Vernon Rosario, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant should be able to recognize that, although psychiatry tends to encourage diversity in its members, individuals' experiences with coming out as being gay may vary widely. This workshop aims to expose members, both straight and gay, to some of the related issues that one may experience as a mental health professional in training.

SUMMARY:

"Coming out" is mistakenly thought of as a discrete "developmental" milestone. In one's professional career, however, this process may vary considerably and be driven by both ordinary and unexpected life events. This panel will discuss their individual experiences with coming out in the field of psychiatry. The audience will have a chance to participate by asking questions of each of the panel members.

Dr. Rosario, currently an intern at UCLA, will discuss his experiences as a medical student at Harvard and how this "liminal professional status" impacted his decision to disclose his sexual orientation. Dr. Dasher, a third-year resident at UCLA, will discuss his experience in transitioning from the rather hostile area of internal medicine to psychiatry and how this has allowed him to be a more complete person and hence a better physician. Dr. Gutierrez, in fellowship at UCLA, will discuss his experience of being closeted and then coming out during residency and the difference this made in his personal life and professional relationships. Dr. Callahan is in private practice in Southern California and will discuss how certain factors have been important in his finding a balance between his personal and professional life as an early career psychiatrist. Dr. Arroyo, an attending at USC, will describe his own experiences with coming out and discuss how this process impacted his decision to make over his career.

REFERENCES:

1. Cabaj RP: Gay, lesbian, and bisexual mental health professionals and their colleagues, in Textbook of Homosexuality and Mental Health. Edited by Cabaj RP, Stein TS. Washington, DC, American Psychiatric Press, 1996, pp. 33–42.
2. Atkins DL, Townsend MH: Issues for Gay Male, Lesbian, and Bisexual Mental Health Trainees. Edited by Cabaj RP, Stein TS. Washington, DC, American Psychiatric Press, 1996, pp. 645–658.

Component Workshop 41
THE SEARCH COMMITTEE AND ISSUES FOR WOMEN
APA Committee on Women

Chairperson: Donna E. Stewart, M.D., *Women's Health, The Toronto Hospital, 200 Elizabeth Street, EN 1-222, Toronto, ONT M5G 2C4, Canada*
Participants: Cheryl F. McCartney, M.D., Carol C. Nadelson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the composition, dynamics, process, and perspectives of search committees; to be able to present a more competitive application and interview.

SUMMARY:

Women are now increasingly invited to participate in academic search committees as candidates or committee members. In spite of this representation, however, few women deans, chairs, division directors, program heads, or senior administrators are appointed. The composition, dynamics, process, and perspective of search committees, the systemic environment in which they conduct business, and the candidate's perspective will be discussed by three senior academic women in psychiatry who have broad experience with academic search committees.

Dr. Stewart will describe the search process (composition, mandate, role, and decision making of the search committee), with partic-

ular reference to women. Dr. McCartney will discuss the systemic factors affecting women in search committees, and Dr. Nadelson will speak on the woman candidate's perspective.

The workshop will be interactive and audience discussion will be encouraged, especially among participants who have experience as search committee members or candidates. The workshop will provide an informative and practical guide to women serving on, or appearing before, academic search committees.

REFERENCES:

1. Fried L, Francomano CA, MacDonald SM, et al: Career development for women in academic medicine. JAMA 1996; 276:898–905.
2. Tesch BJ, Wood HM, Helwig AL, Nottinger AB: Promotion of women physicians in academic medicine: glass ceiling or sticky floor? JAMA 1995; 273:1022–1024.

Component Workshop 42
HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE
APA Assembly's Committee of Area Early Career Psychiatrists and APA Committee of Early Career Psychiatrists

Chairperson: William E. Callahan, Jr., M.D., *7700 Irvine Center Dr Ste 530, Irvine CA 92618*
Participants: Ann S. Maloney, M.D., Barry W. Wall, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to develop an individual strategy for launching a successful private practice, maximizing strengths and interests; to utilize a number of different low-cost marketing techniques; to understand the balance required between the functions of manager, technician, and entrepreneur in a small business.

SUMMARY:

This workshop will give participants the framework required to individualize their own comprehensive strategy for launching a successful practice. It is an antidote to the hopelessness expressed by many psychiatrists about being able to thrive in solo private practice. The workshop panel consists of three early career psychiatrists, from three different areas of the nation, who have launched successful private practices in the last three years without accepting managed care at all. All three live and work in areas of high managed care penetration. Each will present the key reasons for their success. The following topics will be covered: (1) small business concepts that apply to private practice; (2) specific marketing ideas requiring no budget; (3) how to streamline costs; (4) how to make yourself (and your practice) unique; (5) individual issues affecting success or failure; (6) how to select a location. Ample time will be given for questions and to foster an exchange of ideas between the panel and workshop participants. At the end, each participant will receive a handout outlining critical areas to consider and a free copy of Patrick Malloy's book titled, "Entering the Practice of Psychiatry: A New Physician's Planning Guide."

REFERENCES:

1. Molloy PJ: Entering the Practice of Psychiatry: A New Physician's Planning Guide. Manhasset, New York, Roerig & Residents Press, 1996.
2. Logsdon L: Establishing A Psychiatric Private Practice. Washington, D.C., American Psychiatric Press, Inc., 1985.

Component Workshop 43
PSYCHIATRIC TRAINING AT HOME AND ABROAD
APA Council on International Affairs

Chairperson: Daniel A. Monti, M.D., *Department of Psychiatry, Jefferson Medical College, 1020 Sansom St. Ste 1652 Thomp, Philadelphia PA 19107*
Participants: James B. Potash, M.D., John H. Lloyd, M.D., Husam Alathari, M.D., Jonathan W. Bolton, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to better understand aspects of psychiatric training in various regions of the world, and have a better appreciation of the various cultural and financial factors that affect the practice of psychiatry.

SUMMARY:

Given the current global mental health crisis, a tremendous need exists for psychiatrists throughout the world to exchange ideas, collaborate on research, and continue to enhance the World Health Organization's efforts to establish a common language in psychiatry. Meeting these goals can be enhanced by involving young psychiatrists-in-training who are interested in these issues. While it would seem that developing countries might be in particular need of such interaction, funding for out-of-country training has been reduced for them in recent years. On the other hand, those in more developed countries have much to learn about cultural aspects of mental disorders, but it has been difficult to integrate international health issues into the medical training curriculum. In response to these concerns, we have begun to directly contact trainees in psychiatry around the globe, which has resulted in a growing database of aspects of psychiatric training and practice for 58 countries worldwide. Our panelists will briefly present selected data of interest from various regions of the world, and the audience will be encouraged to ask questions and provide viewpoints on the topics presented. Members of our developing international network of psychiatrists-in-training will be invited to join the audience and participate in the discussions.

REFERENCES:

1. Sartorious N, Ustun B, Korten A, et al: Progress toward achieving a common language in psychiatry, II: results from the international field trials of the ICD-10 diagnostic criteria for the research for mental and behavioral disorders. Am J Psychiatry 1995; 152:1427–1437.
2. Appleby L, Araya R: Postgraduate training in psychiatry 1977–1987: disturbing trends in the pattern of international collaboration. Medical Education 1990; 24:290–297.

Component Workshop 44
CLINICAL ASSESSMENT MANAGEMENT OF SEXUAL HARASSMENT: 1998 UPDATE
APA New Jersey Psychiatric Association's Committee on Women

Co-Chairpersons: Rita R. Newman, M.D., *Department of Psychiatry, St. Barnabas Medical Center, 1046 South Orange Avenue, Short Hills NJ 07078-3131*, Angela M. Hegarty, M.D., *Department of Psychiatry, New York University, First Avenue and 27th Street, New York NY 10017*
Participants: Annette J. Hollander, M.D., Arlene G. Sherer, M.D., Sharyn A. Lenhart, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe current problems and latest methods of assessment and

management of sexual harassment and/or discrimination, with particular reference to obtaining a meaningful history, documenting symptoms, and treating appropriately patients with these problems.

SUMMARY:

This workshop will allow clinicians to recognize: early subtle sexual harassment or discrimination sequences at work impacting upon individuals; the importance of relating present complaints to prior experiences at work; the affective features and memory traces in victims of harassment/discrimination. It will also help deal with these issues systematically and appropriately in a therapeutic and legal framework.

Charges of sexual harassment continue to surface in the military, government, industry, and academia. Psychiatrists continue to be called upon to treat victims of sexual harassment or to evaluate alleged claims of sexual harassment. This workshop will explore up-to-date methods of assessment of such patients for both treatment and evaluation purposes. Several panelists, representing the Committee on Women of the New Jersey Psychiatric Association, will introduce the "Guide to Clinical Assessment of Sexual Harassment and/or Discrimination Complaints (including a semistructured interview format) developed by the Committee. The Guide provides a checklist of the most common psychological symptoms, a careful review of physical symptoms, and suggestions for obtaining a comprehensive history of prior abuse. Comparisons will also be made with the clinical picture of victim of rape and other forms of harassment and sexual discrimination, and specific treatment approaches will be delineated.

REFERENCES:

1. Shrier D., (Ed): Sexual Harassment in the Workplace and Academia—Psychiatic Issues, Washington DC, American Psychiatric Press, Inc., 1995.
2. Guide to Clinical Assessment of Sexual Harassment and/or Discrimination. The New Jersey Psychiatric Association Committee on Women, 1993.

Component Workshop 45
THE AMERICANS WITH DISABILITIES ACT AND THE RECOVERING PHYSICIAN
APA Committee on Training and Education in Addiction Psychiatry

Chairperson: Jonathan I. Ritvo, M.D., *Department of Psychiatry, Denver Health Medical Center, 777 Bannock Street, MC0490, Denver CO 80204*
Participants: David A. Burlage, J.D., Michael H. Gendel, M.D., David R. McDuff, M.D., Shawn Wilson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe the provisions of the Americans with Disabilities Act to issues regarding recovering physicians that psychiatrists confront in their roles as training directors, employers, credentials committee members, treating physicians, and patient advocates.

SUMMARY:

An attorney will present an overview of the Americans with Disabilities Act and specific observations on its implications for the recovering physician. A recovering physician will discuss her experience with prejudice, stigma, and discrimination in seeking treatment and in postgraduate training, hospital privileging, and licensing. A training director who sits on a hospital impaired-physicians committee will discuss his experience and observations regarding recovering physicians in graduate medical education and the credentialing process. A psychiatrist involved in running a state-sponsored physicians' health program and in the treatment of recovering physicians will discuss his experience helping recovering physicians continue in or return to practice. The audience will be invited to discuss these experiences and raise questions regarding the Americans with Disabilities Act and the recovery process for physicians. Examples of questions that will be discussed: What kinds of questions can physicians be asked about addiction and recovery in applications and interviews? How should the recovering physician approach answering these questions?

REFERENCES:

1. The ADA (42 U.S.C. Secs. 12101 *et seq.*).
2. Hausman K: M.D. battling medical board over demand for records, *Psychiatric News* v. 23, no. 17, Sept. 5, 1997.

Component Workshop 46
RISK MANAGEMENT ISSUES IN PSYCHIATRIC PRACTICE
APA Psychiatrists' Purchasing Group, Inc.

Chairperson: Alan I. Levenson, M.D., *75 North Calle Resplendor, Tucson AZ 85716*
Participants: Ellen R. Fischbein, M.D., Martin G. Tracy, J.D., Frank G. Feeley, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize diagnostic categories that reflect the highest risk for suit; to be familiar with risks presented by organized systems of care as well as common risk management issues that arise out of supervisory relationships; to gain insight into general methods of protecting against risks inherent in these relationships; to understand the part malpractice insurance plays in an overall risk management strategy.

SUMMARY:

Malpractice suits pose a significant problem for psychiatrists, regardless of whether they work in private practice, academic, or institutional settings. At least 8% of practicing psychiatrists are sued each year. It is important that psychiatrists understand the sources of malpractice suits and become aware of malpractice in terms of their own work as clinicians, teachers, and administrators. The workshop will present data from the APA-sponsored Professional Liability Insurance Program identifying common sources of malpractice actions against psychiatrists. The nature of malpractice lawsuits will be described and data will be presented on the cause and outcome of such lawsuits. Special emphasis will be placed on malpractice as it relates to the process of supervision, working with nonpsychiatric providers, and the changes managed care brings to psychiatric practice, as well as the risks associated with new forms of telecommunication. Information will be provided regarding malpractice insurance policies and questions that must be addressed when purchasing such a policy. Finally, risk management/risk prevention techniques for practicing psychiatrists, residents, educators, and administrators will be discussed.

REFERENCES:

1. Slawson PF: Psychiatric malpractice: recent clinical loss experience in the United States. Medicine and Law 1991; 10:129–138.

2. Levenson AI: Risk management in psychiatry. Clinical Psychiatry Quarterly 1993; 16vl:2–3.

Component Workshop 47
SPIRITUAL AND RELIGIOUS ISSUES IN MENTAL HEALTH AND ILLNESS
APA Committee on Religion and Psychiatry and APA Council on National Affairs

Co-Chairpersons: George T. Harding IV, M.D., *445 E. Dublin Granville Road, Worthington OH 43085-3126,* Rev. Clark S. Aist, Ph.D., *Dir. Chaplin's Service, St. Elizabeth's Hospital, 2700 Martin L. King Jr Ave, SE, Washington DC 20032*
Participants: Allen E. Bergin, Ph.D., T. Byram Karasu, M.D., Roger C. Sider, M.D., The Rev. Peter Vankatwyk, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participants should be able to recognize spiritual and religious issues in psychopathology and psychotherapy, the inverse relationship between psychological disturbance and meaningful religious experience, criteria for psychologically healthy religion vs. unhealthy religion, and the role values play in psychotherapy.

SUMMARY:

In this workshop Professor Bergin and the panel will discuss spiritual and religious issues in mental health and illness. This will include the relationship between religious commitment and psychopathology, the inverse relationship between psychological disturbance and meaningful religious experience, the variety of ways of being religious contrasting psychologically healthy ways with psychological unhealthy ways, and the role of values in psychotherapy. Case examples will be used to demonstrate the points including the increasing importance of value issues as a patient improves, with its concurrent importance in preventing relapse and maintaining mental health.

Responding to Professor Bergin's Oskar Pfister Lecture, the panelists will open the discussion with observations and questions designed to clarify the presentation. The audience will participate by asking questions and commenting throughout the workshop.

REFERENCES:

1. Bergin AE: Psychotherapy and religious values. J Consulting and Clinical Psychology, 1980; 48:95–105.
2. Bergin AE, Garfield SL. (editors): Handbook of Psychotherapy and Behavior Change. New York, Wiley, pp. 217–220, 1971.

Component Workshop 48
BEING AFRAID: WHEN TRAINEES FEAR FOR THEIR SAFETY
APA Committee of Residents and Fellows

Co-Chairpersons: Derek G. Puddester, M.D., *Department of Psychiatry, McMaster University, 726 Spring Gardens Road, Burlington, ONT L7T 1J3, Canada,* Zachary Solomon, M.D., *2718 Santa Clara, Albuquerque NM 87106*
Participants: Debra Safek, M.D., Robin R. Randall, M.D., Laura C. Toner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate an understanding of the literature and clinical experience with violence and fear in training; to recognize situations during which their own well being may be threatened; to utilize effective strategies to maintain their well being as outlined in the workshop; to identify the core agencies where curricula on violence and fear may be developed, fostered, promoted, and implemented.

SUMMARY:

Psychiatrists in training are dedicated to the care of the severely mentally ill; however, some residents feel their programs do not address the issues of fear and violence adequately. However, many other programs have yet to address these issues and members-in-training of the American Psychiatric Association have requested a forum to discuss and address such concerns. Consequently, the Committee of Residents and Fellows will both present and facilitate discussion on the following themes: the literature on fear and violence, when patients intrude into your personal life, when residents are falsely accused of sexual misconduct by their patients, being confronted by severe personality disorders, and violence in the emergency room. Forty minutes of time will be set aside for audience discussion. CORF will utilize the information gained at the workshop to shape its efforts in promoting resident well being within APA and allied organizations. The silence surrounding fear and violence in training programs will be broken by proactive education and collaboration.

REFERENCES:

1. Cook D, et al: Resident's experiences of abuse, discrimination and harassment during residency training. Canadian Medical Association Journal 1996; 154:1657–1665.
2. Chaimowitz G, et al: Patient assaults against psychiatric residents. Canadian Journal of Psychiatry 1991; 36:107–111.

Component Workshop 49
CULTURAL OUTCOMES IN THE ELDERLY: AN INDUSTRY PERSPECTIVE
APA Committee on Ethnic Minority Elderly

Chairperson: Jacobo E. Mintzer, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Room PH141, Charleston SC 29425*
Participants: Michael Pontecorvo, Ph.D., Jamie S. Street, M.D., Marc Cantillon, M.D., Thomas McRae, M.D., Peter J. Whitehouse, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, participants will be aware of the strengths and weaknesses of evaluating outcomes in pharmacological clinical trials relevant to ethnic elders from either an agent-specific or disease-specific focus.

SUMMARY:

It became evident at the 1997 APA component workshop on ethnic elders that a number of differences have been observed in outcomes of pharmacological clinical trials in various cultural groups. This is a significant obstacle in the development of adequate outcome domains for international and national clinical trials seeking psychiatric treatments in culturally diverse elderly populations. A consensus conference is being organized to examine this issue. This workshop is the second step to defining the conference's focus by evaluating the two main approaches: pharmacological agent-directed versus disease-directed focus.

Representatives from four major pharmaceutical companies will share data and experience in developing culturally relevant outcome domains in clinical trials. A senior investigator then will synthesize the proposed approach to the issue.

The audience will participate in discussing the strengths and weaknesses of the two different approaches. The success of the workshop in defining the appropriate approach to examining the issue of pharmacological outcomes in ethnic elders will further define the focus of the future consensus conference.

REFERENCES:

1. Kleinman A: Anthropology and psychiatry: the role of culture in cross-cultural research on illness. Br J Psychiatry 1987; 151:447–54.
2. Gibson RC: The age-by-race gap in health and mortality in the older population: a social science research agenda. Gerontologist. 1994; 34:454–62.

Component Workshop 50
PSYCHIATRIC DIMENSIONS OF DISASTERS
APA Committee on Psychiatric Dimensions of Disasters

Chairperson: Robert J. Ursano, M.D., *3900 Cleveland Street, Kensington MD 20895*
Participants: Michael Blumenfield, M.D., Ann E. Norwood, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify the role of psychiatry in disaster preparedness, response, and rehabilitation; to develop strategies for inputting into policy-making to other sectors of the emergency response system.

SUMMARY:

Disasters have affected the U.S. in recent years with significant losses. Recent examples include the explosion of TWA Flight 800 and the ValuJet crash in Florida. The mental health impact of a disaster extends both before the disaster and for a long time afterwards. The providers of mental health care need to be responsive to the shifting needs of the affected population throughout these protracted time periods. This workshop will continue to elaborate upon the roles that a psychiatrist is well-suited to assume in disaster planning and response. Psychiatrists who have worked on recent disasters will be invited to attend and share their experiences. Historically, many workshop attendees have a wide range of experiences in disasters at both national and international levels. The workshop provides a forum for sharing expertise and raising issues of concern for further exploration by the Committee on Psychiatric Dimensions of Disaster.

REFERENCES:

1. Ursano RJ, McCaughey BG, Fullerton CS (eds): Individual and Community Responses to Trauma and Disaster: The Structure of Human Chaos. Cambridge, England, Cambridge University Press, 1994.
2. Ursano RJ, Fullerton CS, Norwood AE: Psychiatric dimensions of disaster: patient care, community consultation, and preventive medicine. Harvard Review of Psychiatry 1995; 3:196–209.

Component Workshop 51
PRINCIPLES OF ABUSE AND MISUSE OF PSYCHIATRY
APA Committee on Abuse and Misuse of Psychiatry in the United States

Co-Chairpersons: Margaret F. Jensvold, M.D., *Instit. Rsrch on Women's Hlth., 1616 18th Street, NW, Ste 109, Washington DC 20009,* Eric A. Plaut, M.D., *912 Michigan Avenue, Evanston IL 60202*
Participants: Alban J. Coghlan, M.D., Abraham L. Halpern, M.D., Andrew Siegel, M.D.

EDUCATIONAL OBJECTIVES:

At the end of the workshop the participant should be able to articulate principles by which to recognize abuses and misuses of psychiatry.

SUMMARY:

The Committee on Abuse and Misuse of Psychiatry in the U.S., of the Council on National Affairs, and the Committee on Abuse of Psychiatry and Psychiatrists, of the Council on International Affairs, have been working on a draft statement of principles for identification of abuse and misuse of psychiatry. In this workshop members of both committees will lead the audience in discussion of and feedback about the draft principles. Topics to be discussed by committee members and audience include the following: definitions of abuse and misuse of psychiatry, universal principles transcending individual cultures versus individual cultural mores, observations and concerns of audience members about abuses of psychiatry they are observing today, etc.

In September 1997 the National Council and International Council passed an action item about principles of abuse and misuse of psychiatry. The action item will go to the Joint Reference Committee and APA Board for consideration for passage and distribution by the Division of Government Relations and Public Affairs office. Meanwhile, the U.S. and International Committees are continuing to develop the principles with the goal of submitting to the APA a position statement on the topic, later to be followed by a statement of annotations and opinions of the committees.

This workshop will disseminate information important to psychiatrists, facilitate communication with APA members, and assist the committees in being responsive to the needs of psychiatrists in the U.S. and internationally.

REFERENCES:

1. American Psychiatric Association: Position statement on abuse and misuse of psychiatry. American Journal of Psychiatry 1994; 151(9):1399.
2. Committee on Abuse and Misuse of Psychiatry in the U.S.: Misuse and abuse of psychiatry in the U.S.: a definition and discussion. American Psychiatric Association, Washington, D.C., 1991 (unpublished draft).

Component Workshop 52
SEX AND POWER IN THE WORKPLACE: YOUR ROLE AND LIABILITY
APA Committee on Occupational Psychiatry

Chairperson: Marcia Scott, M.D., *Disability, Prudential Insurance, 227 Beacon Street, Boston MA 02116*
Participants: Nada L. Stotland, M.D., Peter Petesch, J.D., Leora Rosen, Ph.D., Robert C. Larsen, M.D.

EDUCATIONAL OBJECTIVES:

This workshop, sponsored by the Committee on Occupational Psychiatry, will familiarize attendees with the clinical, legal, and personnel implications of sexual harassment in today's workplace.

SUMMARY:

Power in work relationships can be played out through individual or group dynamics. Not uncommonly, sexual feelings cross boundaries and interfere with work relationships resulting in decreased productivity, demoralization, and legal problems in both the individual and the extended work team. The employee subjected to sexual harassment is frequently in a job position with less control and authority relative to the instigator.

The workshop presenters will cover the basics of sexual harassment—who wins, who loses—the effect on organizations and productivity, the laws and regulations, as well as the differences between harassment and the usual diverse and important relationships people have in the workplace community. Included will be case presentations and strategies for both individual intervention and organizational prevention.

REFERENCES:
1. Gutek B: Sex in the Workplace. Jossey Bass San Francisco.
2. Fitzgerals L: Sexual harrassment the last great secret, in No Safe Haxz. Edited by MaryKoss et al: APA, Washington, DC.

Component Workshop 53
PSYCHOTHERAPY WITH LESBIANS AND BISEXUAL WOMEN
APA Northern California Psychiatric Society's Committee on Gay, Lesbian and Bisexual Issues

Chairperson: Ellen Haller, M.D., *Department of Psychiatry, University of CA at SF, 401 Parnassus Avenue, San Francisco CA 94143*
Participants: Karin L. Hastik, M.D., Kathryn J. Lee, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: (1) demonstrate, an increased awareness of unique relationship dynamics for lesbians and bisexual women, (2) recognize dynamics unique to a psychotherapy group for lesbians and understand issues related to whether or not the group therapist self-discloses her own sexual orientation, and (3) summarize similarities and differences in the development and identity between lesbians and bisexual women.

SUMMARY:

Psychotherapists working with lesbians and bisexual women in their practices can benefit from increased awareness of the unique issues faced by these women. For some lesbians and bisexual women, the coming out process and struggles with recognizing a homosexual identity may be the reason for their presentation to a therapist. For others, their homosexuality or bisexuality is the context within which they present for treatment but is not related directly to their reason for seeking psychotherapy. This workshop will include several presentations on unique psychotherapeutic issues of import to therapists working with this population. Relationship dynamics in same gender female couples will be reviewed and will be contrasted with heterosexual and homosexual male couples. Both the supervisor and the therapist will present issues related to doing group therapy in an all lesbian psychotherapy group. Issues to be presented will include self-disclosure of sexual orientation by the therapist, recruitment and retention of group members, and unique group dynamics identified over the course of the group's existence. Lastly, this workshop will include a presentation on the many unique developmental and identity issues for bisexual women. Clinical experiences of the audience will be elicited and discussed by the panel members.

REFERENCES:
1. Bradford J, Ryan C, Rothblum ED: National lesbian health care survey: implications for mental health care. J Consulting and Clin Psychology 1994; 62:228–42.
2. Fox RC: Bisexuality: an examination of theory and research, in Textbook of Homosexuality and Mental Health. Edited by Cabaj RP, Stein TS. Washington DC, American Psychiatric Press, Inc, 1996.

Component Workshop 54
CHANGING MODELS OF RURAL MENTAL HEALTH CARE
APA Corresponding Task Force on Rural Psychiatry

Chairperson: Stuart A. Copans, M.D., *Dartmouth Medial School, 75 Linden Street, Brattleboro VT 05302*
Participants: James L. Day, M.D., Diane K. Fast, M.D. Richard T. Palmisano, M.S., Edward Gordon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be aware of potential benefits of introducing new technologies into rural mental health care systems, of resources that could help with such developments, of ways to combine rural service deliverers into comprehensive systems of care, and of impending changes in funding mechanisms.

SUMMARY:

This workshop begins with a brief overview of the major problems of rural psychiatry, including geography, communication, transportation, cultural issues, and financial problems. It then focuses on four approaches to these problems: new technologies, changes in the political models for organizing psychiatric care, new models of psychiatric care networks in rural areas, and changes in reimbursement policies.

The workshop will combine short presentations by experts with experience and knowledge in each of these areas, with open discussion in which workshop participants will have an opportunity to share their experiences or to present problems for discussion by the panel and other participants.

Presentations will include Dr. James Day speaking about computer networks and telemedicine, Dr. Diane Fast on the effects of the change to local control of psychiatric services in British Columbia, Mr. Rick Palmisano and Dr. Stuart Copans speaking about the development of a comprehensive system of psychiatric care in Vermont, focusing respectively on the fiscal and administrative issues and on the clinical issues involved, and Dr. Edward Gordon on recent and upcoming changes in Medicaid and Medicare and the implications of these changes for rural psychiatry.

REFERENCES:
1. Brown Frank W: A survey of telepsychiatry in the USA. Journal of Telemedicine and Telecare 1995; 1:19–21.
2. Reed, DA: Adaptation: the key to community psychiatric practice in the rural setting. Community Mental Health Journal, 1992; Vol. 28, No. 2, p. 141–154.

Component Workshop 55
PATHOLOGY TO PRIDE: EVOLVING VIEWS OF HOMOSEXUALITY
APA New York County District Branch's Committee on Gay and Lesbian Issues

Co-Chairpersons: Kenneth B. Ashley, M.D., *85 East 10th Street, #1F, New York NY 10003-5407,* Laura J. Bernay, M.D., *Department of Psychiatry, New York University, 44 West 10th Street, #5E, New York NY 1001-8762*
Participant: Robert J. Mitchell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand how psychiatry's view of homosexuality has changed in the last 25 years and how these changes have affected the lives of homosexual patients and the professional lives of gay and lesbian psychiatrists. They will be able to recognize and address ongoing problems with homophobia in the field.

SUMMARY:

This year marks the 25th anniversary of the deletion of homosexuality from the Diagnostic and Statistical Manual of the APA. Ten years ago, ego-dystonic homosexuality was also removed. We will explore attitudes toward homosexuality in American psychiatry since those controversial changes were made. While gays and lesbians—as well as many heterosexuals—celebrated the removal of homosexuality from the list of psychiatric diseases and syndromes, some members of the psychiatric community have had difficulty in making the transition from viewing homosexuality as pathology to seeing it as a normal variant on the continuum of sexual expression. A quarter century after the APA's decision, a small but vociferous group of mental health professionals still deride the deletion as politically

motivated, and present unsubstantiated "data" on reparative therapies. This workshop will focus on the past, present, and future of education about homosexuality. Panelists will report on the current status of gay and lesbian studies in academic and clinical medicine, and ongoing problems with homophobia in these arenas. Participants will be encouraged to share their experiences in medical school and psychiatric and psychoanalytic training. We will discuss how trainees learn about homosexuality now, and *what* they learn from their teachers, supervisors, and psychiatric textbooks.

REFERENCES:

1. Bayer R: Homosexuality and American Psychiatry: The Politics of Diagnosis with a New Afterword on AIDS and Homosexuality. Princeton, NJ, Princeton University Press, 1987.
2. Cabaj RP and Stein TS, (eds.): Textbook of Homosexuality and Mental Health. American Psychiatric Press, Inc., Washington DC, 1996.

Component Workshop 56
FIGHTING MANAGED CARE COMPANIES: EMPLOYMENT RETIREMENT INCOME SECURITY ACT (ERISA) LIMITATIONS
APA's Council on Psychiatry and Law, Commission on Judicial Action and Joint Commissions on Government Relations and Public Affairs

Chairperson: Renee L. Binder, M.D., *Department of Psychiatry, Univ. of CA, San Francisco, 401 Parnassus Avenue, Box F, San Francisco CA 94143*
Participants: Paul S. Appelbaum, M.D., J. Richard Ciccone, M.D., Ronald A. Shellow, M.D., Nada L. Stotland, M.D., Michelle Riba, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant will understand how ERISA limits the accountability of managed care companies and protects them from state regulations and lawsuits.

SUMMARY:

The purpose of this presentation is to give an overview of ERISA and how it limits the accountability of managed care companies and protects them from state regulations and lawsuits for denying care. Dr. Binder, chair of the Council on Psychiatry and Law will give an introduction. Then, Dr. Paul Appelbaum, secretary of the APA, will give an overview of ERISA and discuss its origins. Dr. Richard Ciccone, chair of the Commission on Judicial Action, will describe efforts in the courts to deal with ERISA and the fact that the court route does not appear promising. Dr. Ronald Shellow, chair of the Joint Commission on Government Relations, will then explain efforts of legislation to modify ERISA. Finally, Dr. Nada Stotland, chair of the Joint Commission on Public Affairs, will discuss how public education and member education might help us deal with ERISA problems. There will be time for discussion and audience interchange about what we can do about ERISA regulations.

REFERENCES:

1. Hoge SK: ERISA, Part 2: the malpractice liability of managed care companies: a ray of hope. Journal of Practical Psychiatry and Behavioral Health Vol 2, No. 5, September 1996, p 315–318.
2. Mariner WK: Sounding board. State regulation of managed care and the Employee Retirement Income Security Act. The New England Journal of Medicine December 26, 1996: Vol 335, No. 26, p 1986–1990.

Component Workshop 57
CONSENSUS WORKSHOP ON PSYCHODYNAMIC INSTRUCTION
APA Consortium on Special Delivery Settings and APA Commission on Psychotherapy by Psychiatrists

Chairperson: Vivian B. Pender, M.D., *Department of Psychiatry, NY Hospital/Cornell Med Center, 247 West 87th Street, #7F, New York NY 10024-2847*
Participants: Norman A. Clemens, M.D., Ruth E. Frydman, M.D., Lawrence C. Sack, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to formulate the need for psychodynamic instruction in psychiatric resident education.

SUMMARY:

Using a collaborative approach, this workshop will attempt to arrive at a consensus on the need for psychodynamic instruction in psychiatric resident education. Decreasing managed care coverage for long-term psychotherapy is leading to a lessening of training in psychodynamic and psychoanalytically oriented theory and psychotherapy for residents. This decrease in education will likely affect the psychodynamically informed aspects of psychiatric treatments. Although it is widely accepted that such concepts as resistance, defense, conflict, transference, countertransference, and working alliance are important in the doctor-patient relationship, there is controversy about how these are best taught. Some authorities are of the opinion that psychodynamic psychotherapy training because of its complex nature be done in a different setting, i.e., fellowships or psychoanalytic training. However, a diminished psychodynamic approach might impart an undesirable, less than comprehensive treatment of the patient. Failure to include psychodynamic concepts may compromise the treatment of mental illness, such as in the area of compliance with pharmacologic therapy. The intent of this workshop is to examine the issue of psychodynamic instruction in psychiatric training, its value, its timing, and its current relevance.

REFERENCES:

1. Robertson MH: Psychotherapy Education and Training: An Integrative Perspective. Madison, CT, International University Press, Inc., 1995.
2. Beitman BD: The Structure of Individual Psychotherapy. New York, Guilford, 1987.

Component Workshop 58
GLOBAL EDUCATION IN PSYCHIATRY: UNITY AND DIVERSITY
APA Committee on International Education

Chairperson: Winston W. Shen, M.D., *Department of Psychiatry, St. Louis University, 1221 South Grand Boulevard, St. Louis MO 63104-1016*
Participants: Houshang G. Hamadani, M.D., J. Randolph Hillard, M.D., Michael J. Napoliello, M.D., Suzane M. Renaud, M.D., Alan Gorden, M.D., Miguel A. Leibovich, M.D., John B. Sikorski, M.D., Cassandra E. Harewood, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be more knowledgeable about international aspects of psychiatric educa-

tion, and more culturally sensitive in delivering the psychiatric care of ethnic minority patients in North America.

SUMMARY:

This workshop is expanded and revised from the one from the previous year, and is intended to explore further an educational program in psychiatry of worldwide relevance for medical students, postgraduate trainees, practicing psychiatrists, primary care physicians, and subspecialists in psychiatry. The workshop presenters, who are members of the APA Committee on International Education, will highlight various unity versus diversity issues of a worldwide psychiatric educational program, in such areas as child and adolescent psychiatry, transcultural issues of psychotherapy, psychopharmacology, Internet communications, etc. Similarities and differences between Canadian and American psychiatric training will also be presented. The audience, both international and North American, will have ample opportunity to discuss their own first-hand experiences in psychiatric education. This workshop is intended to provide the audience with better understanding of educational needs in and outside North America, learning from psychiatrist colleagues in other parts of the world, and enhancing cultural sensitivity in delivering psychiatric care to ethnic minority patients in North America.

REFERENCES:

1. Ruiz P: Clinical care update: the minority patient. Comm Ment Health J 1985; 21:3:208–216.
2. Franklin RR, Sarr D, Gueye M, Sylla O, Collignon R: Cultural response to mental illness in Senegal: reflections through patient companions—part 1. methods and descriptive data. Soc Sci Med 1996; 42:3:325–338.

Component Workshop 59
GETTING YOUR PATIENT HOUSING, ENTITLEMENTS AND FREE MEDICATIONS: A PRIMER
APA Committee on Poverty, Homelessness and Psychiatric Disorders

Chairperson: Stephen M. Goldfinger, M.D., *Department of Psychiatry, SUNY Downstate Medical Center, 450 Clarkson, Boston MA 02115-6106*
Participants: Andrea White, M.S.W., Joel S. Feiner, M.D., Walter S. Jennings, Jr., M.D., Albert A. Hyman, M.D.

SUMMARY:

"In 34 years of practice, I've never before filled out an SSI disability form. My patient deserves it, but I have no idea how to see that she gets the resources I believe she's entitled to."

"My patient does wonderfully on risperidone, but has NO money. What can I do?"

"This new Medicaid patient I started seeing was evicted, and is far too psychotic to find an apartment. Where can I refer someone for shelter or group living programs?"

With changes in Medicaid and other forms of health care reimbursement, psychiatrists are finding themselves working with populations that may be quite different from those they had dealt with previously. Many practitioners may be experts in psychotherapy and pharmacologic interventions, yet have NO idea where to find housing for a homeless patient, or how to access the free medications for impoverished individuals available through a number of pharmaceutical companies.

This year, the APA's Committee on Poverty, Homelessness and Psychiatric Disorders has decided to eschew the esoteric for a practical, hands-on workshop, which will provide direct information and instruction on getting your patients what they need. Andrea White, a well known and respected social worker and advocate, will join members of the committee in training participants in such essentials as finding local residential service providers and telling the SSI office what they want to hear. Names and contact numbers for free medications from major pharmaceutical companies and their current policies, will be provided in handouts. Ample time will be set aside for specific questions from attendees, and information not available at the session will be sent out to those who request it.

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.

Component Workshop 60
CROSS-CULTURAL MENTAL ILLNESS: THE TRUE CHAMELEON
APA CMHS and Zeneca Minority Fellowships

Chairperson: Xenia H. Johnson, M.D., *Department of Psychiatry, Medical University, 171 Ashley Avenue, Charleston SC 29425*
Participants: Husam Alathari, M.D., Daniel B. Martinez, M.D., Jacquelyn B. Chang, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop, the audience will have an understanding of the individual dynamic issues across cultures, the familial factors that affect treatment and diagnosis across cultures, and have a working model to use in designing treatment of mental illness as it varies across cultures.

SUMMARY:

This group of culturally diverse residents and fellows affiliated with the Center for Mental Health Services fellowship program will talk about cross-cultural issues as they pertain to the field of psychiatry. We will present a forum where the individual as well as the family cultural beliefs are explored as they relate to the diagnosis and treatment of psychiatric illnesses in an environment unfamiliar with such beliefs. As evidenced by the recent occurrence in New York City regarding the Haitian male, there are racial issues driving the fabric of American life. The last ten years encapsulate the American struggle to embrace various cultures and their beliefs. The aim of this workshop is to present information that will aid the mental health professional better assess and treat patients from a myriad of cultural backgrounds. The first presenter will discuss the effect upon the individual who shares a different cultural belief from his therapist. He will explore issues such as the influence of Qi-gong upon a single Asian male who feels overwhelmed by the pressures from family to follow his cultural tradition. The second presenter will invite the audience to discuss their beliefs about certain practices defining mental illness when seen in certain cultures. The third presenter will introduce a vignette of a challenging dilemma with regard to a clinical symptom and the working diagnosis exclusively found in a minority population. The discussant will then engage the audience in how to accurately assess all of the above and then discuss with them successful treatment options.

REFERENCES:

1. McGoldrick M, Giordano G, Pierce JK: Ethnicity and Family Therapy, 2nd Edition. New York, Guiford Press, 1996.

2. Cross TL, Bazron BJ, Dennis KW, et al: Towards a Culturally Competent System of Care. Washington, DC, CASSP Technical Assessment Center, 1989.

Issue Workshop 1
INSIGHT INTO ILLNESS: A DETRIMENT OR AN ENHANCEMENT?

Chairperson: Thankamma Mathew, M.D., *UNIV Services, Rochester Psychiatric Center, 1111 Elmwood Avenue, Rochester NY 14620-3005*
Participants: John F. Crilly, M.S.W., Elizabeth DiMartino, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the issues, difficulties, and positive aspects inherent in patients developing insight into their severe mental illness.

SUMMARY:

The literature on addressing awareness of mental illness (i.e., insight) offers differing viewpoints, either that patients with "insight" are at greater risk for suicide behavior or that it is a positive aspect and necessary for success in the community. One group recommends the goal of treatment focus on increasing awareness of the aspects of illness associated with lack of acceptance of treatment and allowing other aspects of poor awareness to persist.

For this workshop, the presenters will be discussing a unique approach to addressing both the lack of insight into illness and increasing awareness of the impact of treatment noncompliance on one's life using two separate interventions: a "direct" (psychoeducational group) and an "indirect" (viewing/discussing movies depicting mental illness) approach.

The audience will be provided both with typical clips from movies used in the "indirect approach" group and material used in the "direct approach" group. These will serve as a basis for discussion about how the approaches are provided and whether they help or impede the patient's progress. Audience participation will be encouraged throughout this entire process, culminating in discussion about how this and other approaches fit into the debate about insight into illness.

REFERENCES:

1. Amador XF, Strauss DH, Yale SA, Gorman JM: Awareness of illness in schizophrenia. Schizophrenia Bulletin 1991;17:113–132.
2. Amador XF, Friedman JH, Kasapis C, et al: Suicidal behavior in schizophrenia and its relationship to awareness of illness. American Journal of Psychiatry 1996;153:9:1185–1188.

Issue Workshop 2
CARDIAC PSYCHIATRY

Chairperson: Susan E. Abbey, M.D., *Department of Psychiatry, Toronto Hospital, 200 Elizabeth Street, 8EN-212, Toronto, Ontario M5G 2C4, Canada*
Participants: Francois Lesperance, M.D., Brian Baker, M.D., Paul Dorian, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the role of psychiatry in the care of cardiac patients, and to recognize special issues involved in the psychiatric care of cardiac patients.

SUMMARY:

The role of psychiatrists in the care of cardiac patients is expanding with the recent recognition of the significant independent impact of depression and phobic anxiety on mortality in cardiac patients. Research has documented the negative impact of psychiatric disorders on successful cardiac rehabilitation, particularly in premenopausal and perimenopausal women. Cardiac disorders are extremely common, are the cause of death in 40% of women and 38% of men, and are associated with marked impairment in quality of life. Yet to date, psychiatrists have been considerably underrepresented in the care of cardiac patients. This workshop will engage the audience in a discussion of the role of psychiatry in the care of cardiac patients. It will provide brief summaries of the major areas of interest in cardiac psychiatry including the essential research references psychiatrists need to know about in order to practice effectively in this area. Depression, anxiety disorders, and the role of gender in psychopathology will be discussed. The cardiologists' perspective on the role of psychiatry in the care of cardiac patients will be discussed.

REFERENCES:

1. Frasure-Smith N, Lesperance F, Talajic M: The impact of negative emotions on prognosis following myocardial infarction: is it more than depression? Health Psychology, 1995;14(5):388–398.
2. Kawachi I, Colditz GA, Ascherio A, et al: Prospective study of phobic anxiety and risk of coronary heart disease in men. Circulation: 1994;89:1992–1997.

Issue Workshop 3
MEDICAL CAREERS AND MID-LIFE TRANSITION

Chairperson: Anna G. Engel, M.D., *Department of Psychiatry, Stratton VA MC, 200 Shaker Ridge Drive, Niskayuna NY 12309-1964*
Participants: Hera J. Cohn-Haft, M.D., Virginia L. Susman, M.D., Virginia L. Susman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize how midlife transitions influence professional direction, and to achieve an understanding of how gender influences career choices by reviewing the literature and comparing experiences.

SUMMARY:

The purpose of this workshop is to examine medical career paths at midlife and the influences on their direction at this point of the life cycle. The career paths of men and women physicians diverge soon after medical school and follow distinct patterns. Decisions made by women are influenced by constraints of family life, marital circumstances, and practice style. For women, professional development seems to be an interweaving of personal and work life. Men tend to attain higher status increasing their working while their family expands. Their work seems to be the centerpiece around which family life and personal interests conform. Research reveals that at midlife there is a switch. Women increase their professional time and men reduce theirs. What is not known is how the developmental, generational, biological, and economic issues of midlife influence career decisions. This workshop will provide opportunities to explore these issues. Workshop participants will be invited to compare experiences and perspectives following brief presentations by the panelists.

REFERENCES:

1. De Konnick M, Bergeron P, Bourbonnais R: Women physicians in Quebec. Soc Sci Med 1997;44(12):1825–1832.

2. Shy D: Gender differences in Israeli physicians' career patterns, productivity and family structure. Soc Sci Med 1991;32(10):1169–1181.

Issue Workshop 4
TREATING MENTAL ILLNESS IN PRISONS

Chairperson: James E. Dillon, M.D., *Child & Adol Psych Hosp., Univ. of Michigan Medical Ctr., 1500 East Medical Center Drive, Ann Arbor MI 48109*
Participants: Richard S. Jackson, M.D., Lee H. Rome, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize factors leading to criminalization of the mentally ill; to learn how to develop a model prison treatment program.

SUMMARY:

The mentally ill have always comprised a significant if often ignored minority in prison populations. In recent years, however, deinstitutionalization has dramatically increased the role of penal facilities in the social management of mental illness and substance abuse, a phenomenon often referred to as "criminalization" of the mentally ill. This workshop will address the phenomenon, using experiences in Michigan's correctional facilities to provoke discussion of similar problems faced nationwide.

The dialogue will be organized around three brief presentations. The first speaker (Rome) will describe the effects of a consent decree in *United States v. Michigan et al.*, as a result of which federal monitors were assigned to oversee the massive reorganization of mental health services in the state's correctional system. The second speaker (Jackson) will describe a model residential treatment program within a women's correctional facility made possible in large measure due to the consent decree. The third speaker (Dillon) will argue that "criminalization" may not be an unmitigated evil, in that it offers unique treatment opportunities that are no longer available in civil mental health systems.

REFERENCES:

1. Osofsky HJ: Psychiatry behind the walls: mental health services in jails and prisons. Bull Menniger Clin 1995;60:464–479.
2. Farmer KA, et al: Medically serious suicide attempts in a jail with a suicide prevention program. J Forensic Sci 1996;41:240–246.

Issue Workshop 5
HOW TO TEACH THE BIOPSYCHOSOCIAL MODEL EFFECTIVELY

Co-Chairpersons: Hoyle Leigh, M.D., *Department of Psychiatry, University of California, 2615 East Clinton Avenue, Fresno CA 93703-2223,* Trevor D. Glenn, M.D., *2615 East Clinton, Fresno CA 93703*
Participants: Don R. Lipsitt, M.D., Jon M. Streltzer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the challenges in teaching biopsychosocial approaches to medical students and residents, and demonstrate the use of life chart and the Patient Evaluation Grid as teaching tools as well as be familiar with other teaching tools.

SUMMARY:

This workshop will discuss innovative methods of teaching the biopsychosocial model to medical students and psychiatric residents. Although the biopsychosocial model is particularly suited for understanding psychiatric syndromes and psychiatric patients, teaching it is often a challenge because there is no systematic way of organizing biopsychosocial data. If the biopsychosocial model is to survive into the next century, an urgent task is to develop an operational method of its practice. Two such methods have been utilized in the training program of the University of California, San Francisco, Fresno Psychiatry Program. One is the Patient Evaluation Grid (PEG), developed by Leigh, Feinstein, and Reiser. The PEG consists of the three dimensions of the patient (biological, psychological, and environmental) intersected by three time contexts (current, recent, and background), forming nine areas in which data must be collected. This approach forces the student to collect information in all areas of the patient, leading to comprehensive evaluation and management. As the PEG and its management form have been computerized, a clinician can generate both a narrative history and the PEG forms. We found this approach to be useful for biopsychosocially oriented clinicians.

A simpler, and easier method, especially for medical students, is the life chart, first used by Adolf Meyer. Our modified life chart consists of three columns: column one traces major events of the patient's life chronologically from birth to the present, column two indicates the actual year and age of the patient, and column three indicates any abnormal/pathological/traumatic events, such as the development of symptoms, hospitalization, or bereavement. The audience will participate in constructing the PEG and/or the life chart and share their experiences in teaching the biopsychosocial model.

REFERENCES:

1. Leigh H: From biopsychosocial model to patientology, in Biopsychosocial Approaches in Primary Care: State of the Art Challenges for the 21st Century, Edited by Leigh H. 1997; pp. 137–148.
2. Meyer A: Psychobiology: A Science of Man. Charles C. Thomas, Springfield, IL, 1957.

Issue Workshop 6
COLLABORATION IN EASTERN AND SOUTHERN AFRICA

Chairperson: Lawson R. Wulsin, M.D., *Department of Psychiatry, University of Cincinnati, 231 Bethesda Avenue (ML 559), Cincinnati OH 45267-0559*
Participants: Athanase Hagengimana, M.D., Pius Akivaga Kigamwa, M.D., Alan S. Bergsma, O.D., Cliff W. Allwood, M.D., Dr. Margaret Makanyengo

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to understand the current resources and obstacles for collaboration in Eastern and Southern Africa.

SUMMARY:

This workshop begins with brief accounts of new opportunities for collaboration within the region of Eastern and Southern Africa, and between American and African psychiatrists. Then the chairperson will ask participants to add to the list of resources and discuss current obstacles to and opportunities for collaboration.

Dr. Wulsin will summarize the activities of the APA Corresponding Task Force on Sub-Saharan Africa. Dr. Hagengimana will discuss faculty sharing through the U.N. Development Project. Dr. Bergsma will describe the current status of efforts to establish an ECT equipment donation project. Dr. Kigamwa will present an update on the survey of academic psychiatry in the region, with suggestions for improving collaboration. Dr. Allwood (and/or Dr. Emsley) will discuss strategies for promoting publication of recent research in regional journals. Dr. Nel will discuss clinical trials in the region and links with the pharmaceutical industry. Dr. Mak'anyengo will discuss opportunities for women psychiatrists in Kenya.

This workshop will contribute to a report to the American Psychiatric Association's Council on International Affairs, recommending

strategies to improve collaboration between American and African psychiatrists as well as within the African region.

REFERENCES:

1. Odejide AO, Oyewunmi LK, Ohaeri JU: Psychiatry in Africa: an overview. Am J Psychiatry 1989;146:708–716.
2. Sugar JA, Kleinman A, Eisenberg L: Psychiatric morbidity in developing countries and American psychiatry's role in international health. Hospital and Community Psychiatry 1992;43:355–360.

Issue Workshop 7
THE HAMILTON-WENTWORTH HSO MENTAL HEALTH PROGRAM

Chairperson: Nick S. Kates, M.B., *Department of Psychiatry, McMaster University, 43 Charleton Avenue East, Hamilton, ONT L8N 1Y3, Canada*
Participants: Anne Marie Crustolo, B.ScN., Marilyn Craven, M.D., Lambrina Nikolaou Sheryl Farrar

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to apply the principles and concepts discussed when working with family physicians in their own community.

SUMMARY:

With the family physician playing an increasingly central role in managing individuals with mental illnesses, new approaches are needed for linking psychiatric services with primary care practices. One way is for mental health personnel to work within family physicians' offices. This workshop is based upon the experience of a program in Hamilton, Ontario, that brings counselors and psychiatrists into the offices of 90 local family physicians serving 170,000 people and will present practical strategies to make such a model work. The presenters will review the goals and principles on which the program is built and describe how it works. Issues covered will include what the family physician is looking for, advantages and benefits, new opportunities for continuing education, ways of enhancing the care of the seriously mentally ill, and how to go about setting up this kind of model, which the presenters believe is transportable to most North American communities Throughout the workshop participants will be asked to share their own experiences in working with primary care physicians and lessons that can be learned when embarking upon an approach to an emerging and exciting area of consultation-liaison psychiatry.

REFERENCES:

1. Jackson G, Gater R, Goldberg D, et al: A new community mental health team based in primary care. A description of the service and its effect on service use in the first year. Br J Psychiatry 1993;163:375–384.
2. Kates N, Craven M, Nikolaou L, et al: Integrating mental health services within primary care. Gen Hosp Psych October 1997.

Issue Workshop 8
OUR FUTURE: MEDICINE, CULTURE AND HUMAN RIGHTS ISSUES
Joint Session with the American Association of Psychiatric Administrators

Chairperson: Paul A. Rodenhauser, M.D., *Department of Psychiatry, Tulane Univ School of Medicine, 1430 Tulane Avenue, SL-23, New Orleans LA 70112-2699*
Participants: Humberto L. Martinez, M.D., L. Mark Russakoff, M.D., Pedro Ruiz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should be able to identify the forces impacting the present medical environment while adjusting to the future ones; learn about the effects that culture will have in the delivery system; and meet the challenges while guaranteeing the patients' and physicians' human rights.

SUMMARY:

This workshop will present the point of view of three psychiatrist-administrators, one from a nonprofit hospital, another from a public hospital, and the other from a nonprofit community-based environment. Each one, with at least two and half decades of experience, sees the future from the perspective: (1) of organized medicine, the hospital environment; (2) how culture will impact the service delivery through the eyes of a clinician administrator and the population served; (3) how we can have a win-win situation and improve outcomes while guaranteeing the human rights of both patient and physician. Particular attention will be devoted to the managed care expansion and how it interacts with the issues at hand. That is our future within medicine, the cultural nuances, and the human rights guarantees. How can we preserve the physician-patient relationship in the future? How can we meet the challenges? How can we best position our patients and our role in medicine? This workshop will attempt to provide a framework, some answers, and elicit much discussion from the audience and panelists.

REFERENCES:

1. Council on Ethical and Judicial Affairs, American Medical Association: Ethical issues in managed care, JAMA, 1995;273:330–335.
2. Ranz J, Eilenberg J., Rosenheck S: The psychiatrist's role as medical director: task distributions and job satisfaction, Psychiatric Services, 1997;48:915–920.

Issue Workshop 9
VALUES IN THE PHYSICIAN TO PATIENT TO MANAGED HEALTH CARE RELATIONSHIP

Chairperson: Harold J. Bursztajn, M.D., *Department of Psychiatry, Harvard Medial School, 96 Larchwood Drive, Cambridge MA 02138-4639*
Participants: Alan A. Stone, M.D., Patricia Illingworth, J.D., Bryant Welch, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to use transdisciplinary tools to recreate autonomy and authenticity in today's cost-sensitive doctor-patient relationship; to specify value-sensitive concepts such as medical necessity in case-relevant terms so as to enable patients to avoid or respond effectively to MCO denial of benefits.

SUMMARY:

The workshop will present transdisciplinary perspectives on how the physician-patient relationship is being transformed by managed health care practices and how clinical values can be promoted today and tomorrow. Among the values highlighted by the workshop presenters are the enhancement of autonomy of clinical judgment and the preservation of authenticity of patient choice of care in cost-conscious public and for profit private health care systems.

An up-to-date set of clinical advocacy resources will be made available in the workshop. Underutilized but potentially effective tools to be highlighted include the principle that the denial of psychiatric benefits based on nonclinical determination of medical necessity constitutes an experimental and relatively involuntary medical procedure and business practice, and thus that such denials are a violation of both medical and business codes of ethics and related legal statutes. Participants will learn how to apply their own knowledge to influence changes in clinical practices, ethical codes, and the interpretation of legal statutes that support these fundamental values.

REFERENCES:

1. Bursztajn HJ, Brodsky A: A new resource for managing malpractice risks in managed care. Archives of Internal Medicine. 1996;156:2057–2063.
2. Stone A: Paradigms, pre-emptions, in stages: understanding the transformation of American psychiatry by managed care. International Journal of Law and Psychiatry. 1995;18(4):353–387.

Issue Workshop 10
THE PSYCHODYNAMIC FORMULATION: WHY BOTHER?

Co-Chairpersons: Carlos Blanco, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York NY 10032,* Donna T. Chen, M.D., *741 West End Avenue, New York NY 10025-6220*
Participants: Gita Vaid, M.D., Robert Michels, M.D., Paul H. Ornstein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to present the theoretical and practical bases of the dynamic formulation; to present how the psychodynamic formulation can be applied to nonanalytic treatments to increase understanding of the patient and therapeutic success.

SUMMARY:

There is a long tradition in psychoanalysis and psychodynamic psychotherapy of summarizing our knowledge of the patient in a relatively brief, condensed, focused form known as the psychodynamic formulation. Its purpose is to clarify concisely the central issues and conflicts of the patient in order to anticipate the transferences, countertransferences, and resistances that will occur in the treatment. There is a common misconception that a psychodynamic formulation is indicated only for those patients in long-term, insight-oriented psychotherapy. In fact, the psychodynamic formulation is useful in the understanding and treatment of all kinds of patients, independent of the therapy and setting selected.

The younger generations of clinicians are getting progressively less training in expressive therapy. This is accompanied by a decreased understanding of the dynamics of patients they may be treating with other modalities. There is a danger that the psychodynamic formulation may become a lost art.

This workshop will present the basic elements involved in a psychodynamic formulation and three examples of formulations in different settings: psychopharmacologic treatment, emergency room visit, and consult in the general hospital. Ample opportunity will be provided to discuss the why and how of the formulation in these and other patients.

REFERENCES:

1. Perry S, Cooper AM, Michels R: The psychodynamic formulation: its purpose, structure, and clinical application. Am J Psychiatry 1987;144:543–550.
2. MacKinnon RA, Yudofsky SC: DSM-III-R diagnosis and the psychodynamic case formulation, in The Principles of Psychiatric Evaluation, Philadelphia: Lippincott, 1991.

Issue Workshop 11
FAITH AND COPING IN PATIENTS AND PSYCHIATRISTS

Chairperson: Elizabeth S. Bowman, M.D., *Department of Psychiatry, Indiana University, 541 Clinical Drive, Room 291, Indianapolis IN 46202*
Participants: Francis G. Lu, M.D., Terry Bard, Ph.D., Roger C. Sider, M.D., Linda K. George, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize and sensitively assess patients' uses of faith to address life transitions/crises; and to identify three styles by which clinicians and patients utilize faith to cope with life or work.

SUMMARY:

Research shows that American patients are highly religious and frequently use faith to cope. However, psychiatrists' personal religious interests and considerable interest in nonreligious expressions of spirituality seldom enter scientific discussions. This workshop explores personal and clinical uses of faith in coping.

This workshop begins with a brief presentation of research on the frequency of religious/spiritual beliefs and practices among psychiatrists and patients, on Pargament's studies of religious coping styles, and on the ethics of addressing faith in treatment. Next, this material is explored via interactive discussion of two cases, one each about a patient and a psychiatrist utilizing faith adaptively to cope with life transitions or crises. Each case includes 15 minutes of case presentation and 15 minutes of panel-audience interaction. The panel includes psychiatrists and clergy (three with dual mental health and theological training) representing Buddhist, Jewish, and Christian viewpoints. Discussion will focus on respectfully identifying and incorporating adaptive spiritual coping in treatment and on psychiatrists utilizing faith in self-care.

REFERENCES:

1. Pargment KI: The Psychology of Religion and Coping. New York: Guilford Press; 1997.
2. Ellison CG, Taylor RJ: Turning to prayer: social and situational antecedents of religious coping among African Americans. Review of Religious Research 1996;38:111–131.
3. Koenig HG, Cohen JJ, Blazer DG, et al: Religious coping and cognitive symptoms of depression in elderly medical patients. Psychosomatics 1995;36:9–375.

Issue Workshop 12
GROUP TREATMENT FOR TRAUMATIZED DRUG-USING WOMEN

Chairperson: Paula G. Panzer, M.D., *Columbia University, 500 West End Avenue, GR-J, New York NY 10024*

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize the impact of traumatic experiences on addicts and the value of peer-facilitated groups in stabilizing clients in drug treatment settings. Participants will identify methods of integrating trauma treatment into their addiction programs, particularly group interventions.

SUMMARY:

Alcohol and substance abuse disrupt women's lives. Drug seeking and other addictive behaviors take priority over relationships, parenting, self-care, and economic planning. Also, exposure to violence increases. Women become victims, perpetrators, caretakers of victims, and mediators in disrupted families. There is evidence that violence across the lifespan is frequent for women addicts. Furthermore, PTSD, dissociative disorders, and other post-traumatic adaptations and maladaptations disrupt standard addiction treatment. Recognition of traumatic responses is necessary for recovery from addiction and trauma.

This workshop will present a model for early stabilization of traumatized addicts. The model involves two peer-counselor-facilitated short-term groups, *connecting* and *coping*. The first is an open-ended drop-in group with lessons focused on connecting and communicating in relationships. The second is a closed group that builds coping skills necessary for trauma and drug-use recovery. The group manuals have undergone a formative evaluation and informal feedback has been received from hundreds of facilitators in a variety of settings across the country. The manual will be described, including

methods of integrating the groups into drug treatment programs. A portion of an exercise will be conducted and a facilitated discussion will occur. Evaluation information will be shared.

REFERENCES:

1. Fullilove MT, Fullilove RE, Smith M, et al: Violence, trauma, and post-traumatic stress disorder among women drug-users. J of Traumatic Stress 1993;6(4):533–543.
2. Najavits LM, Weiss RD, Liese BS: Group cognitive-behavioral therapy for women with PTSD and substance use disorders. J of Substance Abuse Treatment 1996;13(1):13–22.

Issue Workshop 13
ENHANCING SUPERVISOR-RESIDENT RELATIONSHIPS TO FACILITATE LEARNING

Co-Chairpersons: Richard G. Tiberius, Ph.D., *Department of Psychiatry, University of Toronto, 399 Bathurst Street, Toronto, ONT M4X 1B3, Canada,* Janet M. deGroot, M.D., *Department of Psychiatry, Toronto Hospital-Western Div., 399 Bathurst Street, Toronto, ONT M5T 2S8, Canada*
Participants: Joanne Sinai, M.D., Peter Voore, M.D., Aileen S. Brunet, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop participants should be able to recognize six central processes of supervisor-resident relationships that are important to learning, to use effective strategies for engaging in two of these processes, and to appreciate the subtleties involved.

SUMMARY:

The importance of the social context of teaching and learning has become established both in contemporary educational theory and research on the teaching of psychotherapy. Using examples and handouts, participants will be introduced to six central processes of supervisor-resident relationships that are important to learning: negotiating the educational contract, dealing with personal traits and boundary issues, building trust through communication, resolving issues of power and competitiveness, developing supportiveness, and enhancing respect. Two of these will be the focus of the workshop. Participants will observe an enactment of a brief role-play by the presenters, demonstrating a common relationship problem. Participants will then be invited to comment on their perceptions of the scenario. The scenario will be reenacted using the "commenting alter ego" procedure: at intervals during their interaction the protagonists will pause while their "alter egos" (two other workshop presenters) "interpret" their actions to the participants. Their interpretations will be more candid and often less socially correct than the dialogue that the two protagonists allow themselves during their first enactment. After the second enactment participants will be invited to disclose their feelings, perceptions, and their plan of action. Various effective strategies will be discussed and then demonstrated.

REFERENCES:

1. Davis LL, Little MS, Thornton WL: The art and angst of the mentoring relationship. Academic Psychiatry 1997;21:61–71.
2. Shanfield SB, Matthews KL, Hetherly V: What do excellent psychotherapy supervisors do? American J Psychiatry 1993;150:1081–1084.

Issue Workshop 14
CHALLENGES TO CONFIDENTIALITY IN CHILD PSYCHIATRY

Co-Chairpersons: Daniel M.A. Freeman, M.D., *Department of Psychiatry, MCP-Hahnemann, c/o Ganime 335 Garrison Way, Conshohocken PA 19428,* Peter D. Ganime, M.D., *Department of Psychiatry, MCP-Hahnemann, c/o Ganime 335 Garrison Way, Conshohocken PA 19428*
Participants: Marshall D. Schechter, M.D., David M. Ellis, M.D., Leroy J. Byerly, M.D., Barbara B. Zulick, Esq.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should better appreciate that now is the time to be proactive on behalf of a child's right to privacy in mental health treatment.

SUMMARY:

This workshop aims to provoke discussion among participants about important issues involving confidentiality as they affect the daily practice of child psychiatry. Three teams of workshop leaders will present brief dialogues about areas of practice where confidentiality is of special importance. An attorney will offer a short comment and then attendees will be invited to join the discussion. Three areas will be addressed: (1) the child's perception of confidentiality in the patient-therapist relationship; (2) the demands of those outside of the therapeutic relationship (schools, the court, insurance reviewers, etc) and how they place confidentiality in jeopardy; and (3) the threat to privacy posed by conducting child custody evaluations.

Now is the time for mental health and legal professionals to act so that the right of the child to confidentiality in treatment will be upheld.

REFERENCES:

1. Quinn KM: Ethical dilemmas in forensic child and adolescent psychiatry. Child and Adolescent Psychiatric Clinics of North America; 1995;4:4.
2. Slovenko R: Confidentiality and testimonial privilege, in Principles and Practice of Forensic Psychiatry. Edited by Rosner R. New York: Chapman and Hall, 1994.

Issue Workshop 15
MODEL FOR MULTIPLE AFFILIATIONS FOR PSYCHIATRIC PRACTICE

Co-Chairpersons: Anil G. Godbole, M.D., *Dept. of Psychiatry, Ravens Wood Hospital, 4550 N. Winchester, Chicago IL 60640,* Anthony M. D'Agostino, M.D., *Department of Psychiatry, Alexian Bros. Medical Center, 800 Biesterfield Road, Elk Grove Village IL 60007*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate an understanding of various options for affiliations with hospitals, PHO's, integrated delivery systems, and managed care organizations; and to demonstrate knowledge of legal, economic, and clinical issues important in decisions about such affiliation and making them successful.

SUMMARY:

The rapid and fundamental change in the health delivery system, growth of managed care, public sector reforms, employer and consumer activism, and several other factors have forced psychiatrists to examine their practice modes, explore resources and available partnerships, and develop special skills and other survival methods. Similar predicaments are felt by other specialty medical practices and even by hospitals and larger health systems. Various models of alignments between practitioner, institutions, and managed care companies are underway. This workshop explores these alignments from a practitioner's point of view and describes a case study in which practicing psychiatrists, a large multiple hospital-based health care system, a large university academic department, a large multispecialty medical group, and a psychiatrist-owned managed care company come together to form a psychiatrist-driven behavioral health system with the goal of preserving the integrity of psychiatric practice and integrating it with general medical care. The focus will be on the process of development, leadership requirements, alternate choices, goals and vision, and implementation strategies to bring

about such collaborations from legal, fiscal, and clinical perspectives. Psychiatrists need to seize every opportunity for such affiliations.

REFERENCES:

1. Pomerantz JM, Liptzin B, Carter AH, Pearlman MS: The professional affiliation group: a new model for managed mental health care. Hospital Community Psychiatry 1994;45:308–310.
2. Lazarus A: Taking issue: payers, players, and providers: the new lexicon. Psychiatric Services 1995;46:977.

Issue Workshop 16
USING STANDARDIZED PATIENTS TO EVALUATE PSYCHIATRIC CLINICAL CLERKS

Chairperson: Debra L. Klamen, M.D., *Psychiatry, University of Illinois, 912 South Wood M/C 912, Chicago IL 60612-4303*
Participant: Kathleen R. Merikangas, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to develop and implement a standardized patient program for evaluating psychiatric clinical clerks; to understand the pros and cons of using such a system for end-of-clerkship evaluations.

SUMMARY:

Standardized patients have been used to evaluate medical students' competence in interview situations at many medical schools. For the year 1996–1997, the department of psychiatry at the University of Illinois at Chicago began to use standardized patients at the end of the third-year medical school psychiatry rotation. Students were asked to interview a standardized patient for 30 minutes, develop a differential diagnosis, and write a mental status examination on the patient. This sequence was repeated with two other standardized patients, with the final patient interview being written up entirely by the student that evening and turned in the next morning. A variety of indices were used to evaluate competency, including patient satisfaction questionnaires, question checklists, differential diagnoses, mental status exams, and the final write-up. This method has resulted in medical students being more active in seeking out opportunities to interview and write up cases while on the rotation, and has identified students with deficient interviewing skills. The audience will participate throughout the workshop by reviewing the videos of actual student-patient encounters, reviewing and commenting upon associated documents, and discussing the development and pros and cons of the use of this kind of system with the presenter.

REFERENCES:

1. Cohen DS, Colliver JA, Marchy MS, et al: Psychometric properties of a standardized-patient checklist and rating-scale form used to assess interpersonal and communication skills. Acad Med 1996;71:S87–S89.
2. Niehaus AH, DeRosa DA, Markwell SJ, Folse R: Is test security a concern when OSCE stations are repeated across clerkship rotations? Acad Med 1996;71:287–289.

Issue Workshop 17
HELLO DOLLY: PSYCHIATRY AND ASSISTED REPRODUCTION

Chairperson: Martha J. Kirkpatrick, M.D., *988 Bluegrass Lane, Los Angeles CA 90049-1433*
Participants: Jane L. Rosenthal, M.D., Miriam B. Rosenthal, M.D., Ian E. Alger, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the bioethical and psychosocial issues presented to individuals and society by assisted reproductive technologies; to learn to treat persons with infertility problems using alternative medications.

SUMMARY:

Psychiatrists have always been interested in reproduction and its relation to human behavior, sex, parenting, children, and psychosocial development. Technology has had a great impact on this field. Scientists now can intervene in many ways, but should they? The Group for the Advancement of Psychiatry's Social Issues Committee is studying this question. This workshop will address the psychiatric, social, and bioethical aspects including postmenopausal childbearing, cloning of human embryos, use of alternatives to medications, and drugs to treat depression and anxiety in patients undergoing infertility treatments, children born of these technologies, as well as a neglected group, namely, third party individuals involved.

The workshop will be conducted via use of case presentations (including videos) with active encouragement of audience participation and discussion. This workshop will also demonstrate the need for psychiatrists' participation in this area of medicine.

REFERENCES:

1. Robertson JA: Children of Choice: Freedom and the New Reproductive Technologies. Princeton University Press. Princeton: New Jersey, 1991.
2. Rosenthal MB: Psychological aspects of infertility and the assisted reproductive technologies, in: Bailliere's Clinical Psychiatry. Edited by Weller M, Van Kammen DP. 1996;2:751–767.

Issue Workshop 18
NEW ROLES FOR PSYCHIATRISTS RESOLVING COMMUNITY CONFLICTS

Chairperson: Stuart W. Twemlow, M.D., *5040 SW 28th Street, Topeka KS 66614-2302*
Participant: Frank C. Sacco, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participants should be able to recognize and intervene in community situations where coercive power dynamics exist, particularly in city government, labor disputes between municipalities, and the school system.

SUMMARY:

In our framework, the psychiatrist shifts from an individual clinical role to a role in assisting communities to function in a more healthy fashion. Particularly, we explore a dialectical theory of community interaction in which a change in power dynamics affects the way a variety of community agencies interact. We present three successful projects using this dialectical victim and victimizer theory: (1) a city in a third-world country with a very high homicide rate where we created a low-cost, multisystem intervention using volunteers that successfully addressed the specific needs articulated by the community; (2) a four-year dramatically successful intervention in a Midwestern elementary school producing a peaceful and creative school learning environment; (3) an intervention in a labor-management dispute in which a coercive power dynamic existed between the chief of the department and his immediate supervisees.

REFERENCES:

1. Twemlow SW, Sacco FC: Peacekeeping and peacemaking: the conceptual foundations of a plan to reduce violence and improve the quality of life in a midsized community in Jamaica. Psychiatry 1996;59:156–174.

2. Twemlow SW, Sacco FC, Williams P: A clinical and interactionist perspective on the bully-victim-bystander relationship. Bulletin of the Menninger Clinic 1996;60:296–313.

Issue Workshop 19
PSYCHIATRISTS' CHILDREN SPEAK ABOUT UNIQUE ISSUES

Co-Chairpersons: Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville, 323 Chestnut Street, Louisville KY 40202,* Michelle Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 East Med Ctr Dr/ Box 0704, Ann Arbor MI 48109-0704*
Participants: Daniel P. Dickstein, M.D., Alissa Riba, Michael F. Myers, M.D., Briana Myers, Donna M. Norris, M.D., Marlaina Norris, Kailie R. Shaw, M.D., Daniel Shaw, Carolyn B. Robinowitz, M.D., David Robinowitz, Chris Stewart, Donna E. Stewart, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand and recognize unique experiences, assets, and liabilities of children born to and/or raised by psychiatrists.

SUMMARY:

This workshop will consist of three-minute presentations by a panel of the children of nine well-known psychiatrists. Each psychiatrist will have one minute to comment. The audience will then be offered sufficient time to comment and ask questions of the children and psychiatrist-parents.

REFERENCES:

1. Chessick RD: Intensive psychotherapy for the psychiatrist's family, Am J Psychotherapy, 1977;31:516–24.
2. Maeder T: Children of Psychiatrists and Other Psychotherapists, New York: Harper and Row, 1989.

Issue Workshop 20
CULTURALLY RELEVANT SERVICES FOR AFRICAN AMERICANS

Chairperson: Reta D. Floyd, M.D., *Medical Association, Barbour and Floyd, 2610 Industrial Way #A, Lynwood CA 90262*
Participants: Michelle O. Clark, M.D., Jack M. Barbour, M.D., Linda L. Connery, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate an understanding of cultural relevance in service delivery; to develop culturally relevant interventions that are based on cultural values; and to develop strategies for implementing culturally relevant interventions.

SUMMARY:

In this workshop the presenters will discuss the importance of culturally relevant services for African Americans. They will describe two programs in different geographic areas serving African Americans in culturally consistent and relevant ways. The historical creation of the interventions used by each program to ensure congruence between the culture, norms, and behaviors of the target population will be discussed. This will include the use of the community and the natural supports available to patients and their families. Following the presentation, the audience participants will be involved in focus groups, as will the other group members. Each focus group will choose a cultural norm of a racial or ethnic minority and develop an intervention that supports this cultural norm. The full workshop will reconvene, and the focus groups will present their intervention. A question-and-answer session will promote an interactive environment between presenters and participants.

REFERENCES:

1. Flaskerud JH: The effects of culture-compatible interventions on the utilization of mental health services by minority clients. Community Mental Health Journal, 1986;22:127–141.
2. Gary LE: Attitudes of black adults toward community mental health centers. Hospital and Community Psychiatry, 1987;38:1100–1105.

Issue Workshop 21
NMS: DIAGNOSIS, TREATMENT AND AFTERCARE

Chairperson: Gerard C. Addonizio, M.D., *Department of Psychiatry, NY Hosp.-CUMC-WD, 21 Bloomingdale Road, White Plains NY 10605*
Participants: Virgina L. Susman, M.D., Stanley N. Caroff, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to have an organized framework for the diagnosis, treatment, and aftercare of patients with neuroleptic malignant syndrome.

SUMMARY:

Neuroleptic malignant syndrome (NMS) is a potentially fatal disorder caused by neuroleptic medication. As NMS has been increasingly recognized in clinical practice, there is an even greater need for adequate diagnostic criteria and guidelines for treatment and aftercare. While there has been an expanding literature on NMS, there remains a great deal of controversy and debate about how to diagnose, treat, and manage a patient after NMS has resolved. The panel discussants will give very brief presentations regarding current knowledge of NMS including differential diagnosis, risk factors for NMS, use of laboratory data to diagnose and track the course of NMS, and various treatments such as bromocriptine, dantrolene, benzodiazepines, and ECT. Panelists will promote discussion with audience participants. Attendees may provide vignettes from their own practice to be discussed by panel members. Also, audience members will be encouraged to offer their experience in the management of the patient with NMS and offer comments on the adequacy of diagnostic criteria in DSM-IV.

REFERENCES:

1. Addonizio G, Susman VL: Neuroleptic Malignant Syndrome—A Clinical Approach. St. Louis, Mosby-Year Book, 1991.
2. Caroff SN, Mann SC: Neuroleptic malignant syndrome. Medical Clinics of North America 1993;77:185–202.

Issue Workshop 22
FORENSIC RISKS IN THE NEW AGE OF PSYCHOPHARMACOLOGY

Chairperson: David W. Preven, M.D., *110 Riverside Drive, New York NY 10024*
Participants: Donald F. Klein, M.D., Michael M. Welner, M.D., Amy B. Rowan, M.D., Martin G. Tracy, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to appreciate the increased forensic risks in clinical psychiatry with the advent of sophisticated psychopharmacology with high doses, augmentation, drug interaction, use of non-FDA approved drugs, and consequences of non-drug treatments.

SUMMARY:

As the psychopharmacological formulary expands, the expectation for successful treatment grows among doctors and patients, even among those with refractory illness. The use of non-FDA or of higher-than-FDA-approved doses, unusual drug augmentation, and clinical approaches that ignore conventional drug interaction warnings all raise the specter of liability for the psychiatrist.

If the psychiatrist is challenged by the patient's lawyer because of a negative outcome, can the standard of care in the innovative use of drugs be supported by letters to the editor, Internet comments, or "personal communication"? In addition to "acts of commission," what are the risks of "acts of omission" when the psychiatrist uses too low a dose or no medication for a patient who most psychiatrists would treat pharmacologically. What strategies can the psychiatrist use to decrease exposure to litigation? Which of the several "treatment guidelines" now available offer the best protection? Will liability insurance protect psychiatrists who practice "cutting edge" psychopharmacology? The workshop will attempt to answer these questions.

REFERENCES:

1. Zarin DA, Pincus HA, West JC, McIntyre JS: Practice-based research in psychiatry. Am J Psychiatry 1997;154:1199–1208.
2. APA Council on Psychiatry and Law: American Psychiatric Association Resource Document on Principles of Informed Consent in Psychiatry. J American Academy of Psychiatry and the Law 1997;25,1:121–125.

Issue Workshop 23
ISSUES IN NEGOTIATING A MANAGED CARE CONTRACT

Chairperson: Nancy H. Halleck, J.D., *Counsel, SNMG/ EDISON, 431 New Karner Road, Albany NY 12205*
Participants: C. Deborah Cross, M.D., Andrea Lefton, M.D., Jay L. Zucker, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize major legal and ethical issues in negotiating a contract with a managed care company. The participants will also be better informed as to what one's rights are going into the negotiating process, as well as once the contract is in place.

SUMMARY:

Most psychiatrists now have some type of affiliation with a managed care organization. If not, he or she will probably have to deal with one at some point in his/her professional lifetime. This agreement is usually written in the form of a contract. This workshop will explore what the clinician needs to know before, during, and after the contracting process with a managed care entity; that is, what provisions of a contract are unacceptable, what are one's rights under the contract, what are one's ethical obligations vis-a-vis the contract, and what legal rights are available if the contract is terminated? An update on legislative action in this area will also be presented.

The presenters will include an attorney for a behavioral managed care company, a psychiatrist from an academic/community hospital in charge of managed care for her department, a psychiatrist in private practice, and an attorney in the public sector specializing in mental health managed care. Each participant will describe issues he or she looks at in negotiating a managed care contract. By bringing together presenters from both sides of the negotiating process, we expect to have a thorough and informed discussion of the issues.

We would like to elicit from those in the audience their experiences in (or questions about) managed care contracting, which should make for a lively exchange. At the conclusion of this workshop participants will have a clearer understanding of the issues, a better grasp of each side's legal rights and responsibilities, and be able to negotiate a better managed care contract.

REFERENCES:

1. Davis GS: Managed care contracting: advising the provider, BNA, Health Law & Business Series 1800, 1996.
2. Rosenbaum S, et al: Principal Findings From an Analysis of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Centers, Final Report to the Office of Managed Care, SAMHSA, Rockville, MD. 1996.

Issue Workshop 24
PROTEASE INHIBITORS IN THE MENTALLY ILL WITH HIV

Chairperson: Dan H. Karasic, M.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7E, San Francisco CA 94110*
Participants: George H. Harrison, M.D., Charles T. Robinson III, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize and address issues affecting adherence to protease inhibitor regimens in HIV-positive mentally ill patients and substance abusers.

SUMMARY:

Triple antiviral therapy is proving to be an effective intervention in preventing the advancement of HIV infection. The effectiveness of these agents is dependent upon careful attention to excellent adherence to treatment. Adherence to a complex, protracted, often unpleasant medication regimen such as three-drug therapy for HIV requires a persistent effort on the part of the individual to remain engaged with treatment providers and to maintain a consistent regimen in his/her home environment. This adherence is compromised when HIV disease is complicated by mental illness and substance abuse. A challenge for psychiatrists is to find ways to help stabilize patients so that they are able to adhere to antiretroviral regimens. This workshop will discuss clinical issues facing the psychiatrist treating the mentally ill and substance abusing patient infected with HIV. Drug interactions of the protease inhibitors with psychiatric drugs and drugs of abuse will be discussed. Psychological and social factors contributing to nonadherence will be presented. Strategies of crisis intervention with the goal of maintaining adherence to antiretroviral therapy will be presented. Audience discussion will allow sharing of philosophies and strategies from varying treatment settings.

REFERENCES:

1. Karasic DH, Dilley JW: HIV-associated psychiatric disorders: treatment issues, in The AIDS Knowledge Base. Edited by Cohen P, Sande MA, Volberding P, Waltham MA: The Medical Publishing Group/Massachusetts Medical Society. 1994, pp. 5.31-1-5.
2. Bangsberg D, Tulsky JP, et al: Protease inhibitors in the homeless. JAMA. 1997;278:63–65.

Issue Workshop 25
SHORT-TERM INTEGRATIVE THERAPY FOR PERSONALITY DISORDERS

Chairperson: Miguel A. Leibovich, M.D., *83 Cambridge Park Way, #609W, Cambridge MA 02142*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to learn specific techniques of short-term therapy effective in the

treatment of patients exhibiting personality disorders and be able to distinguish the type of patients unsuitable for this kind of treatment and to offer alternative therapies.

SUMMARY:

Patients exhibiting personality disorders such as borderline, narcissistic, dependent, histrionic, etc. are amenable to short-term integrative therapeutic interventions. The expectations of both patient and therapist have to be clearly understood and explained in a realistic manner from the start of the therapeutic encounter. The focus of the therapy, one of the basic technical aspects of the short-term therapies, has to be delineated firmly and adhered to during the course of treatment.

During the workshop a description of various personality disorders amenable to short-term therapy will be delineated, and guidelines about the technical aspects of this approach as well as guidelines for the necessary and appropriate therapist's stance will be discussed. In this era of managed care, the short-term techniques are more than ever of crucial importance for the psychiatrist. The workshop will be interactive, and there will be ample time for discussion with the audience and for the presentation of clinical vignettes.

REFERENCES:

1. Leibovich MA: Why short-term psychotherapy for borderlines?, Psychotherapy and Psychosomatics, 1983;39:1–9.
2. Groves JE., ed. Introduction, Essential Papers on Short-term Dynamic Therapy, New York University Press, 1996; pp. 1–25.

Issue Workshop 26
CONSULTATION-LIAISON PSYCHIATRY: PROBLEM SOLVING AND LIFELONG LEARNING

Chairperson: Barbara A. Schindler, M.D., *Department of Psychiatry, AUHS-Hahnemann, Broad & Vine Streets, Philadelphia PA 19102*
Participants: Marian A. Ormont, M.D., Donald J. Kushon, Jr., M.D., Randy A. Inkles, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be more familiar with the complex challenges encountered by consulting psychiatrists, be able to better problem solve in the unpredictable C-L setting, and be familiar with strategies to enhance independent physician learning.

SUMMARY:

Consultation-liaison (C-L) psychiatry has been described as complex and unpredictable, necessitating quick problem solving and action on the part of the consultant. As medical technology changes and lifestyles become less traditional, C-L psychiatrists are faced with increasingly complicated cases and must remain cognizant of advances in other medical specialties.

This workshop will focus on three C-L cases in which medical advances, psychodynamics, and liaison issues combine in particularly complex ways. The cases describe: a 41-year-old male physician with retinitis pigmentosa, a history of controlled substance addiction, and a history of treatment for bipolar disorder admitted to the hospital with syncope; a 39-year-old female with a 28-year history of hair-pulling and childhood sexual abuse admitted to the hospital with staphylococcus aureus septicemia, septic arthritis, and abscesses; and a 24-year-old male seven months status post cardiac transplantation, admitted to the hospital with a third episode of rejection due to medication noncompliance and a positive urine toxicology. Using a modified problem-based learning approach, these cases will be presented and discussed; participants will work with presenters to arrive at differential diagnoses and to formulate management strategies. Problem-solving techniques will be emphasized and strategies for independent physician education will be addressed.

REFERENCES:

1. Okasha A: The future of medical education and teaching: a psychiatric perspective. Am J Psychiatry 1997;154:77–85.
2. Foldevi M, Sommansson G, Trell E: Problem-based medical education in general practice: experience from Linkoping, Sweden. Br J Gen Practice 1994;44:473–6.

Issue Workshop 27
HUMAN RIGHTS AND MENTAL HEALTH SYSTEM REFORM

Chairperson: Eric Rosenthal, J.D., *Mental Disability Rights Intl., 1101 15th St. N.W. Ste 1212, Washington DC 20005*
Participants: Humberto L. Martinez, M.D., Robert L. Okin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, participants should be able to recognize and understand the implications of international human rights law to mental health practice. Participants will also learn the requirements of the United Nations "Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care."

SUMMARY:

This workshop will examine evolving international human rights standards relating to people with mental disabilities. In December 1991, the United Nations adopted the "Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care" (the "MI Principles"). The MI Principles are the most detailed, internationally recognized human rights standards to date on the rights of people with mental disabilities. The workshop will provide a background on the requirements of the MI Principles and their use as a guide to the requirements of international human rights treaties.

Presenters will describe the findings of Mental Disability Rights International (MDRI) in South America and Eastern Europe, as represented in two recent reports, Human Rights and Mental Health: Uruguay (1995) and Human Rights and Mental Health: Hungary (1997). Presenters, who participated in fact-finding missions in these countries, will describe findings in these countries and reforms needed to bring conditions in mental health systems into conformity with the MI Principles and international human rights law. The workshop will provide an opportunity to evaluate the impact of international human rights reporting. Presenters will also describe other opportunities for international collaboration on disability rights and the promotion of mental health system reform.

REFERENCES:

1. MDRI: Human Rights and Mental Health: Uruguay, 1995.
2. MDRI: Human Rights and Mental Health: Hungary, 1997.

Issue Workshop 28
MENTAL HEALTH OF ELDERLY ASIAN INDIANS: ISSUES AND SOLUTIONS
Joint Session with the Indo-American Psychiatric Association

Chairperson: Jagannathan Srinivasaraghavan, M.D., *Department of Psychiatry, VA Medical Center, 400 Fort Hill Avenue, Canandaigua NY 14424*
Participants: Seetharaman Vivek, M.D., Ganesan Gopalakrishnan, M.D., Ajaya K. Upadhyaya, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant should be able to identify major issues confronting elderly Asian Indians, both at home and abroad, and possible solutions to reduce morbidity.

SUMMARY:

Relaxation of immigration laws resulted in a large influx of immigrants from Asia beginning in the 1960's. There are over a million Asian Indians in North America. Most of this population arrived within the last 25 years. There are two groups of elderly Asian Indians. The first group is the immigrants who are getting older, and the second group is the parents of immigrants who moved permanently to live with their children. The group of elderly who have grown old in America have developed reasonable strategies to reduce stress and function independently. The latter group of elderly are vulnerable to several stressors including value conflicts, lack of appropriate support systems, dependence, and ambiguity of roles and identity. There are changes occurring in India that have a major impact on the elderly; these include increased longevity, breakdown of joint family system, migration from rural areas to cities, and industrialization. With the decline of stigma and more education available through the media, the mental health of the elderly in India is just emerging as a problem to be tackled. Due to historic connections the United Kingdom has a much larger Asian Indian population settled over many decades and thus has faced several issues relating to elderly. The panelists have expertise and experience functioning as psychiatrists in India, the United States, and the United Kingdom. Similarities and differences in issues faced by elderly Asian Indians will be addressed and workable solutions will be explored. Audience participation will be encouraged.

REFERENCES:

1. Ananth J, Ananth K: Growing old in America, in, East Indian Immigrants to the United States: Life Cycle Issues and Adjustment. Indo-American Psychiatric Association, 1995.

Issue Workshop 29
ADOLESCENTS AND POPULAR CULTURE

Co-Chairpersons: Debra S. Rosenblum, M.D., *55 Sacramento St Apt 3, Cambridge MA 02138-1933,*
Lawrence Hartmann, M.D., *Harvard University, 147 Brattle Street, Cambridge MA 02139*
Participants: Neal S. Kass, M.D., Peter T. Daniolos, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize that certain aspects of popular culture, specifically music and fashion, influence and reflect the developmental tasks and defensive structures of adolescents; to appreciate that the therapist's awareness of these issues aids in clinical work with teenagers.

SUMMARY:

The aim of this workshop is to explore the relationship between adolescents and popular culture within a psychodynamic and developmental framework. Presenters will synthesize theory, case presentations, and audio and visual material to highlight the role of music and style in the lives of contemporary adolescents. Specific examples from rock songs and music theory illustrate how music addresses inner concerns and identity formation in teenagers. This discussion also will focus on adolescent self-expression and understanding through fashion, including tattoos and body piercing. As adolescents often are difficult to engage in therapy, the practitioner's appreciation of music and style can enhance alliance formation and provide a vehicle for working through issues and anxieties in displacement. Members of the audience will be encouraged not only to introduce clinical material from their own work, but also will be called upon to discuss their personal experiences with and reactions to certain characteristics of music and style.

REFERENCES:

1. Bettelheim B: The Uses of Enchantment. New York: Vintage Books, 1989.
2. Winnicott DW: Through Paediatrics to Psycho-Analysis: Collected Papers. New York: Basic Books, 1958.

Issue Workshop 30
HOMEOPATHIC MEDICINE AND PSYCHIATRY

Chairperson: Edward B. Gogek, M.D., *3116 East Shea Blvd, #115, Phoenix AZ 85028*
Participant: Todd A. Rowe, M.D., Sandra N. Kamiak, M.D., Arlin E. Brown, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will understand the principles of homeopathy, the basic science explaining its mechanism of action, and clinical research validating its efficacy. They should know how homeopathy differs from other forms of alternative medicine and understand the psychiatric conditions for which it is useful.

SUMMARY:

As homeopathic treatment becomes more widespread and more mainstream, even clinicians with no interest in alternative medicine will have to talk to their patients about homeopathy and sometimes communicate with alternative practitioners. Psychiatrists who are open to alternatives often find homeopathy fits in very well with psychiatric practice. This workshop will present an overview of classical homeopathy. The first half of the workshop will cover homeopathic basic science, the scientific research explaining and validating homeopathy and the homeopathic treatment of psychiatric disorders. We will also explain how classical homeopathy differs from other forms of alternative medicine. The second half will be question and answer/discussion. Homeopathy is a controversial topic, and open dialogue is the best way to approach many of the issues important to physicians. The presenters are psychiatrists who use homeopathy in their practices. Besides their traditional medical and psychiatric training, all studied at the Hahnemann College of Homeopathy. Dr. Rowe has a full-time private homeopathic practice, Drs. Brown and Kamiak use homeopathy in private psychiatric practice, and Dr. Gogek integrates homeopathy into a community mental health center practice with both children and adults.

REFERENCES:

1. Bellavite P, Signorini A: Homeopathy: A Frontier in Medical Science. Berkeley, CA: North Atlantic Books, 1995.
2. Kleijnen J, Knipschild P, ter Riet G: Clinical trials of homeopathy. British Medical Journal 1991;302:316–323.
3. Reilly D, Taylor MA, Beattie N, et al: Is evidence for homeopathy reproducible? The Lancet 1994;344:1601–6.

Issue Workshop 31
DYNAMIC THERAPY WITH SELF-DESTRUCTIVE BORDERLINE PATIENTS

Chairperson: Eric M. Plakun, M.D., *Admissions, The Austen Riggs Center, P.O. Box 962, 25 Main St., Stockbridge MA 01262*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to enumerate principles in the dynamic psychotherapy of self-destructive borderline patients, recognize the importance of the establishment and maintenance of a therapeutic alliance with such patients, and be familiar with the countertransference problems inherent in work with these patients.

SUMMARY:

Psychotherapy with self-destructive borderline patients is recognized as a formidable psychotherapeutic challenge. Although much has been written about metapsychological and dynamic issues with these patients, little has been written that helps clinicians focus on technique. This workshop begins with a 25-minute presentation of seven principles crucial to the establishment and maintenance of the therapeutic alliance in the psychodynamic psychotherapy of self-destructive borderline patients. The principles are: (1) inclusion of the self-destructive behavior in the initial therapeutic contract, (2) metabolism of the countertransference, (3) engagement of affect, (4) nonpunitive interpretation of the patient's aggression, (5) assignment of responsibility for the preservation of the treatment to the patient, (6) a search for the perceived injury from the therapist that may have precipitated the self-destructive behavior, and (7) provision of an opportunity for reparation. After the presentation, the remaining hour will be used for an interactive discussion of case material. Although the workshop organizer will offer cases to initiate discussion, workshop participants will be encouraged to offer case examples from their own practices. The result should be a highly interactive opportunity to discuss this challenging treatment problem.

REFERENCES:

1. Plakun EM: Prediction of outcome in borderline personality disorder. Journal of Personality Disorders. 1991;5:93–101.
2. Plakun EM: Principles in the psychotherapy of self-destructive borderline patients, Journal of Psychotherapy Practice and Research 1994;3:138–148.

Issue Workshop 32
VIDEO CASE STUDIES OF COUPLES IN TREATMENT

Chairperson: Ian E. Alger, M.D., *AM AC Psychanalysis, 19 East 19th Street, 6th Floor, New York NY 10003*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify critical stages of couples therapy and have an increased awareness and understanding of his/her style as a couples therapist.

SUMMARY:

Video segments of several actual clinical situations from the practice of the workshop leader will be used to focus on issues of impasse and stress during different stages of couples treatment, including issues of engagement, problem identification, change facilitation, and termination.

Workshop participants will join in discussion and comparison of their own clinical experiences around problems related to dual careers; struggles during separation and divorce, second marriages, sexuality and intimacy; and issues involving children as well as extended family members and peer and friendship networks.

REFERENCES:

1. Alger I: Marital therapy with dual-career couples. Psychiatric Annals. 1991; Vol. 21, No. 8.
2. Alger I: Marital crises, Psychiatric Therapies, 20th Edition, Grune & Stratton, 1981.

Issue Workshop 33 Cancelled

Issue Workshop 34
CREATING AND USING ADDICTION TREATMENT GUIDELINES, CONTINUED

Chairperson: Richard J. Frances, M.D., *Silver Hill Foundation, 208 Valley Road, New Canaan CT 06840*
Participants: Sheldon I. Miller, M.D., Steven M. Mirin, M.D., Robert B. Millman, M.D., Sheila B. Blume, M.D., Lionel P. Solursh, M.D., John S. Tamerin, M.D., Allen J. Frances, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be familiar with the need for treatment guidelines, how they are developed, and how they are being applied.

SUMMARY:

Last year's workshop on Creating and Using Addiction Treatment Guidelines led to such lively discussion that it was a decision of the group to continue with discussion for the 1998 APA annual meeting. Treatment guidelines for substance abuse had been developed by the American Psychiatric Association and will soon need to be upgraded. Placement criteria have been developed by ASAM, and a number of other groups are also working on reviewing and refining guidelines. This will be the 31st year of a meeting of senior clinicians, which was originally founded by John Ewing. The workshop consists of three, five-minute presentations by an expert panel, followed by a wide-ranging discussion and extensive audience participation. Last year Allen Frances was brought in to a lively guideline discussion with Dr. Steven Mirin and Dr. Sheldon Miller, all of whom have been active in the formation of treatment guidelines. Audience participation included discussion by Dr. David Mee-Lee who had led the development of the ASAM placement criteria.

REFERENCES:

1. Frances RJ, Miller SI, (eds): Clinical Textbook of Addictive Disorders. New York, Guilford Press, 1991
2. American Psychiatric Association: Work Group on Substance Use Disorders: Practice guidelines for the treatment of patients with substance use disorders: alcohol, cocaine, opioids. Am J Psychiatry Nov 1995;152(suppl):11

Issue Workshop 35
UPDATE ON MENTAL HEALTH IN THE OREGON HEALTH PLAN

Chairperson: David A. Pollack, M.D., *Mental Health Services, West Inc., 710 SW 2nd Street, Portland OR 97204-3112*
Participants: Bentson H. McFarland, M.D., Robert A. George, M.D., Richard H. Angell, M.D., Magnus Lakovics, M.D.

EDUCATIONAL OBJECTIVES:

Participants will become familiar with issues pertaining to the integration of mental health services into an overall health care reform plan. Persons who participate in this workshop will have a foretaste of political and economic questions to be addressed in their own states as health reform proceeds.

SUMMARY:

In its four years of operation, the Oregon Health Plan has increased access to health care by providing services according to a prioritized list of conditions and their treatments. Chemical dependency services are now integrated and mental health services are still being phased into this innovative system. The integration of mental health and chemical dependency services mandated by the Oregon Health Plan has led to a dramatic restructuring of public and private behavioral

health programs in Oregon. This workshop will briefly review the development of an integrated statewide program that addresses mental illness and chemical dependency on a basis of parity with physical conditions. Discussion will then address the political, organizational, and financial aspects of the movement away from fragmented, fee-for-service systems and toward carved out and integrated, prepaid programs. The workshop will also consider other aspects of the Oregon Health Plan including mental health and chemical dependency preventive services, the interface with primary care providers, practice guidelines, and the development of managed care systems designed to deliver integrated services. Participants in the workshop will be able to utilize this information as their own states and the nation struggle with health care reform.

REFERENCES:

1. Pollack DA, McFarland BH, George R, Angell R: Prioritization of mental health services in Oregon. Milbank Quarterly 1994;72(3).
2. Minkoff K, Pollack D (eds): Managed Mental Health Care in the Public Sector: A Survival Manual. Amsterdam, Harwood Academic, 1997.

Issue Workshop 36
FACING TELEVISION VIOLENCE IN CLINICAL PRACTICE

Chairperson: Paul A. Kettl, M.D., *Dept of Psychiatry, Penn State University, P.O. Box 850, Hershey PA 17033-0850*
Participant: Robert T.M. Phillips, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the effect of TV violence on their child and adolescent patients. Participants will be able to take a TV history and counsel patients and their families about TV violence.

SUMMARY:

Our child and adolescent patients are flooded each day by images of violence on television. The average child spends three to four hours per day viewing television—more time than any other waking activity. Television teaches children about violence, and is one cause of violent behavior. In addition, the large volume of TV viewing removes a child from socialization with peers, social learning from adults, physical play, or exploring their world.

In our workshop, we will explore how this vast exposure to television violence affects our child and adolescent patients. Workshop participants will discuss specific cases and discuss how specific examples of TV entertainment could affect their patients. We will review how to take a television history in a child and the importance of evaluating television use in a violent or impulsive child. Initiatives from the federal government and the television industry to address the problem of TV violence including the V chip and television rating systems will be discussed with workshop participants.

REFERENCES:

1. Kettl PA: The power of "Power Rangers." Pediatric Health Care 1995;9:101–102.
2. Venbrux N, Kettl P, Bixler EO: The effect of television violence on children. Abstract. Program and Abstracts on New Research, 146th Annual Meeting of the American Psychiatric Association, APPI Press, Washington, D.C., 1993.

Issue Workshop 37
SWIMMING WITH THE SHARKS

Chairperson: Michelle Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 East Med Ctr Dr/Box 0704, Ann Arbor MI 48109-0704*
Participants: John S. McIntyre, M.D., Elissa P. Benedek, M.D., Marcia Slomowitz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize systematic issues within organizations that promote or hinder advancement, (2) begin to understand personal goals versus organizational goals and how they may intersect or be at odds with one another, (3) listen to examples from workshop participants about experiences within organizations and how to learn from the mistakes or successes.

SUMMARY:

The ability of a psychiatrist to succeed within an organization depends on many factors—personal as well as institutional. There are multiple types of organizations in which we may want to participate and move ahead but because of personnel or structural reasons, it may be difficult to do so. This workshop will offer participants an opportunity to hear various experiences that the panel has to offer with ample time to hear from the audience what pitfalls, problems, or successes they have encountered. The panelists will help lead the audience in a discussion of the various issues that make succeeding and living in an organization so complex. (Note: This workshop was given last year and participants strongly recommended that it be repeated.)

REFERENCES:

1. Barton WE, Barton GM: Mental Health Administration. Human Sciences Press, New York, 1983.
2. Talbott JA, Kaplan SR: Psychiatric Administration. Grune and Stratton, New York, 1983.

Issue Workshop 38
ABPN EXAMINATIONS AND CANADIANS
Joint Session with the American Board of Psychiatry and Neurology, Inc., and the APA Board of Trustees

Chairperson: Michael F. Myers, M.D., *Department of Psychiatry, St. Paul's Hospital, 1081 Burrard Street, Vancouver, BC V6Z 1Y6, Canada*
Participants: Stephen C. Scheiber, M.D., William Bebchuk, M.D., Stella L. Blackshaw, M.D., Peter E. Tanguay, M.D., Emmanuel Persad, M.B., Carol A. Bernstein, M.D., J.P. Des Groseilliers, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand more clearly the current position of the ABPN toward eligibility of Canadian applicants for its examinations.

SUMMARY:

In 1995, the American Board of Psychiatry and Neurology decided to no longer accept Canadian medical licenses as a prerequisite to sit their examinations in the year 2007. This has resulted in much consternation by individuals and associations and many meetings in both countries. This workshop will explain the history of and reasons for this decision, the facts, the misunderstandings and myths, and

current efforts underway toward a resolution. The presenters are from Canada and the United States and represent the ABPN, the Royal College of Physicians and Surgeons of Canada, the American Psychiatric Association, the Canadian Psychiatric Association, the Association of Directors of Postgraduate Education in Psychiatry, and elected residents in Canada. One third of the workshop time will be dedicated to interaction with the audience.

REFERENCES:

1. Janda P: Board revises licensure policy. ABPN Newsletter 1995;1:2.

Issue Workshop 39
COGNITIVE THERAPY FOR PERSONALITY DISORDERS

Chairperson: Judith S. Beck, Ph.D., *Cognitive Therapy & Research, The Beck Institute, 1 Belmont Avenue, Suite 700, Bala Cynwyd PA 19004*
Participants: Jesse H. Wright, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) conceptualize personality disorder patients according to the cognitive model, (2) recognize therapeutic alliance issues in the treatment of personality disorders, (3) set goals and plan treatment for patients with characterological disturbance, (4) combine pharmacotherapy and cognitive therapy for personality disorder patients, (5) describe and implement cognitive techniques.

SUMMARY:

Cognitive therapy, a short-term, structured, problem-solving-oriented psychotherapy, has been shown in over 120 trials to be effective in treating Axis I disorders. In the past 10 years cognitive therapy methods have been developed for Axis II disorders and outcome research has verified the utility of this treatment approach. Cognitive therapy for personality disorders requires substantial variation from Axis I treatment. A far greater emphasis is placed on developing and maintaining a therapeutic alliance, modifying dysfunctional beliefs and behavioral strategies, and restructuring the meaning of development events.

In this workshop, a variety of case examples of patients with personality disorders will illustrate the principles of cognitive therapy, conceptualization of individual patients, developing the therapeutic relationship, planning treatment, and the adjunctive use of medication. Role plays will provide clinicians with demonstrations of how cognitive and behavioral techniques are employed. Questions and clinical material from participants will be encouraged throughout and a final segment will instruct interested participants in the steps they can take to learn about this empirically validated approach for a difficult patient population.

REFERENCES:

1. Beck AT, Freeman A, et al: Cognitive Therapy of Personality Disorders. New York: Guilford, 1990.
2. Beck JS: Cognitive approaches to personality disorders. In American Psychiatric Press Review of Psychiatry, Vol. 16. Edited by Dickstein, LJ, Riba MB, Oldham JM. Washington, DC: American Psychiatric Press, 1997.

Issue Workshop 40
THE STANDARDIZED PATIENT IN PSYCHIATRIC EDUCATION

Chairperson: Susan E. Abbey, M.D., *Department of Psychiatry, Toronto Hospital, 200 Elizabeth Street, 8EN-212, Toronto, Ontario M5G 2C4, Canada*
Participants: Brian D. Hodges, M.D., Jodi S. Lofchy, M.D., Nancy McNaughton, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize educational activities that could be potentially enhanced by the use of standardized patients, and (2) understand the logistics of using standardized patients in educational programs.

SUMMARY:

Standardized patients (SPs) offer important learning opportunities. The use of SPs in the three phases of psychiatric education—undergraduate, postgraduate, continuing medical education (CME)—will be described. SPs are used in evaluating third-year clinical clerks during the 5th week of their six-week psychiatry rotation via clinical vignettes assessing the student's ability to manage psychiatric emergencies and handle common psychiatric problems in primary care. In residency training, SPs are primarily used in teaching emergency psychiatry where they allow the replication of emotionally charged or dangerous situations and the teacher or student can stop the role play at any point to discuss areas of concern. CME is beginning to use SPs in teaching practical interviewing and patient management skills to psychiatrists and primary care physicians. Data from a variety of educational projects will be presented to highlight the potential strengths and weaknesses of SPs as an educational technique. Logistical concerns in SP use will be described including developing roles, recruiting and training SPs, ensuring quality control of SP performances, coordinating a SP program, and the financial aspects of using SPs including interacting with the pharmaceutical industry in the development of industry-sponsored CME. An actual SP will be integrated into the presentations.

REFERENCES:

1. Hodges B, Turnbull J, Cohen R, Bienenstock A, Norman G: Evaluating communication skills in the OSCE format: reliability and generalizability. Medical Education. 1996;30(1), pp. 38–43.
2. McDermott JF, Streltzer J, Lum KY, Nordquist CR, Danko G: Pilot study of explicit grading criteria in the American Board of Psychiatry and Neurology part II examination. American Journal of Psychiatry 1996;153:1097–1099.

Issue Workshop 41
PREDATORY ABUSE: EXPLOITATION OF THE ELDERLY

Chairperson: Michael J. Tueth, M.D., *Department of Psychiatry, University of Florida, PO Box 100256/College of Med, Gainesville FL 32610*
Participant: Vikram Mehra, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) understand medical and legal constructs of exploitation of the elderly, (2) recognize common characteristics of abuser and victim, and (3) appreciate the psychological and financial damage inflicted on elder victims of exploitation.

SUMMARY:

Elder abuse is mandated by statute to be reported in at least 42 states. Exploitation or financial abuse of the elderly differs in specific ways from physical abuse: it is accompanied by deception and intimidation; it lacks physical signs; it is carried out in an insidious, predatory manner. While neglect is passive, financial abuse is slow, deliberate, and calculated. The essential features of exploitation are psychological power and control over the victim and expected material gain for the abuser. The workshop format consists of an initial overview of financial abuse of the elderly including common characteristics of the abuser and the victim, epidemiological data, and various modus operandi. A discussion of the facts of recent cases decided in the state of Florida will follow. The audience will have a vital role in the unfolding of the case discussions, including strategy, psychiatric input, and testimony, by the presenters encouraging comments and questions. Interactive discussion will be facilitated using a hypothetical case presentation. Dr. Tueth has served as prosecution consultant and expert witness on a number of elder exploitation cases.

REFERENCES:

1. Members of the Council on Aging. APA physician statement on elder abuse, neglect, and exploitation. Am J Psychiatry 1995;152:820
2. Goldstein MZ: Maltreatment of elderly persons. Psychiatric Services 1995;46:1219–1225

Issue Workshop 42
ISSUES IN TOBACCO USE AND SCHIZOPHRENIA

Chairperson: Peter E. Cook, M.D., *350 King St E #102, Hamilton ON L8N 3Y3, Canada*
Participants: Douglas M. Ziedonis, M.D., Joel O. Goldberg, Ph.D., Sandra Moll, M.Sc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize the high rate of nicotine dependence in schizophrenia and the reasons for the addiction including current biological explanations, (2) assess readiness for altering smoking habits based on stages of change model, and (3) understand what options are available for support and intervention.

SUMMARY:

Smoking rates among people with severe mental illness can be up to triple the rates found in the general population. This issue workshop will provoke the audience participants to grapple with the so-called "benefits" and "costs" of nicotine dependence and schizophrenia. Dr. Ziedonis will provide an overview of the theoretical and clinical context for the discussion, including review of key biological explanations about nicotine stimulating both the subcortical brain reward mechanisms and the prefrontal cortex, which can be hypoactive in schizophrenia. Smoking has been thought to reduce some medication side effects, to improve concentration, and prevent boredom. Patients who try to quit are at heightened risk for depression. Dr. Goldberg and Sandra Moll will describe recent survey results (sample of 105 community-based schizophrenia patients) and focus group findings, which highlight the patient's perspectives on barriers to quitting, and factors that influence readiness to change smoking habits, based on the Prochaska et al (1988) transtheoretical model. Dr. Cook will facilitate the discussion portion, raising provocative questions for practitioners (for example, impact of smoking bans in hospitals); audience probes that were highly successful in generating focus group discussion will be used.

REFERENCES:

1. Ziedonis DM, Kosten TR, Glazer WM, Frances RJ: Nicotine dependence and schizophrenia. Hospital and Community Psychiatry 1994;45:204–206.
2. Goldberg JO, Moll S, Washington A: Exploring the challenge of tobacco use and schizophrenia. Psychiatric Rehabilitation Skills 1996;1:51–63.

Issue Workshop 43
CULTURAL ISSUES IN CONSULTATION-LIAISON PSYCHIATRY

Co-Chairpersons: Jon M. Streltzer, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, 4th Flr, Honolulu HI 96813-2427,* Wen-Shing Tseng, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, Honolulu HI 96813-2427*
Participants: James J. Strain, M.D., Norman B. Levy, M.D., Hoyle Leigh, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the impact of culture in various ways on diagnostic and management issues relevant to consultation-liaison psychiatry.

SUMMARY:

The consultation-liaison psychiatrist not only diagnoses and treats psychopathology, but also facilitates doctor-patient and nurse-patient relationships, resolves conflicts within the medical milieu, and generally tries to optimize medical management and the patient's psychological health. Cultural issues can be important in all these areas, yet there are few studies that elucidate the influence of culture on medical practice.

The patient's cultural background contributes to his/her appreciation and presentation of symptoms, motivation for treatment, expectations of the physician, adjustment to illness, understanding of medical interventions, and compliance with them. The physician's cultural background contributes to his/her expectations of the patient, and to the approach to patients who do not meet these expectations. Cultural factors influence the doctor-patient relationship, which is often a critical part of the healing process. In addition, there is a "medical culture" that also strongly influences medical practice and interacts with other cultural issues. An example is the practice of telling or withholding the prognosis from a dying patient.

Panel members will use case examples and data from several countries in their presentations. Audience members will be encouraged to share experiences and opinions after each presentation and during general discussion with the panel.

REFERENCES:

1. Tseng WS, Streltzer J, (Editors): Culture & Psychopathology: A Guide To Clinical Assessment. New York: Brunner/Mazel, 1997.
2. Abbey SE, Garfinckel PE: Neurasthenia & chronic fatigue syndrome: the role of culture in the making of a diagnosis. American Journal of Psychiatry 1991;148:1638–1646.

Issue Workshop 44
MANAGEMENT OF SEXUAL PREDATORS AFTER THE SUPREME COURT RULING IN KANSAS vs. HENDRICKS

Chairperson: James E. Dillon, M.D., *Child & Adol Psych Hosp., Univ. of Michican Medical Ctr., 1500 East Medical Center Drive, Ann Arbor MI 48109*
Participants: Melvin Guyer, Ph.D., J.D. Lee H. Rome, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: (1) understand the decision in Hendricks, (2) appreciate the impact of Hendricks on mental health systems, and (3) be able to prepare for the influx of sexual predators in civil hospitals.

SUMMARY:

In Kansas v. Hendricks the United States Supreme Court recently found legislation providing for the civil commitment of sexual offenders upon expiration of criminal sentences to be constitutionally permissible. The controversial ruling allows civil commitment based upon very broad definitions of mental illness that include disorders such as pedophilia and, presumably, Axis II conditions such as antisocial personality disorder. Two potentially calamitous consequences flow from the decision. First, by blurring the distinction between "mad" and "bad," Hendricks promotes preventive detention, under the guise of psychiatric treatment, of large classes of people traditionally not viewed as mentally ill. Second, legislation in many states is now proceeding that threatens to absorb large fractions of mental health budgets for the custodial care of convicted criminals. Discussion will follow three brief presentations. The first speaker (Guyer) will review the legal background and implications of Hendricks. The second speaker (Rome) will examine the implications of the ruling for forensic mental health services, using the state of Michigan, where sexual predator legislation modeled after Kansas has already been drafted, as a case in point. The third speaker (Dillon) will consider prospects for treatment of sexual offenders detained under the expected new wave of sexual predator laws.

REFERENCES:

1. Kansas v. Hendricks, U.S. Supreme Court, No. 95-1649, 1997.
2. Abel GG, et al: Current treatments of paraphilas. Ann Rev Sex Res 1992;3:255–290.

Issue Workshop 45
ACADEMIC MEDICAL CENTERS MANAGING CARE

Chairperson: Arthur L. Lazarus, M.D., *MBA, Prudential Health Care, 102 Rock Road, Horsham PA 19044*
Participants: Thomas Carli, M.D., Allen Daniels, Ed.D. Bruce J. Schwartz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should be able to identify various mechanisms academic medical centers employ to manage behavioral health care and evaluate contrasting approaches to managing care.

SUMMARY:

Increasingly, providers are being given greater responsibility for managing care. Many providers have formed strategic alliances resulting in integrated delivery systems. In some areas of the United States integrated delivery systems are academic medical centers. In preparing for managed care, academic medical centers have developed provider networks across a continuum of risk and have emerged as insurers in their own right. Under global risk contracts, academic medical centers are now assuming fiscal, administrative, and clinical responsibilities for large populations of patients or covered lives.

Commonly, patient populations are "carved-in" to academic medical centers through physician owned or affiliated primary care networks. The behavioral health care treatment and management of these patients is then "carved-out" to the department of psychiatry or a similar entity. Thus the carve-out is a subset of providers affiliated with the academic medical center, consisting of a provider network as well as a management services organization. The model varies in terms of organizational structure, legal arrangements, financial risk sharing, and so forth.

This workshop will evaluate various methods that the following four academic medical centers use to manage care: MCP◆Hahnemann School of Medicine (Allegheny Behavioral Health Services), the University of Michigan School of Medicine (Michigan Center for Diagnosis and Referral), the University of Cincinnati School of Medicine (Alliance Behavioral Care), and Albert Einstein College of Medicine-Montefiore Medical Center (University Behavioral Associates).

REFERENCES:

1. Riba MB, Carli T: Will academic psychiatry survive managed care? In: Controversies in Managed Mental Health Care. Edited by Lazarus A. Washington, DC, American Psychiatric Press, 1996.
2. Wetzler S, Schwartz BJ, Saunderson W, et al: Academic psychiatry and managed care: a case study. Psychiatric Services 1997;48:1019–1026.

Issue Workshop 46
INTERNATIONAL PERSPECTIVES ON GAY PSYCHIATRY

Co-Chairpersons: Gene A. Nakajima, M.D., *1740 Butler Avenue, Los Angeles CA 90025,* Siegmund Dannecker, M.D., *Department of Psychiatry, Krankenhaus Spandau, Griesinger Str 27-33, D-13589 Berlin, Germany*
Participants: Pierre Cochand, M.D., Oyvind Erik Jensen, M.D. Ruedi Gloor, M.D., Dr. Pascal Singy

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) describe similarities and diversity of gay people from different cultures around the world, and (2) how public attitudes toward gay people affect the gay community in different ways.

SUMMARY:

In this workshop, psychiatrists from countries outside North America will discuss their work concerning homosexuality and mental health. Participants will have the opportunity to discuss with the panelists how psychiatric professionals in other countries have examined homosexuality.

Dr. Jensen will speak about the issue of same-sex marriage in Norway. During the past five years, the Norwegian government has allowed registered domestic partnerships. Highlights of his presentation will include a discussion of the influence that same-sex marriage has had on public attitudes toward homosexuality and its possible implications for other countries.

Dr. Dannecker will speak about the necessity of special training and supervision for gay and lesbian mental health workers in Germany. He will also report on his participation in a gay Balint group for mental health professionals.

Dr. Cochand will speak about HIV prevention work with gay couples from Switzerland. His remarks will address the correlation between couples' negotiation capacity and risk behavior. Dr. Gloor, from Switzerland, will speak about counseling parents of gay and lesbian children.

Dr. Nakajima will speak about organizing gay and lesbian psychiatrists internationally and current efforts to start a gay and lesbian issues section in the World Psychiatric Association.

REFERENCES:

1. Cabaj RP, Stein TS: Textbook of Homosexuality & Mental Health. Washington, DC, APA Press, Inc., 1996
2. Oldham JM, Riba MB, Tasman A: American Psychiatric Press Review of Psychiatry, Vol. 12, APA Press, 1993

Issue Workshop 47
HOW TO HELP YOUR PATIENTS STOP SMOKING
Collaborative Session with the National Institute on Drug Abuse

Co-Chairpersons: John R. Hughes, M.D., *Department of Psychiatry, University of Vermont, 38 Fletcher Place, Burlington VT 05401-1419,* Susan J. Fiester, M.D., *35 Wisconsin Circle, Suite 345, Chevy Chase MD 20815*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to motivate patients to attempt to stop smoking and assist smokers in stopping smoking.

SUMMARY:

The most common smoking intervention is brief (<10 min), non-confrontational advice to smokers not presently interested in quitting or more extended advice to smokers who have failed OTC nicotine replacement or other methods. Since many psychiatrists are unfamiliar with these two strategies, we role-play three brief scenarios: a schizophrenic young man who has little interest in quitting, a woman who has just remitted from depression and wants to quit, and a manic patient who won't be hospitalized due to smoking restrictions. Participants then ask questions of the experts or share how they have handled similar cases. The workshop will highlight issues such as when is the optimal timing of cessation, how to monitor for worsening psychopathology, etc. Techniques and therapies will be those recommended in the APA Practice Guideline for the Treatment of Nicotine Dependence. The aim of the workshop is to make psychiatrists comfortable enough to approach smoking cessation in all their patients.

REFERENCES:

1. Hughes JR, Fiester S, Goldstein MG, et al: American Psychiatric Association Practice Guideline for the Treatment of Nicotine Dependence. Am J Psychiatr 1996;153:S1–31.
2. Hughes JR, Frances RJ: How to help psychiatric patients stop smoking. Psychiatr Services 1995;46:435–445.

Issue Workshop 48
PHARMACOTHERAPY OF ADDICTIVE DISORDERS

Chairperson: Norman S. Miller, M.D., *Department of Psychiatry, University of IL at Chicago, 912 South Wood Street/MC 913, Chicago IL 60612*
Participants: Raye Litten, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to discuss pharmacotherapy of addictive disorders.

SUMMARY:

The audience will understand the current standards of practice for the use of pharmacological therapies in addictive disorders. The pharmacological agents contained in the pharmacotherapies for alcoholism (and other drug addictions) can be classified according to these major categories: (1) intoxication—agents that reverse the pharmacological effects of alcohol; (2) withdrawal—agents that suppress the pharmacological withdrawal from alcohol; (3) desire and compulsion—agents that block the preoccupation with acquiring alcohol and the desire to use, or to continue to use, alcohol; (4) psychiatric complications—agents that treat or ameliorate the psychiatric symptoms induced by alcohol and other drugs; (5) psychiatric disorders—agents that are used in patients who have addictional independent psychiatric disorders; and (6) concurrent drug addiction—agents used in drug addictions in addition to alcoholism. Conclusions for clinical practice and directions for research will be presented to, and discussed with, the audience.

REFERENCES:

1. Miller NS: Pharmacotherapy in alcoholics. Directions in Psychiatry 1993;13(20):1–7
2. Gorelick DA: Overview of pharmacological treatment approaches for alcohol and other drug addictions. Psychiatric Clinics of North America 1993;16(1):141–156

Issue Workshop 49
THE ROLE OF ENACTMENT IN PSYCHIATRIC TREATMENT

Co-Chairpersons: Eric M. Plakun, M.D., *Admissions, The Austen Riggs Center, P.O. Box 962, 25 Main St., Stockbridge MA 01262,* Edward R. Shapiro, M.D., *Admissions, Austen Riggs Center, P.O. Box 962, 25 Main St., Stockbridge MA 01262*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to define enactment, differentiate it from near neighbor phenomena, list clinical situations in which enactments frequently occur, understand the use of enactments to advance treatment, and apply this new learning in his/her own work setting.

SUMMARY:

As psychiatric practice and training change in response to recognition of the limitation of resources for treatment, fewer clinicians think psychodynamically about their clinical work. The psychodynamic concept of enactment, defined as nonverbal interactional behavior in which doctor and patient unwittingly collude in repeating conflicted events in the patient's life, is a useful one for psychiatrists, regardless of whether or not they practice psychodynamic therapy. This is because enactments arise frequently in any kind of clinical work with treatment-resistant patients, particularly those with personality disorders and/or trauma histories. Further, treatment in a managed care environment often unwittingly leads to enactments involving doctor, patient, and managed care reviewer. This workshop will define enactment, clarify its components (including countertransference and projective identification), review commonly encountered enactments, and offer paradigms for advancing treatment by bringing the meaning of the enactment into the treatment relationship. After the presentation, the remaining hour will be used for an interactive discussion of case material. Although cases will be offered to initiate discussion, workshop participants will be encouraged to offer case examples from their own practices. The result should be a highly interactive opportunity to discuss ways of responding to challenging treatment problems.

REFERENCES:

1. Shapiro ER: The boundaries are shifting: renegotiating the therapeutic frame. In The Inner World in the Outer World: Psychoanalytic Perspectives. Edited by Shapiro, ER, Yale, 1997 (in press).
2. Plakun EM: Economic grand rounds: treatment of personality disorders in an era of resource limitation. Psychiatric Services 1996;47:128–130.

Issue Workshop 50
CONCEPTUALIZATION AND BOUNDARIES OF TRAUMA

Chairperson: Malkah T. Notman, M.D., *Department of Psychiatry, Cambridge Hospital, 54 Clark Road, Brookline MA 02146*
Participants: Carl P. Malmquist, M.D., Elissa P. Benedek, M.D

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation participants should be able to have a clearer knowledge of criteria for judging trauma vs. stress,

and PTSD and its long-term course, and a more comprehensive understanding of the process.

SUMMARY:

The term trauma has been used increasingly widely. DSM-IV has broadened the definition of trauma to include individuals who have learned from someone else about an event that "involves death, injury or a threat to the physical integrity of another person," not only those that have the direct personal experience of such an event. This has brought recognition of the victims of secondary trauma, such as the therapist of traumatized individuals. However, it also contributes to a blurring of the concept of trauma and of PTSD. When is an experience traumatic and when is it a stressful event in the course of life? What are the criteria? How does one judge and when should it be considered as a cause for PTSD? How long can one expect the PTSD to last? These experiences raise clinical issues as well as philosophical and legal ones. Internship, childbirth, the loss of an important person, hostile remarks, as well as witnessing violence, rape, or experiences of the magnitude of the Holocaust have been considered traumatic. Without minimizing the seriousness of these experiences and their effects it is important to discuss and clarify criteria for assessing them. This workshop will address these questions from a theoretical, clinical, and forensic perspective. Dr. Benedek will present a videotape of a patient who had a past traumatic experience for discussion by presenters and participants. This workshop was presented last year. It was well attended and occasioned a lively discussion until the very end of our time. This workshop will place emphasis on an aspect that was of particular interest, i.e., the contrasts and overlap of the clinical and forensic points of view.

REFERENCES:

1. Herman J: Trauma and Recovery, Basic Books, 1992.
2. Speigel D, Classen C: Acute stress disorder. In: Treatment of Psychiatric Disorders, Vol 2, Edited by Gabbard G. Washington DC, APPI, pp. 1521–1535.

Issue Workshop 51
SEXUAL ACTIVITY IN LONG-TERM PSYCHIATRIC FACILITIES

Chairperson: Thomas P. Welch, M.D., *Mental Health Partners, Inc., 13317 S.E. Powell Blvd., Portland OR 97236-3335*
Participant: Allan W. Wood, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be better able to critically evaluate issues such as patients' rights and safety, as well as staff's attitude, in devising a policy on the sexual activity of patients in long-term psychiatric facilities.

SUMMARY:

Sexual expression and activity by patients residing in long-term psychiatric facilities such as state hospitals and community-based facilities continues to generate a great deal of debate among staff, administrators, patients, and their advocates. After a brief review of the literature pertaining to this subject and a description of the creation and use of a policy on human sexuality at the presenters' facility, the presenters will lead a group discussion about attitudes and approaches to this issue. The presenters will use case vignettes to help start a free exchange about issues such as competency to consent to sexual activity, abuse and exploitation, sex education, and staff's countertransference. Participants will be encouraged to share their own experiences in approaching this complicated aspect of caring for adults with severe and persistent mental illness.

REFERENCES:

1. Buckley PF; Hyde JL: State hospitals' responses to the sexual behavior of psychiatric inpatients. Psychiatr Serv 1997;48:398–9.
2. Commons ML; Bohn JT; Godon LT; et al: Professionals' attitudes towards sex between institutionalized patients. Am J Psychother 1992;46:571–80.

Issue Workshop 52
HOW TO WRITE AND PUBLISH IN PSYCHIATRY

Chairperson: Carol C. Nadelson, M.D., *Director, Office for Women's Careers, A3, 75 Francis Street, Boston MA 02115*
Participants: Sydney Bloch, M.D., Nancy C. Andreasen, M.D.

SUMMARY:

Writing for publication can be a daunting task, with many obstacles. This workshop, presented by three editors, will consider organization of papers and chapters, journal and book policies, choice of journals and publishers, referencing, bibliography, the process of submission, and how to understand and address referee and editor comments. It is designed to facilitate and encourage writing and to provide feedback.

REFERENCES:

1. Day RA: How to write and publish a scientific paper, 4th ed. Oryx Press, 1994.
2. Huth E: How to write and publish papers in the medical sciences 2nd ed. Williams & Wilkins, 1990.

Issue Workshop 53
GEORGE GERSHWIN AT 100: A CREATIVE GENIUS RE-EXAMINED

Chairperson: Richard Kogan, M.D., *30 E 81st Street #9E, New York NY 10028*
Participant: William A. Frosch, M.D.

SUMMARY:

There has been a longstanding tendency to divide American music into serious (classical) and popular forms, such as jazz and musical theatre. No one in history has fused "high" and "low" culture more successfully than George Gershwin (1898–1937). In a year marking the 100th anniversary of his birth, Gershwin's music remains as beloved as ever.

Psychiatrist and award-winning concert pianist Dr. Richard Kogan (first prizes-Chopin Competition, Casadessus International Piano Competition, and frequent collaborator with violinist Lynn Chang and cellist Yo-Yo Ma) will perform the complete piano solo arrangement of Rhapsody in Blue, as well as other musical examples. He and Dr. Frosch will examine how a man with virtually no formal education in music could develop an extraordinary facility as a composer. They will trace the arc of his creative output, from bursting on the scene as a Tin Pan Alley songwriter to composing the innovative Rhapsody in Blue, which astounded and shocked the musical establishment. His creative decline (following Porgy and Bess), unsuccessfully treated by psychoanalysis, was caused by an undiagnosed brain tumor.

Drs. Kogan and Frosch will explore and discuss the general concepts of creativity and genius. The final 30 minutes will be reserved for audience question and answer.

Issue Workshop 54
ART AND AUDIENCE: THE CREATIVE INTERACTION

Chairperson: Albert Rothenberg, M.D., *52 Pine Ridge Rd Box 236, Canaan NY 12029-3101*
Participants: Ellen H. Spitz, Ph.D., Richard Selzer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand aspects of the artistic creative process and art appreciation and apply this understanding to the enjoyment of art, the facilitation of healthy mental processes, the treatment of artists, and to general principles of psychotherapy.

SUMMARY:

The focus of this workshop will be on the interrelationship between the creative process and appreciation of art. Rothenberg will present a series of Rembrandt's self-portraits and demonstrate how the artist used a specific cognitive creative process, the homospatial process, in a statistically significant proportion of these productions, and produced the characteristically effective depiction of human emotion and expressiveness. Spitz will describe a creative process of art appreciation by showing how the poets Rilke and Auden worked out their feelings for paintings by Picasso and Breughel, respectively, through the writing of poems. Author Richard Selzer will discuss his own creative processes of translating medical experience into literature in comparison with artists' translation of visual experience into art. Audience accounts will be elicited, based on their own and their patients' experiences, where works of art have stimulated responses that may or may not have resulted in art products. These will be related to reactions to artworks presented and to a general process of creative art appreciation. Applications to creative therapeutic interaction will be designated.

REFERENCES:

1. Rothenberg A: Creativity and Madness: New Findings and Old Stereotypes. Chicago: University of Chicago Press, 1990.
2. Spitz EH: Art and Psyche. New Haven: Yale University Press, 1985.
3. Selzer R: Down from Troy. New York: William Morrow, 1992.

Issue Workshop 55
TONING AND CHANTING: ACCESSING AND EXPRESSING THE NONVERBAL

Co-Chairpersons: Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville, 323 Chestnut Street, Louisville KY 40202,* Alice H. Cash, Ph.D., *3219 Marion Court, Louisville KY 40206*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize appropriate patients needing behavioral treatment techniques of toning and chanting to uncover and work through nonverbal emotions.

SUMMARY:

Toning and chanting are tools of vibrational medicine that are regaining acceptance in traditional allopathic medicine. Though ancient, these practices fell out of general use when medicine became more technologically oriented in the 20th century. New research in music therapy and music medicine has led to an increased awareness and accessibility to memories and to long-repressed feelings. Measurable results based on self-report and biofeedback have been gathered and will soon be published in journals of psychiatry and behavioral medicine.

The applications of toning and chanting with mood disorders is becoming clear and documentable.

Dr. Dickstein and Dr. Cash have been utilizing these techniques in conjunction with more psychodynamically oriented therapy and pharmacotherapy for about five years. Their workshop will focus on learning to utilize these techniques and teaching them to patients. A large part of the workshop will be experiential and the remainder, didactic.

REFERENCES:

1. Unkdfer R (ed.): Music Therapy in the Treatment of Adults With Mental Disorders, Schirmer Books, New York, 1992.
2. Music Therapy Perspectives, vol. 10, #1, National Association of Music Therapy, 1992.

Issue Workshop 56
SEVERE MENTAL ILLNESS IN FAMILY MEDICINE SETTINGS

Chairperson: Rebecca S. Lewin, M.D., *Department of Psychiatry, University of Colorado, 4200 East 9th Ave. Box C249-51, Denver CO 80262*
Participant: Deborah Seymour, Psy.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to become familiar with (1) types of treatment-resisting, severely mentally ill patients seen by family practitioners; (2) the role of family physicians in assessing, treating, and maintaining them in the community; (3) the role of the psychiatrist in such settings; (4) family medicine centers facilitating access to additional mental health services.

SUMMARY:

Primary care physicians (PCP's) are often the first or only health care professionals contacted by people with mental illnesses. Some can easily be treated in the PCP's practice. Some will access formal mental health services, if referred. There is also a very diverse population of people who will not. This workshop will use cases drawn from a university-based family medicine clinic as examples of people who will not accept mental health services in any other setting. These are people who (a) have been in psychiatric treatment and refuse to return, (b) lack insight that they have psychiatric illnesses, or (c) are unable to comply with psychiatric care in mental health settings. These individuals present a compelling rationale for collaborative care and for psychiatric education in family medicine. Thus, psychiatrists can play a vital role in the care of these patients in primary care settings. There, they can participate in treatment directly—seeing patients—or indirectly, by co-treating patients and teaching diagnostic and treatment skills to primary care physicians.

Brief presentations will be used to stimulate discussion of participants' experiences.

REFERENCES:

1. Katon W., Von Korff M., Lin E, et al: Collaborative management to achieve treatment guidelines. Journal of the American Medical Association 1995;273(13):1026–1031.

2. Schurman, RA, Kramer, PD., Mitchell, JB: The hidden mental health network: treatment of mental illness by nonpsychiatric physicians. Archives of General Psychiatry 1985;42(1):84–94.

Issue Workshop 57
TRANSGENDER ISSUES

Chairperson: Dan H. Karasic, M.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7E, San Francisco CA 94110*
Participants: James W. Dotson, M.D., Shoshanna Gillick, M.D., Donald E. Tarver, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the spectrum of transgendered individuals and address issues frequently encountered in working with transgendered individuals.

SUMMARY:

Psychiatry historically has labeled transgender identification or gender identity confusion as a sexual perversion, immature developmental stage, psychotic state, or delusional distortion of self-image. Psychiatrists now are recognizing the utility of a respectful, nonpathologizing approach to the spectrum of transgendered patients seeking treatment for disorders related or unrelated to transgenderism.

In this workshop, a transgendered child psychiatrist will discuss the development of gender identity, and gender diversity in children, adolescents, and adults. Vignettes will demonstrate issues developing from the intersection of psychiatry with the "gender community."

Other presenters will discuss psychopharmacology and hormonal treatment, issues specific to female-to-male transsexuals, and issues involving the HIV-positive transgendered patient. Proposed guidelines for care will be presented. Audience members will be encouraged to share their experiences with transgendered patients.

REFERENCES:

1. Israel GE, Tarver DE: Transgender Care: Recommended Guidelines, Practical Information, and Personal Accounts. Temple University Press, Philadelphia. In press, 1997.
2. Roback HB, et al: Psychopathology in female sex-change applicants and two help-seeking controls. Journal of Abnormal Psychology, 1976; 85 (4):430–432.

Issue Workshop 58
ACUPUNCTURE, ORIENTAL MEDICINE AND PSYCHIATRY

Chairperson: Antoinette W. Jakobi, M.D., *Department of Psychiatry, Park Ridge Health, 1561 Long Pond Road, Ste 117, Rochester NY 14626*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the interface between oriental medicine and psychiatry; appreciate the techniques of acupuncture evaluation and treatment; recognize psychiatric conditions that could respond to acupuncture as a complementary treatment.

SUMMARY:

In recent years there has been an increased interest in complementary or alternative medicine from consumers, insurance carriers, and research institutions. The NIH has created an Office of Alternative Medicine that funds research proposals to study alternative treatments. A large percentage of licensed acupuncturists in the U.S. are M.D.'s. In this workshop participants will be introduced to the theories underlying the practice of acupuncture and oriental medicine by a psychiatrist who is also a licensed acupuncturist. There will be discussion of the use of acupuncture in the treatment of addictions, chronic pain, anxiety, and depressive disorders. The participants will have the opportunity, with the help of volunteers from the group, to experience history-taking, a review of systems and physical examination, as well as a mental status examination, from the perspective of oriental medicine. They will be able to participate in the formulation of an acupuncture differential diagnosis and treatment. Demonstration of diagnostic techniques will include tongue diagnosis and pulse diagnosis. Consideration will be given to understanding the patient's "biopsychotype," and the meaning of this with regard to the present complaint. At the end of the workshop the participant should have an appreciation of the techniques of various acupuncture schools and an understanding of how acupuncture may or may not be helpful in certain conditions.

REFERENCES:

1. Helms JM: Acupuncture Energetics: A Clinical Approach for Physicians. Berkeley, CA, Medical Acupuncture Publishers, 1995.
2. Kaptchuk TJ: The Web That Has No Weaver. NY, Congdon and Weed, 1983.

Issue Workshop 59
WOMEN'S ISSUES IN DRUG ABUSE: VIOLENCE, TRAUMA AND VICTIMIZATION
Collaborative Session with the National Institute on Drug Abuse

Chairperson: Kathleen T. Brady, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425-0742*
Participants: Linda Teplin, Ph.D., Sheila B. Blume, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participants should be able to recognize the prevalence of traumatization among women with substance use disorders in a number of settings and discuss public policy and ethical considerations specifically related to the treatment of substance use disorders in women.

SUMMARY:

Issues specific to women with substance use disorders have been relatively understudied. Recently, a number of studies have indicated that trauma, violence, and victimization are particularly common in the lives of women with substance use disorders. In this workshop, data from treatment settings as well as data from a large study of incarcerated women will be presented to demonstrate this point. Psychiatric comorbidity and psychosocial complications for substance abusing women will be reviewed. Appropriate techniques for identification and treatment of traumatized women with substance use problems will be discussed. The most appropriate treatment remains a controversial point. The use of medications and psychotherapy specifically directed at trauma-related symptoms is not widely accepted, although preliminary evidence supports these approaches. Another controversial issue specific to women and substance use is the treatment of the pregnant substance user and the substance using mother with young children. Punitive approaches and stigmatization may act as barriers to appropriate treatment for these individuals. In this sense, women may become victims of the limitations of the substance abuse treatment system. Specific case examples as well as policy issues will be discussed.

REFERENCES:

1. Brady KT, Grice DE, Dustan L, Randall C: Gender differences in substance use disorders. Am J Psychiatry 1993;150(11), 1707–11.

2. Breslau N, Davis GC, Peterson EL, Schultz, L: Psychiatric sequelae of posttraumatic stress disorder in women. Arch Gen Psychiatry 1997;54(1): 81–7.

Issue Workshop 60
TRANSGENDER AWARENESS

Chairperson: David E. Seil, M.D., *196 W Springfield St, Boston MA 02118-3407*
Participant: Laura Patrina Perri, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the nature of the transsexual experience, its position as a sexual minority, and the role of psychiatry in assessment for sexual reassignment.

SUMMARY:

After a brief presentation of basic information about transsexualism provided by the three presenters, the workshop will be open to questions to explore the transsexual experience from a theoretical, clinical, and experiential perspective. The presenters represent a spectrum of familiarity with this sexual minority including the author of the chapter on transsexualism in the Textbook of Homosexuality and Mental Health, an individual who runs a support group for transgendered individuals in a community mental health clinic, and an individual who is a post-operative transsexual in private practice of psychiatry. This will provide an opportunity to discuss this topic from a variety of perspectives. The workshop is *not* intended to be a forum to debate the validity of the diagnosis of gender identity disorder.

REFERENCES:

1. Textbook on Homosexuality and Mental Health. APA Press. Edited by Cabaj, Stein 1995.
2. True Selves: Understanding Transsexualism for Families, Friends, Coworkers and Helping Professionals. Brown, 1996.

Issue Workshop 61
BEHAVIORAL INDEPENDENT PROVIDER ASSOCIATION: A LOOK AT THE FUTURE?

Chairperson: Bruce J. Schwartz, M.D., *Department of Psychiatry, Montefiore Medical Center, 111 East 210th Street/Klau B, Bronx NY 10467*
Participants: Robert B. Ostroff, M.D., Ronnie S. Stangler, M.D., Andrea J. Weiss, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the usefulness of an IPA for providing behavioral health services to HMO subscribers. Participants will learn about different structures for providing management services, differences between for-profit and not-for-profit IPA's, fee-for-service versus capitated payment methodologies, and how each can impact utilization and quality management issues.

SUMMARY:

Behavioral Independent Provider Associations (IPA's) are being rapidly formed throughout the U.S. as a means to empower behavioral health care providers (psychiatrists, psychologists, social workers, etc.) in their dealings with managed care organizations and HMO's. This phenomenon has been little examined, is generally poorly understood by providers, and can create divisiveness in the provider community when such an entity succeeds in obtaining a contract in a community that then excludes the majority of providers from the panel. The presenters will discuss with the attendees the structure of their IPA's, the manner in which UM and QM are performed, strengths and weaknesses of the IPA structure as well as payment methodologies (fee for service versus capitation), and ethical issues surrounding provider organizations. The organizations represented are geographically and demographically dissimilar and are in different phases of development and operation. Audience participants should find much with which they can identify and react. The organizations represented include University Behavioral Associates, a not-for-profit management services organization; Montefiore Behavioral Care IPA, a not-for-profit behavioral health IPA; PsychCare, a not-for-profit IPA; Psych Management, a for-profit management services organization; and Pacific Mental Health Associates, a not-for-profit behavioral services organization.

REFERENCES:

1. Wetzler S, Schwartz BJ, Sanderson W, Karasu TB: Academic psychiatry and managed care: a case study. Psychiatric Services 1997;48:1019–1026.
2. Inglehart JK: Managed care and mental health. New England Journal of Medicine 1996;334:131–135.

Issue Workshop 62
IMG's IN THE UNITED STATES: PROBLEM OR SOLUTION?

Co-Chairperson: Renato D. Alarcon, M.D., *Department of Psychiatry, Emory University, 1670 Clairmont Road, Atlanta GA 30033,* Alejandra Hallin, M.D., *20 Chapel Street, Apt. C709, Brookline MA 02146-5468*
Participants: Inomata Tomomi, M.D. Nyapati R. Rao, M.D., Frederick C. Miller, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to assess the significance of the number and roles of IMGs in American psychiatry; to recognize the main areas on controversy surrounding the IMG issue; to offer possible responses to the educational, cultural, and clinical challenges posed by the presence of IMGs.

SUMMARY:

International medical graduates (IMGs), physicians trained in medical schools from foreign countries, represent approximately 25% of the general membership of the American Psychiatric Association and almost half of the psychiatric residents in the United States. As such, IMGs have become a visible presence in American psychiatry and the subject of increasing controversy with regards to their contribution, relevance, quality, and durability as a workforce source in our profession. After a historical account of the academic, social, political, and legal circumstances surrounding the increasing migration of foreign doctors to the United States, which began shortly before World War II, and the presentation of personal experiences about being an IMG in the U.S., this workshop will foster a discussion with the audience about the following issues: a) heterogeneity of the IMG group, i.e., changing demographics or potential differences between American and non-American IMGs; b) acculturation and other factors in the adaptation and performance levels of IMGs; c) training requirements and didactic innovations aimed at reaching high levels of professional competence; d) the future of IMGs as members of the American psychiatric workforce.

REFERENCES:

1. Lin TY, Char WR, Brody EB, et al: Psychiatric training for foreign medical graduates: a symposium. Psychiatry 1971;34:233–257.
2. Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, American Medical Association, American Osteopathic Association, Association of Academic Health Centers, and National Medical Association:

Consensus Statement on the Physician Workforce. Washington, DC: February 1997, p. 5.

Issue Workshop 63
SPIRITUALITY/RELIGION IN THE MEDICAL SCHOOL CURRICULUM

Chairperson: Francis G. Lu, M.D., *Department of Psychiatry, University of CA at SF, 1001 Potrero Avenue, San Francisco CA 94131*
Participants: David B. Larson, M.D., James L. Collins, M.D., Christina M. Puchalski, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand model curricular programs at 15 medical schools that have integrated religion/spirituality into their curriculum; to discuss barriers and strategies toward implementing similar programs at the participants' own medical schools.

SUMMARY:

The importance of spirituality/religion/faith in medical practice and medical education has grown dramatically in recent years. Dr. Lu will first present an overview of existing curricular programs on spirituality/religion/faith at 15 U.S. medical schools including the following: George Washington, West Virginia, Case Western Reserve, Bowman Gray, Johns Hopkins, and Ohio State. Although the programs vary by duration (one to four years), extent of required vs. elective courses and number of hours, they are similar in focusing on the importance of physician-patient rapport and an attitude of respect; skills in interviewing and assessment; and applications to ethical, cross-cultural, and death/dying arenas in practice. Of note, while only a minority of course directors were psychiatrists, the programs were often within interdisciplinary courses. Dr. Puchalski will then describe the program at George Washington, which has been integrated into the required four-year Practice of Medicine curriculum. Program content, teaching methods (lecture, small-group discussion, and role playing, PBL case discussions), and evaluation methods will be reviewed. Dr. Collins will discuss the barriers and strategies useful in implementing these programs. The last 30 minutes will focus on discussion of how these model programs may facilitate development of similar programs at participants' own medical schools.

REFERENCES:

1. Larson D, Larson S: The Forgotten Factor in Physical and Mental Health: What Does The Research Show? Rockville, MD: National Institute for Healthcare Research, 1991.
2. Larson D, Puchalski C: Conference Proceedings—Spirituality and Medicine: Curricular Development. Rockville, MD: National Institute for Healthcare Research, 1997.

Issue Workshop 64
PSYCHIATRIC ASSESSMENT OF JUVENILE DANGEROUSNESS

Chairperson: Charles L. Scott, M.D., *Tulane University, 1430 Tulane Avenue, SL23, New Orleans LA 70112*
Participants: Catherine F. Lewis, M.D., Barbara McDermott, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to review current statistics on juvenile violent crime; to identify risk factors of violence in juveniles; to describe psychiatric disorders associated with juvenile violence; and to conduct a dangerousness assessment in juveniles.

SUMMARY:

Violent juvenile crime is an increasing focus of national concern. Male juveniles between the ages of 14–17 represent the majority of violent youthful offenders. The addition of more than 500,000 young men to the 14–17 male population by the year 2000 is projected to send juvenile crime skyrocketing. Mental health professionals are increasingly faced with evaluating and treating violent youthful offenders. This workshop will instruct clinicians in the assessment of juvenile dangerousness and risk-prevention planning.

The instructors will present videotaped and written vignettes of juvenile offenders to the audience in a small-group format. Participants will identify general risk factors for violence in each vignette. Particular attention will be given to risk factors for recidivism in juvenile murderers and sex offenders. Members of the audience will discuss the contribution of possible psychiatric diagnoses to the violent crime. The audience will determine which psychological testing and risk-assessment instruments should be requested. Participants will write a prevention plan addressing each identified violence risk factor. Attendees will formulate recommendations to the referring agency.

REFERENCES:

1. Snyder HN, Sickmund M: Juvenile Offenders and Victims: A National Report. National Center for Juvenile Justice. August, 1995.
2. O'Shaughnessy RJ: Clinical aspects of forensic assessment of juvenile offenders. Psychiatric Clinics of North America, 1992; Volume 15, No. 3.

Issue Workshop 65
ABPN UPDATE: REQUIREMENTS FOR THE ABPN EXAMINATION
Joint Session with the American Board of Psychiatry and Neurology, Inc.

Chairperson: Stephen C. Scheiber, M.D., *Amer Brd of Psych & Neuro, 500 Lake Cook Road, Suite 335, Deerfield IL 60015-5249*
Participants: Glenn C. Davis, M.D., Michael H. Ebert, M.D., William T. McKinney, M.D., Sheldon I. Miller, M.D., Pedro Ruiz, M.D., John E. Schowalter, M.D., Peter M. Silberfarb, M.D., Elizabeth B. Weller, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate the policies and procedures of the ABPN for certification, recertification, and subspecialization, especially for residents in training and early career psychiatrists.

SUMMARY:

The directors of the American Board of Psychiatry and Neurology will focus discussion on conditions for admission to the certification examination, the examination process and plans for recertification, and the current status of subspecialization. This information will be most helpful to residents and early career psychiatrists. Residents and early career psychiatrists will be encouraged to ask questions about certification, recertification, and subspecialization, in addition to the Part I and Part II written and oral examinations for certification. They will be urged to discuss child and adolescent psychiatry, addiction psychiatry, forensic psychiatry, geriatric psychiatry, and clinical neurophysiology. An update on plans for recertification will be given.

REFERENCES:

1. Shore J, Scheiber SC: Certification, Recertification and Lifetime Learning, APPI Press, Washington, D.C., 1994.

2. American Board of Medical Specialties: Recertification for Medical Specialists, ABMS, Evanston, IL, 1987.

Issue Workshop 66
THE OCCURRENCE OF DISSOCIATIVE IDENTITY DISORDER IN PSYCHIATRIC INPATIENTS

Chairperson: Arthur Rifkin, M.D., *Hillside Hospital, 7559 263rd St, Glen Oaks NY 11004-1150*
Participants: Tracy T. Latz, M.D., Colin A. Ross, M.D., Glen N. Saxe, M.D., David Spiegel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to comprehend the variation in results concerning the occurrence of dissociative identity disorder in psychiatric inpatients and the methodological problems involved.

SUMMARY:

Many think it is underdiagnosed and misdiagnosed, resulting in inappropriate treatment. Recent inpatient studies have shown a wide disparity in the rates of occurrence. In this workshop, we have assembled a discussant and four investigators who have completed studies on the occurrence of DID among psychiatric inpatients. The workshop will include a discussion about many of the controversial issues, such as the "gold standard" for diagnosis the strengths and weakness of rating instruments, and the methodological problems inherent in these studies.

REFERENCES:

1. Saxe G, van der Kolk B, Berkowitz R, et al: Dissociative disorders in psychiatric inpatients. Am J Psychiatry 1993;150:1037–1042.
2. Latz TT, Kramer SI, Hughes DL: Multiple personality disorder among female inpatients in a state hospital. Am J Psychiatry 1995;152:1343–1348.

Issue Workshop 67
WHEN A MEDICAL STUDENT COMMITS SUICIDE

Co-Chairpersons: Donald A. Misch, M.D., *Department of Psychiatry, Medical College of GA, 1515 Pope Avenue, Atlanta GA 30912,* Stewart A. Shevitz, M.D., *Dept of Psych/Hlth Beh., Medical College of Georgia, 1515 Pope Avenue, Augusta GA 30912-3800*
Participants: Donna L. Londino, M.D., Diana L. Thorne, M.D., Cheryl D. Anderson, B.S., Jennifer Prichard, B.S., Joel Tieder, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the impact on medical classmates of medical student suicide, and design, facilitate, and implement effective personal and institutional responses to such an event.

SUMMARY:

How common is medical student suicide; how do other medical students react to the suicide of one of their peers; and what are appropriate personal and institutional responses to such events? This workshop will explore these important questions concerning the response of medical students and medical schools to the suicide of a medical student. After a brief review of the epidemiology of medical student suicide and the common reactions of suicide survivors, several medical students will discuss their personal reactions to the suicide of one of their classmates. Subsequently, a formal survey of medical classmate reactions and responses to peer suicide will be presented, and institutional responses, both helpful and counterproductive, will be outlined. This will be followed by a discussion of workshop participants' experiences related to medical student suicide and the personal and institutional responses that facilitate or hinder the processing of the event.

REFERENCES:

1. Kaltreider NB: The impact of a medical student's suicide. Suicide and Life-Threatening Behavior 1990; 20:195–205.
2. Hays LR, Cheever T, Patel P: Medical student suicide: 1989–1994. Am J Psychiatry 1996 153:553–555.

Issue Workshop 68
PSYCHIATRY, EUTHANASIA, AND ASSISTED SUICIDE

Co-Chairpersons: Leigh C. Bishop, M.D., *Menninger Clinic, PO Box 829, Topeka KS 66601-0829* Samuel B. Thielman, M.D., *394 Merrimon Avenue, Asheville NC 28801-1222*
Participant: Robert D. Orr, M.D.

EDUCATIONAL OBJECTIVES:

After this workshop, the participant should be familiar with the historical background regarding euthanasia and physician-assisted suicide (PAS); be able to describe the principal arguments for and against euthanasia and PAS; and be able to describe the problems posed by euthanasia and PAS for psychiatry and psychiatrists.

SUMMARY:

Public and professional discussions have recently raised the question of whether the longstanding proscription against physician-assisted suicide (PAS) for terminally ill patients should be eliminated or changed. Unquestionably, if this proscription is lifted, psychiatrists, and psychiatry, will have integral roles in the implementation of PAS. In this workshop, participants will be provided with a brief pre-test, and then three presentations will be made, each to be followed by discussion between panelists and participants. Presenters will review the history of the debate over euthanasia and PAS from ancient times to the present and will summarize the arguments for and against legalization. Adverse consequences to the patient-doctor relationship and the likely extension of the practice to include those who are suffering but not dying, such as those with intractable mental suffering, are some of the principal concerns raised in opposition to PAS. Presenters will review the 10-year social experiment with euthanasia in the Netherlands. They will discuss why psychiatry should continue to oppose the legalization of PAS, focusing on likely adverse effects on the special role of the therapist in preventing suicide and the limitations of psychiatric assessment of the competent patient's motivation for requesting assistance in commiting suicide.

REFERENCES:

1. Orr RD, Bishop LC: Why psychiatrists should not participate in physician-assisted suicide. *Am J Forensic Psychiatry* (In press).
2. Ganzini L, Lee MA: Psychiatry and assisted suicide in the United States. *N Eng J Med* 1997; 336:1824–1826.

Issue Workshop 69
TESTIMONY: A FORMER POLITICAL PRISONER FROM HAITI
Joint Session with the Haitian-American Psychiatric Association

Chairperson: Jacques Vital-Herne, M.D., *Department of Psychiatry, Hillside Hospital, 7559 263rd Street, Glen Oaks NY 11004-1150*
Participants: Patrick Plantin, M.D., Patrick Lemoine, Pierre A. Jean-Noel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe testimony and information about the catastrophic

conditions under which political prisoners were kept and to promote awareness of this pattern of human rights violation and alert psychiatrists and health care workers to the needs of the victims.

SUMMARY:

During the Duvalier regime in Haiti (1957-1986), state-sponsored terrorism had replaced the rule of law. Arbitrary arrests, torture, "disappearances," and summary executions were commonplace. It is estimated that over 60,000 people were killed on political grounds during this period.

Fort-Dimanche was converted into a jail where dissidents (real, suspected, imagined, or potential) were sent to die under subhuman conditions or by firing squad. No prisoner was expected to survive.

Patrick Lemoine, a Fort-Dimanche survivor and author of a book about his six-year incarceration, will discuss his experiences and survival strategies. A clinical discussion of Mr. Lemoine's experience will be presented; issues of resiliency and psychiatric vulnerability will be discussed. A panel will discuss the pattern of physical and psychological degradation leading to the status of human garbage at Fort-Dimanche. The session will be opened to audience participation.

REFERENCES:

1. Lemoine P: Fort-Dimanche, Fort-la-Mort. Port-au-Prince, Haiti. Editions Regain, 1996.
2. Eth S: Ethical challenges in the treatment of traumatized refugees. Journal of Traumatic Studies 1992; 5:103–110.

Issue Workshop 70
CHALLENGES IN RESOCIALIZING PSYCHIATRIC EDUCATION

Chairperson: Kenneth S. Thompson, M.D., *IPHP, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh PA 15213*
Participants: Bradley E. Lewis, M.D., David A. Pollack, M.D., Stephen M. Goldfinger, M.D., Linda G. Gochfeld, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate knowledge of current approaches to teaching social and community psychiatry to medical students and psychiatric residents.

SUMMARY:

The last 20 years have witnessed the growth of biological psychiatry as psychiatry's dominant paradigm. The sheer volume of biological research, the explosion of new pharmaceuticals in the marketplace, and the rhetoric of the "decade of the brain" have overshadowed other aspects of psychiatry, especially social and community psychiatry. Yet there have been many advances in these areas too, such as the rise of the consumer and family movements and self-help, mutual aid, and support groups; the evolution of the concept of "recovery;" the elaboration of case management and community-based care; and the reemergence of family-oriented and population-oriented mental health care that is cognizant of community, culture, class, and gender.

Teaching social and community psychiatry is a challenge because of the dominance of biological psychiatry in the mind set of trainees. This workshop of presenters from training programs in social and community psychiatry from around the country will discuss their approaches to teaching, describe their curricula, and elucidate the pedagogical challenges they face. The audience will be encouraged to share their perspectives and to join in an ongoing project of the American Association of Community Psychiatrists to promulgate the teaching of social and community psychiatry.

REFERENCES:

1. Goldston SE (Ed): Concepts of Community Psychiatry: A Framework for Training, US Department of Health, Education and Welfare Public Health Service, NIMH, Bethesda, MD 1965.
2. Brown DB, Goldman CR, Thompson KS, Cutler DL: Training residents for community psychiatry practice: guidelines for curriculum development. Community Mental Health Journal, 1993;29:271–296.

Issue Workshop 71
CULTURAL ISSUES IN THE PSYCHIATRIC PATIENT

Chairperson: Cletus S. Carvalho, M.D., *Department of Psychiatry, St. Vincent's Hospital, 101 West 15th Street, #3-OS, New York NY 10011-6745*
Participants: Juan E. Mezzich, M.D., Manoj R. Shah, M.D., Pamela Y. Collins, M.D., Keh-Ming Lin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation participants should have a clearer understanding of epidemiological, biological, psychodynamic, psychosocial, and cultural issues relevant to psychiatry in Hispanic, African-American, Asian-Indian, and Far-East-Asian psychiatric patients.

SUMMARY:

Cultural and ethnic differences among patients are important at every stage of psychiatric patient care. From initially engaging the patient to termination of care, in medication management, or long-term psychotherapeutic settings, these factors are always prominent. When recognized and properly used they aid in obtaining successful treatment outcomes and enriching clinical experiences.

This workshop will address cultural (and epidemiological, biological, psychodynamic, and psychosocial) aspects of four major groups: Hispanic, African-American, Asian-Indian, and East-Asian psychiatric patients. Speakers will discuss cultural and other issues relevant to each ethnic group using data and clinical material from their respective practices. Active participation of the audience will be encouraged.

REFERENCES:

1. Gurejeo: Somatization in cross-cultural perspective: a WHO study in primary care; Am J Psychiatry 1997;154:989–995.
2. Hsu LK: Somatoform disorders in Caucasian and Chinese Americans. J Nerv Ment Dis 1997;185:382–387.

Issue Workshop 72
PUNK PRISONS AND JUVENILE JUSTICE REFORM IN THE 1990's

Chairperson: James E. Dillon, M.D., *Child & Adol Psych Hosp., Univ. of Michican Medical Ctr., 1500 East Medical Center Drive, Ann Arbor MI 48109*
Participants: Peter Ash, M.D., Lee H. Rome, M.D., Euphemie A. Brown, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the nature of mandatory waiver; the meaning of "punk" prisons; and the impact of recent juvenile justice reforms.

SUMMARY:

Youth violence has risen dramatically over the past decade, even as crime rates for older groups have fallen. The FBI Uniform Crime Reports for 1995 show 18 years to be the modal age for the most violent crimes: homicide and rape. State legislatures have responded

by reducing the age for mandatory waiver of juveniles to adult court and by constructing the first "punk prisons" for the confinement of youthful "superpredators" until they are old enough to complete their adult sentences in adult correctional facilities. This workshop provides a forum for professionals engaged in the assessment and treatment of juveniles to discuss the impact of these trends on disposition and treatment of delinquent populations in multiple jurisdictions. Three brief presentations will promote discussion. The first (Ash) will review the rationale for and national trends in mandatory waiver statutes. The second (Rome and Brown) will discuss the impact of juvenile justice reform in Michigan, which recently created one of the nation's first "punk" prisons. The third speaker (Dillon) will argue that transfer of youth from training schools to correctional settings may represent a rational social response to forces that traditional mental health and developmental approaches cannot influence.

REFERENCES:

1. Fritsch E, Hemmens C: Juvenile waiver in the United States, 1979-1995. Juvenile & Family Court Journal 1995;45:17–35.
2. Alessi NE, Rome LH: Juvenile deliquency: conceptual and forensic implications of depression. Adv Adolesc Mental Health 1988;3:79–100.

Issue Workshop 73
ATOD-TV (ALCOHOL, TOBACCO AND OTHER DRUGS) AND COMMUNITY ATTITUDES REGARDING DRUG ABUSE
Collaborative Session with the National Institute on Drug Abuse

Chairperson: Tim Condon, Ph.D., *NIDA, 5600 Fishers Lane, Rockville MD 20857*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe the purpose and target audience for an interactive educational program to change public perceptions of drug abuse and addiction; to demonstrate the use of the program; and to explain how the tool is evaluated and the research findings to date.

SUMMARY:

Through funding provided by the National Institute on Drug Abuse (NIDA), the Missouri Institute of Mental Health developed an interactive multimedia program called *ATOD-TV*. This program is designed to educate the public about drug abuse and addiction and the importance of research using television metaphors. For example, *Wheels of Misfortune* is a game show that focuses on the epidemiology of drug abuse. *Verdict* is a courtroom drama about the societal consequences of drug abuse where viewers have the opportunity to make a judgment regarding the guilt or innocence of various drugs and their relationship to crime, violence, disease, and accidents. By interacting with each of these segments, the viewer learns about the causes, symptoms, and treatments for drug abuse.

This innovative workshop will demonstrate the use of this interactive educational tool for changing public perceptions about drug abuse and addiction. Specifically, this will involve providing an overview of the history, implementation, and evaluation of the program in local communities throughout St. Louis. Participants also will be invited to interact with the program by selecting various components displayed and responding to questions posed. Information about how and where to access the program in the future will be made available to participants.

REFERENCES:

1. Koballa TR: Persuasion and attitude change in science education. Journal of Research in Science Teaching. 1992;29:63–80.
2. Myers LS, Vankirk G, Gentry T, Wakefield J: Drug attitude factors: comparisons of samples from 1985 and 1992. Journal of Drug Education 1994;24:207–217.

Issue Workshop 74
DISABLED DOCTORS: INSURERS SEEK A SECOND OPINION

Chairperson: Kenneth L. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts, 55 Lake Avenue North, Worcester MA 01655*
Participant: Barry W. Wall, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to learn about the individual disability insurance industry, recent financial losses within the industry, and the relevance of the industry's current problems to forensic psychiatrists. Workshop participants will learn how to improve their clinical evaluation and report writing style when performing IME's (independent medical evaluations).

SUMMARY:

Individual disability insurance generates over $3 billion a year in premiums for the insurance industry. In the past 10 years, a record number of professionals (mostly physicians) have been going out on claim and staying out for longer periods of time. With increased payouts to disabled physicians, insurance companies have suffered unprecedented financial losses. Reasons for their losses include the subjective nature of disability claims, both psychiatric and nonpsychiatric; particularly liberal policies issued to physicians by insurance companies from 1985–1989; and decreased job satisfaction and falling physician salaries, largely due to managed care. The increase in the number of doctors out on claim has led to more requests for independent medical evaluations (IME's) by insurance companies. It is recommended that forensic psychiatrists performing IME's use collateral information in their clinical assessments and back up their opinions with objective data. The forensic psychiatrist's IME is sometimes used to help settle contested disability claims before they go to trial.

Using case examples, the audience will be asked to propose assessment techniques and to offer opinions on claimants' alleged disabilities and treatment needs. The audience will also be invited to present its own cases, and there will be ample time for questions.

REFERENCES:

1. Enelow AJ: Psychiatric disorders and work function. Psychiatric Annals 1991;21:27–35.
2. Meyerson AT, Fine T: Psychiatric Disability. Washington DC, APPI, 1987.

Issue Workshop 75
WHITE HOUSE CASES: RISK ASSESSMENT AND MANAGEMENT

Chairperson: Robert T.M. Phillips, M.D., *1726 Deacon Way, Annapolis MD 21401-5872*
Participant: Margaret H. Coggins, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the complications and obstacles that arise for all systems that share mutual objectives of violence prevention, protection of national leaders, and provision of mental health services.

SUMMARY:

On a regular basis, persons displaying symptoms of mental illness come to the White House with the intent of meeting with the President or another member of the First Family. It is the responsibility of the Secret Service to handle these White House visitors appropriately by determining if they present a danger to Secret Service protectees, if they have violated so-called federal threat or Presidential protection statutes, and/or if their behavior suggests an acute need for mental health evaluation for commitment or treatment purposes. This workshop will describe research conducted by the Secret Service on White House visitors who were referred for psychiatric admission by the Secret Service during the period 1995 through 1997. The data will include demographic and psychiatric symptom characteristics of subjects and will compare rates of referral for admission with those from the early 1970's. It will also describe symptoms and behaviors that influenced Secret Service decisions to refer the case for commitment evaluation and will examine mental health and arrest histories and the nature of previous investigative contacts with the Secret Service. The workshop will also explore the judicial and civil disposition of the cases in the context of emerging risk-assessment literature.

REFERENCES:

1. Shore D, Filson C, et al: White House cases and the Secret Service, Am J Psychiatry, 1985;142:3.
2. Monahan J: Clinical and actuarial predictions of violence, in Modern Scientific Evidence: The Law and Science of Expert Testimony, Vol. 1, West Publishing Co. St. Paul, MN, 1997.

Issue Workshop 76
ADVOCACY: REACHING THE MEDIA ON MENTAL HEALTH

Chairperson: Edward B. Gogek, M.D., *3116 East Shea Blvd, #115, Phoenix AZ 85028*
Participant: Jim Gogek, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should have a stronger belief in the value and necessity of media advocacy. They should know how to write an opinion piece or letter that will be printed, how to talk to journalists, and how to emphasize the link between psychiatric issues and important news stories.

SUMMARY:

This workshop will promote and teach the skills of media advocacy. Our profession needs frontline psychiatrists to speak out on national problems that are affecting our patients. Psychiatric knowledge should be a significant part of many news stories. But it's not happening because journalists don't understand the link and we're not explaining it to them. The presenters, a journalist and a psychiatrist, write a column on mental illness as a minority issue for the New America News Service, a branch of the New York Times Syndicate. They will review important news stories in which the mental health angle was missed or underreported. These include legislation on crime and Social Security, psychotherapy and managed care, parity, children and violence, and, most of all, stigma. Participants will learn how to educate the public about socially significant psychiatric issues both by writing themselves and by having contact with journalists. The workshop will also provide an inside look at how newspapers work. Suggested guidelines for writing mental health editorials will be covered. The format will be partly lecture, but mostly discussion based on participants' ideas and experiences with advocacy in the media.

REFERENCES:

1. Gogek J, Gogek E: Managed care vs. psychotherapy. San Diego Union-Tribune, May 22, 1997.
2. Gogek J, Gogek E: The last lawful prejudice? Los Angeles Daily Journal, August 16, 1996.
3. Gogek E: "Schizophrenic" shouldn't be used as a term of derision. The Dallas Morning News, Mar 7, 1995, 13A.
4. Gogek J, Gogek E: Using public stigma to limit health care. San Diego Union-Tribune, May 3, 1996, B9.

Issue Workshop 77
PRIVACY OR REIMBURSEMENT? AN UNEXPECTED CHOICE

Co-Chairpersons: Kathleen C. Dougherty, M.D., *Department of Psychiatry, Penn State Medical College, P.O. Box 850, Hershey PA 17033,* Kenneth M. Certa, M.D., *Department of Psychiatry, Jefferson Medical College, 111 South 11th Street, Philadelphia PA 19107-4824,*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe the legal reasoning leading to a waiver of confidentiality privilege, simply by applying for insurance reimbursement, and list the options available to the profession to avoid this unintended consequence.

SUMMARY:

The boundaries of confidentiality of psychiatric records have long been of concern. Various laws have been enacted to safeguard patient confidentiality. A recent preliminary opinion in a Pennsylvania civil suit held that global loss of privilege can occur merely from releasing records to an insurance company for routine reimbursement of psychiatrists' fees. Given that insurance reimbursement plays an increasingly pivotal role in access to treatment, this potential waiver of confidentiality could have enormous consequences.

The government relations committee of the Pennsylvania Psychiatric Society has been asked to address this issue. Two members of the committee will present the legal reasoning that the court used to deny privilege in this way. Possible remedies to protect confidentiality/privilege in these circumstances will be discussed, including the approach that our district branch is planning. Participants will be encouraged to share their opinions of the possible courses of action and to reflect on the potential vulnerability to similar case law decisions in their states.

REFERENCES:

1. APA Board of Trustees: Model law on confidentiality of health and social service records. Am J Psychiatry, 1979;136:138–144
2. Packel L: Pennsylvania's new psychotherapist-client privilege. Pennsylvania Bar Association Quarterly, 1990;61:192–199.

Issue Workshop 78
GAY PSYCHIATRISTS: AN AMSTERDAM PERSPECTIVE

Chairperson: Nicolaas F.J. Hettinga, M.D., *CMHC, Riagg Amsterdam-NRD, Keizersgrach 810, Amsterdam 1017-ED 00220, Netherlands*
Participants: Ruud A.M. Feijen, M.D., Bastiaan L. Oele, M.D., Wilco Tuinebreijer, Piet-Hein Van Ham, Wim Van Der Plaats, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify antihomosexual bias in themselves and in psychiatry in general. Participants will learn from experiences of gay colleagues on various issues.

SUMMARY:

Gay psychiatrists from Amsterdam will share and exchange with the participants their experiences and views on issues concerning homosexuality and psychiatry. Amsterdam is the capital of the Netherlands, a country known for its tolerance on controversial issues. The acceptance and integration of homosexuality in Dutch society seems to be ahead of almost any other society in the Western world. Does this mean that homosexuality is fully accepted and equal to heterosexuality? How does this affect the coming-out process of young homosexuals? Does it have consequences for gay-couples therapy? What are the pros and cons of self-disclosure as a gay psychiatrist? What is the influence of the immigration of large numbers of people from South America, Asia, and Africa with an often hostile attitude towards homosexuality due to their culture and religion? What is the role of gay psychiatrists in the prevention and treatment of gay men with HIV and AIDS? Should psychiatrists play a role in physician-assisted suicide concerning young men dying of AIDS? These will be the topics the presenters will discuss.

REFERENCES:

1. Schippers J: Homoseksuele Identiteiten. Thesis Publishers, Amsterdam, 1996.
2. Cabaj P, Stein TS, (eds.): Textbook of Homosexuality and Mental Health. American Psychiatris Press, Inc., Washington D.C., 1996.

Issue Workshop 79
COMMUNITY THERAPY: TREATMENT FOR SEVERE BPD

Co-Chairpersons: Glenn N. Siegel, M.D., *Department of Psychiatry, Rush University, 2001 Butterfield Rd Ste 320, Downers Grove IL 60515-1050,* Mary J. Pittman, M.S., *Department of Psychiatry, Rush University, 2001 Butterfield Rd Ste 320, Downers Grove IL 60515-1050*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand principles, phases, and application of the community therapy model; to compare, contrast, and explore the utility of this model relative to individual psychotherapy; and to recognize countertransference risks in the treatment of BPD.

SUMMARY:

The symptomatic presentation of borderline personality disorder has compelling interpersonal dynamics driven by abandonment anxiety. These dynamics are designed either consciously or unconsciously to elicit responses that can be experienced by the patient as compassionate, nurturing, and soothing. When these responses are not forthcoming, the patient may reach a state of desperation expressed through communication of urgency and risk. As a result the therapist often feels compelled, intimidated, or threatened into providing increased contact and/or protective measures. If the therapist completes this enactment, a destructive interpersonal process is perpetuated and solidified. This workshop offers an effective outpatient alternative to individual psychotherapy in the treatment of severe BPD. The community therapy model, developed and utilized by the presenters, will be defined and phases of treatment delineated with an emphasis on managing abandonment-related dynamics, inherent risk factors, and resistance. Workshop participants will be asked to share relevant case material to which principles of community therapy will be applied in a discussion format.

REFERENCES:

1. Higgitt A, Fonagy P: Psychotherapy in borderline and narcissistic personality disorder. British Journal of Psychiatry, 1992;161:23–43.
2. Quaytman M, Sharfstein SS: Treatment for severe borderline personality disorder in 1987 and 1997. Am J Psychiatry 1997;154:1139–1144.

Issue Workshop 80
AVOIDING ADMISSION: PSYCHIATRIC HOME CARE

Chairperson: David S. Heath, M.B., *Department of Psychiatry, Grand River Hospital, 424 Clairbrook Crescent, Waterloo, ONT N2L 5V7, Canada*
Participants: James Holland, M.S.W., Subaida Hanifa, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe how seriously ill psychiatric patients can be treated at home instead of in the hospital, and to draw up a plan for such a psychiatric home care service in participants' own communities.

SUMMARY:

In the era of managed care, alternatives to hospital admission for psychiatric patients are urgently needed. Psychiatric home care (PHC) provides such an alternative. PCH has been evaluated in 12 studies in the U.K., Australia, Canada, and the U.S., and has been shown to be as effective and cheaper than hospital care for two-thirds of patients.

Participants will learn how this method of health care delivery works through an examination of the Hazelglen Service—a PCH program that started in 1990. They will learn how PCH could work in their own community.

REFERENCES:

1. Fenton FR, Tessier L, Struening EL, et al: Home and Hospital Psychiatric Treatment, University of Pittsburgh Press, 1982.
2. Burns T, Beadsmoore A, et al: A controlled trial of homebased acute psychiatric services. I: clinical and social outcome. British Journal of Psychiatry 1993;163:49–54.

Issue Workshop 81 Cancelled

Issue Workshop 82
INVOLUNTARY CASE MANAGEMENT FOR THE MENTALLY ILL

Chairperson: Howard W. Telson, M.D., *Department of Psychiatry, Bellevue Hospital, 215 East 24th Street #321, New York NY 10010-3804*
Participants: David C. Lindy, M.D., Neil Pessin, Ph.D. Debra Poenisch, B.A. Diana Simons, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the clinical, legal, and ethical principles underlying outreach to and court-mandated case management for the seriously and persistent mentally ill living in the community.

SUMMARY:

The theory of paternalism asserts that the state has the right to restrict an individual's liberty when it is acting for the person's own good. This theory served as the traditional basis for the commitment of nondangerous mentally ill individuals to hospital care. Community care was offered on a voluntary basis and was therefore available only to those who requested it.

Beginning in the 1960's deinstitutionalization became the dominant social policy, and commitment laws were amended to allow for the forced treatment only of individuals who were deemed dangerous to self or others. As a result, many seriously and persistently mentally ill individuals who had limited insight into their need for treatment or who resisted or refused treatment entered the community. Many of these individuals became homeless, deteriorated while living in the community, and/or required repeated rehospitalizations.

Over the past 30 years case management has been developed to meet the needs of the seriously mentally ill living in the community. While many patients respond to the outreach orientation of these services, the legal basis of this clinical approach has always been unclear. Furthermore, some patients object to what they perceive to be an intrusion into their privacy and a meddling in their affairs. Outpatient commitment has recently allowed court-ordered case management for patients who are resistant to these services.

This workshop will examine the clinical, legal, and ethical theories underlying outreach-oriented case management for seriously mentally ill individuals living in the community. It will also explore the implementation of outpatient commitment to case management in New York City. Two case managers will describe their experiences and views of providing services to resistant clients. Participants will be encouraged to share their views and experiences of outreach work and involuntary case management in the community.

REFERENCES:

1. Stone AA: Psychiatry as morality, in Law, Psychiatry and Morality, Washington, D.C., American Psychiatry Press, Inc., 1984, pp. 237–250.
2. Tavolaro KB: Preventive outpatient civil commitment and the right to refuse treatment: can pragmatic realities and constitutional requirements be reconciled?" Medicine and Law 1992; 11:249–267.

Issue Workshop 83
WHEN CLOZAPINE ALONE IS NOT ENOUGH

Chairperson: Jean-Pierre Lindenmayer, M.D., *Department of Psychiatry, Manhatten Psychiatric Center, Ward's Island, Dunlop 14A, New York NY 10035*
Participants: John W. Rosenberger, M.D., Richard P. Brown, M.D., Richard H. McCarthy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be knowledgeable about adjunctive treatment strategies for patients who have an incomplete response to clozapine and who have side effects interfering with optimal clozapine response.

SUMMARY:

Clozapine remains the most important pharmacological treatment for patients with refractory schizophrenia, based on demonstrated efficacy in a double-blind study. However, a significant number of patients treated with clozapine respond only partially or with significant side effects. Some of these partial responders can be converted to full responders with various augmentation strategies. Unfortunately, there are no controlled studies either to guide clinicians in deciding which augmentation strategy to choose for what type of patient or to inform clinicians about the efficacy of such strategies. While anecdotal reports indicate that augmentation strategies have been successfully used by a number of clinicians, they are not available in any systematic format to the average clinician. The aim of this panel is to bring together some expert clinicians who use clozapine extensively in treatment-refractory patients to present their best clozapine augmentation strategies and to discuss possible partial-responder treatment algorithms. Specific strategies to be discussed are the addition of typical and other atypical antipsychotics, anticonvulsants, and antidepressants. In addition, strategies to manage side effects that interfere with compliance and efficacy will also be reviewed. Discussion with audience participation will focus on sharing experiences with such augmentation strategies in various clinical settings.

REFERENCES:

1. Szedgedi A., Wiesner J., Hiemke C: Improved efficacy and fewer side effects under clozapine treatment after addition of fluvoxamine. J Clin Psychopharmacol 1995;15:141–143.
2. Lieberman J., Kane J., Johns C: Clozapine guidelines for clinical management. J Clin Psychiatry 1989;50:329–338.

Issue Workshop 84
GROUP THERAPY: MAKING UNTREATABLE PATIENTS TREATABLE
Joint Session with the American Group Psychotherapy Association, Inc.

Co-Chairpersons: C. Donald Williams, M.D., *402 East Yakima Ave. Suite 330, Yakima WA 98901* Miguel A. Leibovich, M.D., *83 Cambridge Park Way, #609W, Cambridge MA 02142*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to define advantages group therapy offers for treatment of personality disorders. The participant will learn how to explain group therapy to patients and how to establish a treatment contract. Guidelines for integrating medication and individual therapy will be reviewed.

SUMMARY:

Patients referred for psychiatric treatment often have personality disorders; the incidence may be as high as 80%. These conditions complicate the treatment of comorbid conditions such as major depressive episodes, anxiety disorders, and pain disorders. Long-term treatment is usually necessary for these individuals, but both cost factors and patient resistance commonly make this impractical. Group therapy can overcome these difficulties because of the unique nature of its therapeutic process and its relative affordability. Group therapy provides a therapeutic setting in which the patients can "have" the problems that cause them pain and failure in their outside life, with less of the shame and narcissistic injury that evokes powerful resistance in individual treatment. The group as a whole becomes a safe, effective, and incorruptible container of the affects that otherwise lead to acting out. Other advantages include a richer transference field that brings to the surface unresolved family, sibling, and peer issues in addition to the dyadic issues accessed by individual treatment. Less psychologically minded patients benefit from the initially more familiar social aspect of group therapy and can learn concretely from other patients who have successfully resolved issues similar to the ones they are confronting.

The audience and the panelists will review two treatment cases and, by means of an interactive exchange, utilize the principles outlined above to formulate a treatment plan incorporating group therapy. Specific attention will be accorded the process of integrating other treatment modalities, including individual therapy, substance abuse treatment, and pharmacotherapy.

REFERENCES:

1. Alonso A, Rutan J: Character change in group psychotherapy. Int J Group Psychother 1993;43:439–451.

2. Azima F: Group psychotherapy with personality disorders. Comprehensive Group Psychotherapy, Kaplan and Sadock, eds., Third Ed., Baltimore, Williams and Wilkins, 1993, pp. 393–406.

Issue Workshop 85
WORKFORCE AND RECRUITMENT: WE CAN MAKE A DIFFERENCE

Co-Chairpersons: Francis G. Lu, M.D., *Department of Psychiatry, University of CA at SF, 1001 Potrero Avenue, San Francisco CA 94131*, Lisa A. Mellman, M.D., *Columbia University, NY State Psychiatric Institute, 722 West 168th Street, Box 63, New York NY 10032*
Participants: Nalini V. Juthani, M.D., Kenneth S. Thompson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the current workforce demographics and projections as well as the importance of recruitment to the field of psychiatry; to understand the AADPRT-led consortium recruitment effort; to recognize recruitment barriers and strategies for the participants' educational programs.

SUMMARY:

This presentation by the American Association of Directors of Psychiatric Residency Training (AADPRT) Workforce Committee will review the latest trends in workforce and recruitment. These include the continued recruitment of graduates of U.S. medical schools and IMG's in relatively equal proportion, current and proposed legislation to reduce the percentage of physicians and specialists trained, and the potential impact on our residency programs. Now more than ever the AADPRT Action Plan to recruit the best and the brightest into psychiatry is essential to ensure that we maintain our ranks as well as quality. This plan includes a consortium effort between AADPRT, the Association for Academic Psychiatry, the American Academy of Child and Adolescent Psychiatry, and the Association of Directors of Medical Student Education in Psychiatry. Participants will be updated on the latest results of the Action Plan, recruitment barriers, and the recruitment strategies that are novel and successful, including those linking the American Medical Student Association to the American Association of Community Psychiatrists. Participants will have the opportunity to discuss these national efforts as well as recruitment barriers and strategies relevant to their own educational programs.

REFERENCES:

1. Kay J (ed.): Handbook of Psychiatric Residency Training and Education. Washington, D.C.: American Psychiatric Press, 1998.
2. Scully J: Why be concerned about recruitment? Am J Psychiatry. 1995;152:1413–1414.

Issue Workshop 86
LEADERSHIP: THE CHALLENGE FOR THE 21ST CENTURY

Co-Chairpersons: Edgardo L. Perez, M.D., *Executive Vice President, Chief Staff Homewood Hlth Ctr, 150 Delhi St, Guelph, ONT N1E 6K9, Canada* Diane K. Whitney, M.D., *Homewood Health Center, 150 Delhi St., Guelph, ONT N1E 6K9, Canada*
Participant: Kenneth I. Shulman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have an understanding of characteristics that define successful physician leaders; leadership skills and knowledge required for the changing health care system; and the resources for further development of leadership skills.

SUMMARY:

With the changes in health care delivery in Canada and the United States it is time for a higher degree of physician leadership. Since physicians have traditionally functioned autonomously in clinical practice, they will need to acquire knowledge and skills to become involved with team work in organizations and assume leadership positions. The workshop will begin with a case presentation outlining revolutionary change in a university hospital department of psychiatry, and participants will be involved in the discussion. Brief presentations outlining the characteristics of effective leadership and conceptual models of organizational change will be presented for discussion. A model for creating a personal and professional action plan will be presented. Participants will identify several key competencies that they need to develop and begin the process of setting goals for themselves during the workshop. There will be an opportunity for discussion of action plans. At the conclusion of the workshop participants will be provided with resources where they can further develop their leadership skills.

REFERENCES:

1. Merry MD: Physician Leadership for the 21st Century. Qual Manag Health Care 1993;1:31–41.
2. O'Connor KE: The best leaders. Physician Executive 1997;23:4–8.

Issue Workshop 87
CULTURAL ISSUES IN PSYCHIATRIC TRAINING AND PRACTICE

Chairperson: Cletus S. Carvalho, M.D., *Department of Psychiatry, St. Vincent's Hospital, 101 West 15th Street, #3-OS, New York NY 10011-6745*
Participants: Pedro Ruiz, M.D., Nyapati R. Rao, M.D., Henry Chung, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to understand cultural issues pertinent to psychiatrists in the United States, how these impact on their functioning as practitioners and residents in training, and strategies to incorporate these factors into the practice of psychiatry.

SUMMARY:

Psychiatrists in the United States are a culturally, racially, and ethnically diverse group of professionals. Those who've always resided in the U.S. have had to adopt a combination of American and their own native cultures, while others who've immigrated have had to adapt to America after being brought up in cultures that may have been vastly different. These cultural differences if not properly recognized can significantly influence many areas of the interaction between psychiatrists and their patients and issues among psychiatrists themselves.

This workshop addresses such issues in four major groups of psychiatrists: Hispanic, African-American, Asian-Indian, and East-Asian psychiatrists. Speakers will discuss aspects relevant to each of these groups and highlight how these factors interplay in psychiatric residency, psychiatric practice, and patient care. Active participation by the audience will be encouraged as issues raised during discussion will affect psychiatrists of all cultural backgrounds at different career levels.

REFERENCES:

1. Fiscella K: Being a foreigner, I may be punished if I make a small mistake: assessing transcultural experiences in caring for patients; Fam Pract 1997;14:112–116.

2. Chung H: Ethnocultural factors in the development of an Asian-American psychiatrist; Cult Diversment Health 1996;2:99–106.

Issue Workshop 88
BECOMING A PSYCHIATRIST IN THE NEW MILLENNIUM

Chairperson: Daniel P. Dickstein, M.D., *500 Angell Street #703, Providence RI 02906*
Participants: Timothy Bondurant, M.D., Courtney Waltrip, M.D., Leah J. Dickstein, M.D., Beverly Young

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand issues common to psychiatric residents and fellows as they transition from medical school to residency and onward to fellowships and/or psychiatric practice.

SUMMARY:

Each year, hundreds of medical students embark upon a residency training program in psychiatry. With them they bring hopes, dreams, aspirations, and fears about residency training, some of which are warranted and some not. This workshop will explore the issues relating to the transformation from medical student to psychiatrist in the following manner. First, panelists representing various stages of training will discuss their unique experiences and concerns. Dr. LJ Dickstein will discuss her experiences and concerns in mentoring developing psychiatrists. Then, the audience will be engaged in an interactive session designed to promote sharing of experiences, concerns, and innovative solutions for such concerns. Discussion will also explore the effect of residency training upon individual identity, professional identity within a medical facility, and social identity as it relates to family, friends, and significant others.

REFERENCES:

1. Messner E: Resilience Enhancement for the Resident Physician. Essential Medical Information Systems, Inc. 1993.
2. Mogul KM, Dickstein LJ: Career Planning for Psychiatrists. Washington DC, American Psychiatric Association Press, Inc. 1995.

Issue Workshop 89
SPIRITUALITY, FAITH, AND MENTAL HEALTH: AN ISLAMIC VIEW
Joint Session with the World Islamic Association of Mental Health

Chairperson: S. Arshad Husain, M.D., *Department of Psychiatry, University of Missouri, N119 Health Science Center, Columbia MO 65212-0001*
Participants: Jafer H. Qureshi, M.D., Rashid Chaudhry, M.D. Osama M. Alradi, M.D. Afzal Javaid, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will have the opportunity to teach the definitions and details of spirituality and faith's role in achieving and maintaining mental health. It is hoped that the participants will be able to use this knowledge in dealing with their Muslim patients.

SUMMARY:

Each major religion of the world has its own quest for spirituality and wellness. The religious quest in general tells us about the basic human make up, its inner weaknesses, potential qualities, and the need for a set of guiding principles for leading a meaningful life and attaining a healthy state of mind. In this workshop the speakers will discuss the spiritual and moral system of Islamic faith and the value Islam places to the spiritual, mental, and physical health of mankind. It is hoped that through this discussion the audience will develop some understanding of Islamic spiritual principles and will be able to use this knowledge in helping their Muslim patients.

REFERENCES:

1. Fazlur R: Health and Medicine in the Islamic and Tradition, Cross Road Publication, New York, 1987.
2. Husain SA: Muslim and mental health from Islamic perspective, in Handbook on Religion and Mental Health, Koenig HG, ed., Academic Press, San Diego (In Press).

Issue Workshop 90
PSYCHOTHERAPY IN THE 21ST CENTURY

Chairperson: Malkah T. Notman, M.D., *Department of Psychiatry, Cambridge Hospital, 54 Clark Road, Brookline MA 02146*
Participants: Martha J. Kirkpatrick, M.D., Susan G. Lazar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to assess the role of psychotherapy in the current range of options and constraints regarding treatments and recognize where and when its use is appropriate.

SUMMARY:

Major changes are occurring in the structure of the support for psychotherapy. Reimbursement within managed care, constraints on psychotherapy by HMO's, economic pressure for even briefer therapy, and a reliance on psychopharmacology have undermined the importance of psychotherapy. Nevertheless, psychotherapy remains one of the most effective treatments for many conditions and is attracting new interest as an important component of comprehensive treatment. How do we understand its value as the end of the century approaches? This workshop will discuss some key aspects of psychotherapy in this context. The following topics will be addressed: effectiveness and cost-effectiveness of psychotherapy, psychotherapy training, and psychotherapy and feminism. Audience participation will be encouraged.

REFERENCES:

1. Nadelson C, Notman M: Gender issues in psychiatric treatment, in Gabbard G. ed., Treatments of Psychiatric Disorders, 2nd Edition, Washington DC, APPI, 1995, pp. 35–53.
2. Gabbard G: Psychodynamic psychotherapies. In Gabbard, G. ed., Treatments of Psychiatric Disorders, 2nd edition, Washington DC, APPI, 1995, pp. 1205–1220.

Issue Workshop 91
INTERVENTION PROGRAMS FOR MEDICAL STUDENT STRESS

Co-Chairpersons: Paul K. Dagg, M.D., *Department of Psychiatry, University of Ottawa, 1145 Carling Avenue, Ottawa, ONT K1Z 7K4, Canada* Mark H. Ujjainwalla, M.D., *122-1929 Russell Road, Ottawa, ONT K1Z 7K4, Canada*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the impact of stress on medical students, discuss various intervention strategies, and understand the barriers to implementation of programs, including possible solutions.

SUMMARY:

The prevalence of stress and distress in medical students has been recognized for several years with a variety of programs described in the literature. The facilitators will present a range of interventions developed at the University of Ottawa, including curricula aimed at increasing awareness among students and preventing or moderating distress. The experience of providing direct treatment and the resultant programs developed to facilitate detection and intervention will also be presented, along with the facilitators' experience of barriers to implementation of these programs. The goal of these brief presentations is to stimulate discussion among the participants about alternative programs and experiences with implementation. The participants will review all these experiences to brainstorm about new models for intervention and methods to deal with barriers that may arise.

REFERENCES:

1. Sheehan KH, Sheehan DV, White K, Leibowitz A, Baldwin DC: A pilot study of medical student "abuse": student perceptions of mistreatment and misconduct in medical school. JAMA 1990;263:533–537.
2. Hays LR, Cheever T, Patel P: Medical student suicide, 1989–1994. Am J Psychiatry 1996;153:553–555.

Issue Workshop 92
A COMPARISON OF EUROPEAN AND AMERICAN PSYCHIATRY

Co-Chairpersons: Michael A. Schwartz, M.D., *Department of Psychiatry, Case Western Reserve Univ., 34650 Cedar Road, Gates Mills OH 44040,* Bill Fulford, M.D., *Dept. of Philosophy, University of Warwick, Coventry CV4 7AL, United Kingdom*
Participants: Jean Naudin, M.D., Donald M. Mender, M.D., Elena B. Bezzubova, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to recognize the main controversions of the relationship between American and European psychiatry and to understand the humanistic orientation to synergism of the international perspectives and national traditions.

SUMMARY:

The workshop focuses on the role of interactions between American and European psychiatry as a crucial point for contemporary perspective of psychiatric practice as well as theory. This problem is concentrated with a number of controversial views including scientific, academic, social, philosophical, ethics, educational, and political issues. Two trends may be observed. Psychiatrists of the first trend adopt the pragmatism of international models of American psychiatry. Psychiatrists of the second trend—including not only Europeans but also Americans—emphasize the differences between American and European psychiatry. We aim to discover principle controversions and to outline their character and cultural causes, to discuss their backgrounds and ways to overcome them. If American psychiatry holds sway in the world today, does its dominance only reflect economic power or rather scientific, social, and humanistic achievements of the American mental health care system? But the project orients to a larger goal—an understanding of the potential conceptual synergies between American and European psychiatry. This requires not only political cooperation, but also philosophical, ontological daring. International and national psychiatric classification as the core of theoretical disputes will be analyzed. Presentations of American and European colleagues sharing different opinions will encourage the audience to present personal points, disputes, and offer vistas to fruitful development and cooperation of international and national psychiatry.

REFERENCES:

1. Kleinman A, Kohen A: Psychiatry's global challenge. Scientific American. 1997;3:86–89.
2. Mishara AL, Schwartz MA: Conceptual analysis of psychiatric approaches. Current Opinion in Psychiatry. 1995;8:312–316.

Issue Workshop 93
OUTPATIENT COMMITMENT: THE NEW YORK EXPERIENCE

Chairperson: Howard W. Telson, M.D., *Department of Psychiatry, Bellevue Hospital, 215 East 24th Street #321, New York NY 10010-3804*
Participants: Manuel Trujillo, M.D., Luis R. Marcos, M.D., Michael S. Lesser, M.D. Henry J. Steadman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) understand the clinical and legal theories underlying outpatient commitment, (2) understand Bellevue Hospital Center's implementation of the New York State outpatient commitment pilot program, and (3) understand the data of the first three years of New York's pilot program.

SUMMARY:

Over the past 40 years the treatment of seriously and persistently mentally ill individuals has shifted from hospitals to the community due to a variety of changes in mental health practice, law, and policy. One consequence of this has been the so-called "revolving door" syndrome, whereby some psychiatric patients become noncompliant with treatment and require repeated acute hospitalizations in order to regain stability. Outpatient commitment is a controversial intervention that has been developed to compel patients to accept treatment and thereby maintain community tenure.

In 1994 New York state passed legislation calling for a three-year pilot program to provide "involuntary outpatient treatment of mentally ill persons." The law also mandated an independent study to evaluate the program's success in preventing relapse and also participant satisfaction. In 1997 the pilot was statutorily extended for one year.

This panel workshop will describe Bellevue Hospital Center's implementation of the program since July 1995. It will also describe the outcome study being conducted by Policy Research Associates. It will review the first three years of clinical data and provide preliminary conclusions regarding outcome from the perspectives of clinicians, patients, family members, and government officials. Audience participation will be encouraged.

REFERENCES:

1. Swanson JW, Swartz MS, George LK, Burns BJ, et al. Interpreting the effectiveness of involuntary outpatient commitment: a conceptual model. J Am Acad Psychiatry Law 1997;25, 5–16.
2. Torrey EF, Kaplan RJ: A National survey of the use of outpatient commitment. Psychiatric Services 1995;46, 778–784.

Issue Workshop 94
MATCHING DRUG-ADDICTED PATIENTS TO SERVICES
Collaborative Session with the National Institute on Drug Abuse

Chairperson: Pete Delany, D.S.W., *Services Research, NIDA, 5600 Fishers Lane, Rockville MD 20857*
Participants: David R. Gastfriend, M.D., Andrea Barthwell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) define the purpose and structure of the Patient Placement

Criteria (PPC) for the Treatment of Substance-Related Disorders developed by the American Society of Addiction Medicine (ASAM), (2) describe the validity of the PPC as a tool to adequately match patients to appropriate treatment modalities, (3) describe current efforts to match patients to services and the implications for practitioners, (4) discuss how each approach can be utilized to enhance clinical practice settings.

SUMMARY:

By the end of the 1980's, various sets of drug abuse treatment patient placement criteria were in use by various insurers and utilization management firms. In an effort to develop one national set of criteria that could be accepted by employers, purchasers, and providers, the American Society of Addiction Medicine (ASAM) developed the Patient Placement Criteria (PPC) for the Treatment of Substance-Related Disorders. Building on current findings, researchers are examining how to improve the match between the service needs of patients and the services available.

Through the use of didactic presentations and group discussions, this workshop will examine (1) the purpose and structure of the Patient Placement Criteria (PPC) for the Treatment of Substance-Related Disorders developed by the American Society of Addiction Medicine (ASAM), (2) the validity of the PPC as a tool to adequately match patients to appropriate treatment modalities, (3) emerging trends in patient-service matching, and (4) approaches for utilizing the PPC and service level information in clinical practice settings. Information presented will be based on recent health services research supported by the National Institute on Drug Abuse (NIDA). Relevant publications developed by NIDA will be provided to workshop participants.

REFERENCES:

1. Gastfriend, DR, Najavits, LM, Reif, S: Assessment instruments. In Principles of Addiction Medicine. Edited by Miller N., Chevy Chase, MD, American Society of Addiction Medicine, 1994.
2. American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders. (2nd Edition). Chevy Chase, MD, 1996.

Issue Workshop 95
ETHICS IN MANAGING DEPRESSION DURING PREGNANCY

Chairperson: John H. Coverdale, M.D., *Dept of Psychiatry, Univ of Auckland Med School, Private Bag, Auckland 00224, New Zealand*
Participant: Laurence B. McCullough, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to apply ethically justified strategies to the management of depression during pregnancy.

SUMMARY:

Diagnosable depression occurs commonly during pregnancy with prevalence estimates varying from 4% to 18%. Depression is associated with several possible adverse consequences for pregnancy including fetal growth retardation, a failure to attend for antenatal care, and suicidal thoughts and behavior. Depression can also influence a woman's decision to continue a pregnancy or terminate it in an abortion.

The management of the depressed pregnant patient may pose very challenging and controversial ethical dilemmas to psychiatrists, particularly as it applies to decisions concerning abortion. In this workshop, I will emphasize the clinical ethical issues of importance when depression occurs during pregnancy. Workshop participants will evaluate the appropriateness of various possible management responses to the depressed pregnant patient, including those based on the assumption that depressed patients may manifest "chronically and variably impaired autonomy." Appropriate uses of directive and non-directive counseling will be addressed. Case examples will illustrate the principles at stake, and workshop participants are encouraged to bring their own cases for discussion.

REFERENCES:

1. Coverdale JH, Chervenak F, McCullough LB, Bayer T: Ethically justified clinically comprehensive guidelines for the management of depression during pregnancy. Am J Obstet Gynecol 1996;174:169–173.
2. Coverdale JH, McCullough LB, Chervenak F, Bayer T: Clinical implications and management strategies when depression occurs during pregnancy. Aust and New Zealand J of Obstet Gynecol 1996;36:424–429.

Issue Workshop 96
INSANITY LAWS AND PERSONALITY DISORDERS

Chairperson: Alan R. Felthous, M.D., *Dept of Psychiatry, U Of Tx Medical Branch, 301 University Blvd., Galveston TX 77550*
Participants: Ernest S. Barratt, M.D., John M.W. Bradford, M.B., Henning Sass, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to explain the current knowledge about neuroendocrine and neurophysiological findings in offenders with antisocial personality disorders and the extent to which insanity laws in the United States, Canada, and Germany allow for or exclude personality disorders.

SUMMARY:

Insanity laws in the United States exclude conditions manifested only by repeated criminal behavior as a qualifying mental illness or mental defect, and this is widely understood as excluding antisocial personality disorder (APD), if not personality disorders in general. DSM-IV criteria for antisocial personality disorder are essentially behavioral. However, a growing body of literature shows that metabolic and physiological factors are associated with impulsive aggression and conversely impulsive aggression may represent a disorder manifested by more than untoward behaviors alone. Dr. John Bradford will summarize the scientific literature on the relationship between neurotransmitters and specific behaviors and/or personality traits. He will comment on how Canadian insanity laws deal with personality disorders. Dr. Sass will present German concepts of personality disorder that would qualify for an insanity defense in the Federal Republic of Germany. Dr. Barratt will present recent laboratory research demonstrating that profiles of behavioral, cognitive, and electrophysiological brain measures were related differently to impulsive and premeditated behaviors, respectively. All of these subjects had antisocial personality disorders but no other mental disorders. Finally, Dr. Felthous will summarize U.S. statutory and case law for types of disorders or conditions that are excluded from the insanity defense including conditions of impulsive aggression.

REFERENCES:

1. Bradford JMW: The role of serotonin in the future of forensic psychiatry. The Bulletin of the American Academy of Psychiatry and the Law 1996;24(1):57–72

2. Barratt ES, Stanford M, Kent TA, Felthous AR: Neuropsychological and cognitive psychophysiological substrates of impulsive aggression. Biological Psychiatry 1997;41:1047–1061

Issue Workshop 97
MEDICOLEGAL IMPLICATIONS OF NOVEL ANTIPSYCHOTICS

Co-Chairpersons: Douglas Mossman, M.D., *359 Signalfire Drive, Centerville OH 45458,* Douglas S. Lehrer, M.D., *359 Signalfire Dr, Centerville OH 45458-3635*

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should (1) be familiar with several potential ethical and legal issues that have resulted from recent pharmacological advances in treatment of psychoses and (2) be able to describe ways of addressing these issues.

SUMMARY:

"Novel" antipsychotic medications appear to offer patients the benefits of older neuroleptics with lower risks of side effects. This therapeutic advance raises several new medicolegal issues:

- Have the new antipsychotics changed the standard of care, such that even the proper use of traditional neuroleptics poses a liability risk (e.g., related to tardive dyskinesia) that did not previously exist?
- Does the use of older agents require a specific indication (e.g., a demonstrated need for an injectable preparation)?
- Can one ever justify use of older agents when a patient displays prominent negative symptoms?
- In light of the Osheroff case, may clinicians forego telling patients and their families about new, less risky antipsychotics?
- Should the availability of more benign drugs alter legal decision-makers' attitudes toward patients' right to refuse treatment?
- Does the higher per-dose cost of a new medication (a cost often borne by taxpayers, not patients) justify an institutional policy against its use as a first-line drug?
- Would pharmacoeconomic studies support such a policy?
- If so, how should clinicians balance duties to individual patients with the duty to use public resources judiciously?

Workshop presenters will introduce and discuss these questions and will invite participants to share their views, comments, and experiences.

REFERENCES:

1. Tollefson GD, Beasley CM, Tran PV, Street JS, et al: Olanzapine versus haloperidol in the treatment of schizophrenia and schizoaffective disorders: results of an international collaborative trial. Am J Psychiatry 1997;154:457–465.
2. Chouinard G, Jones B, Remington G, et al.: A Canadian multicenter placebo-controlled study of fixed doses of risperidone and haloperidol in the treatment of chronic schizophrenic patients. J Clin Psychopharmacol 1993;13:25–40.

Issue Workshop 98
EMPLOYMENT DISABILITY AND ACCOMMODATION DILEMMAS

Chairperson: Harold J. Bursztajn, M.D., *Department of Psychiatry, Harvard Medical School, 96 Larchwood Drive, Cambridge MA 02138-4639*
Participants: Patricia Illingworth, J.D., Margaret Somerville, M.D., Michael L. Perlin, J.D., Rodney J.S. Deaton, M.D., J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should (1) be prepared to forensically evaluate "chronic fatigue," "fibromyalgia," "multiple chemical sensitivity," as alleged medical causes of employment-related disability and accommodation claims, and (2) be able to identify iatrogenic or administrative causes of medical and psychiatric impairment such as managed care denial of treatment benefits.

SUMMARY:

The continuing evolution of administrative guidelines and judicial rulings regarding the nature and extent of Americans with Disabilities Act (ADA)-mandated employer accommodations of persons suffering from disability by reason of mental illness, challenges psychiatrists to bring professional expertise to an area of public controversy. Psychiatrists who consult with patients or their employers regarding employment-disability-related issues must be clear of the potential clinical, ethical, and legal pitfalls that can compromise their objectivity as professionals. Participants will be provided with the opportunity to explore with panelists with forensic, ethical, and legal expertise case-related concerns such as how to define a clinician's or consultant's role and agency to assure objectivity, how to identify employment disability and accommodation-related ethical dilemmas, and how to preserve fundamental professional values in the midst of adversarial proceedings. Among current special interest areas that presenters will explore with participants is the growing role of forensic psychiatrists in examining claims at the border of psychiatry and other medical specialties, e.g., "multiple chemical sensitivity syndrome." Another cutting edge issue to be addressed is the forensic psychiatrist's role in identifying employment disability secondary to managed health care organization (MCO) denial of psychiatric or other medical benefits.

REFERENCES:

1. Bursztajn HJ, Scherr AE, Brodsky A: The rebirth of forensic psychiatry in light of recent historical trends in criminal responsibility. Psychiat Clinics N Am. 1994;17:611–635.
2. Perlin ML: Mental Disability Law: Civil and Criminal. Vol. I-III. Charlottesville, Virginia: The Miche Company, 1989.

Issue Workshop 99
CULTURAL COMPETENCE AND THE HAITIAN PATIENT

Co-Chairpersons: Jacques Vital-Herne, M.D., *Department of Psychiatry, Hillside Hospital, 7559 263rd Street, Glen Oaks NY 11004-1150,* Pierre A. Jean-Noel, M.D., *Dept of Psychiatry, Brookdale Hospital, 1 Brookdale Plaza, Brooklyn NY 11212*
Participants: Jean B. Tropnas, M.D., Georges J. Casimir, M.D., Joel Pierre-Louis, M.D

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate the impact of cultural issues on the evaluation, diagnosis, and treatment of the Haitian patient.

SUMMARY:

The flow of Haitian immigrants to the United States and Canada has been steady during the past four decades. Multiple cultural factors must be taken into account by health workers when caring for Haitian patients. This workshop will use a longitudinal model to address some of these issues. Dr. Jean-Noel will discuss cultural factors that may affect the child and adolescent Haitian in a clinical setting. Dr. Tropnas will review issues pertaining to adults. Dr. Casimir will present specific issues relating to the elderly Haitian patient. Dr. Pierre-Louis will offer a summation of how a Haitian family deals with severe mental illness in a relative. This workshop will facilitate exchange of information and experiences among psychiatrists treating Haitians in different geographic areas.

REFERENCES:

1. Bibb A, Casimir G: Haitian families. In Ethnicity and Family Therapy. Edited by McGoldrich M, et al. NY, Guilford Press, 1996.
2. Gaw A (Ed): Culture, Ethnicity and Mental Illness. Washington DC, American Psychiatric Press, Inc., 1992.

Issue Workshop 100
TRAINING FOR PSYCHIATRIC ADMINISTRATION Joint Session with the American Association of Psychiatric Administrators

Co-Chairpersons: L. Mark Russakoff, M.D., *Department of Psychiatry, Phelps Memorial Hospital, 701 North Broadway, North Tarrytown NY 10591,* Paul A. Rodenhauser, M.D., *Department of Psychiatry, Tulane Univ School of Medicine, 1430 Tulane Avenue, SL-23, New Orleans LA 70112-2699*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe how multidisciplinary teams may be used as a mechanism to train residents in psychiatric administration, and outline the basic knowledge and skills necessary for psychiatric administrators.

SUMMARY:

The practice of psychiatric administration has become increasingly complex over the past few decades with an escalation in the complexity as managed care has evolved. The approach of carving out psychiatric benefits from others has administrative and practice implications of which psychiatrists must be mindful. The training of most psychiatric residents involves participation in multidisciplinary teams, which can be utilized to teach principles of psychiatric administration. Nevertheless, there is more specific training in leadership that may be useful, if not necessary in these complex and stressful times. An outline of the core knowledge and skills needed to function effectively as a psychiatric administrator will be described. The presentations will encourage participation from the audience to facilitate learning relevant material from the presenters as well as from the audience.

REFERENCES:

1. Ranz J, Eilenberg J, Rosenheck S.: The psychiatrist's role as medical director: task distributions and job satisfaction, Psychiatric Services, 1997;48:915–20.
2. Talbott JA, Hales RE, Keill SL, (eds.): Textbook of Administrative Psychiatry. Washington, DC: American Psychiatric Press, Inc:, 1992.

Issue Workshop 101
UNWELCOME TREATMENT? TREATING THE MANDATED PATIENT

Chairperson: Susan Stabinsky, M.D., *Department of Psychiatry, Bronx-Lebanon Hospital, 2432 Grand Concourse, Ste 201, Bronx NY 10456*
Participants: Harvey Stabinsky, M.D., Michael M. Scimeca, M.D., David W. Preven, M.D., Ali Khadivi, Ph.D.

EDUCATIONAL OBJECTIVE:

At the end of the presentation the participant should be able to delineate areas of focus to define and address pertinent to patients who are either legally mandated into treatment or coerced into treatment by a possible legal threat or by a family situation.

SUMMARY:

This workshop will explore the issues that arise when patients are by one means or another forced into treatment.

Patients are not infrequently mandated by the courts to attend outpatient treatment to achieve certain goals, such as getting children back after court removal or staying out of jail on parole.

Family members also set ultimatums regarding necessity of treatment for a relative.

These patients, in addition to not welcoming treatment, are often unwelcome by the provider.

The focus of this workshop will be to uncover and discuss major resistances and barriers that these patients may set up, and practical strategies for engaging and successfully treating them.

We encourage discussion about provider obstacles and resistances in attempting to treat such patients and will focus in on how to overcome these challenges to make effective treatment possible. This will include discussion of audience cases.

REFERENCES:

1. Collins JJ, Alison M: Legal coercion and retention in drug abuse treatment. Hospital and Community Psychiatry 1983;34:1145–1149.
2. Hubbard RL, Collins, JJ, Rachal JV, Cavanaugh ER: The criminal justice client in drug abuse treatment. In: Compulsory Treatment of drug abuse: Research and Clinical Practice. Edited by Leukefeld CG, Tims FM. OHHS Publication No. (ADM) 88-1578 Research Monograph Series 86, Rockville, MD; National Institute on Drug Abuse, 1988; pp 57–80.

Issue Workshop 102
BEYOND MEDICAL SCHOOL: THE MBA ADVANTAGE

Chairperson: Arthur L. Lazarus, M.D., *MBA, Prudential Health Care, 102 Rock Road, Horsham PA 19044*
Participants: Adele C. Foley, John S. Lloyd, M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the presentation, the participant should be able to recognize the importance of graduate business education for aspiring physician executives and evaluate the advantages and disadvantages of an executive MBA program.

SUMMARY:

Medical management promises to be an area of growth and opportunity for many physicians, including psychiatrists. Although formal training beyond medical school and residency is not required for physicians to enter the ranks of management, physician executives are turning increasingly to graduate-level business training to learn effective management skills. Executive MBA programs, which can be completed in less than two years, offer physicians an opportunity to obtain an MBA degree without interrupting their career.

Workshop leaders will discuss a typical executive MBA curriculum, the MBA "lifecycle," and the resources needed to complete such a program. In addition, workshop participants will have a chance to learn about the physician-executive marketplace. The careers of recent graduates from one executive MBA program (St. Joseph's University) will be profiled. There will be ample time to ask questions and discuss personal experiences to help plan for a career in administrative psychiatry or medical management.

REFERENCES:

1. Lazarus A: The educational needs of physician executives: implications for executive MBA programs. Physician Executive, Nov/Dec, 1997

2. Lazarus A (ed.): MD/MBA: Physicians on the New Frontier of Medical Management. Tampa, Florida: The American College of Physician Executives, 1997.

Issue Workshop 103
CONSCIENCE-CENTERED PSYCHIATRIC ETHICS

Co-Chairpersons: Matthew R. Galvin, M.D., *Dept. of Child Psych., Indiana University, 702 Barnhill Drive, Indianapolis IN 46202,* Margaret Gaffney, M.D., *1001 West 10th Str. WOP M200, Indianapolis IN 46202*
Participant: Barbara Stilwell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) use a conceptual framework for an examination of his or her professional conscience, (2) understand the relationship of professional conscience to medical and psychiatric ethics, and (3) apply this understanding to current and future medical ethical issues.

SUMMARY:

When facing a decision about complex issues, a person is often advised to "consult his/her conscience." What does this mean? In particular, what does it mean for a person entering a mental health care profession when choosing a career; in the midst of the training program; becoming established in community practice; or working in a teaching, mentoring or research role? The field grows in complexity each year as do external efforts to control complexity through regulations and practice guidelines established by government agencies, professional organizations, or health maintenance organizations.

Conscience Centered Psychiatric Ethics (CCPE) is a unique approach to ethical concerns based upon a developmental theory derived from empirical studies of children and adolescents. Conscience is proposed as a bridge that can be constructed over the fact-value gap, specifically the psychological facts about our nature and intrinsic values identifiable with each domain of conscience, which may be, from the time of medical school onward nurtured and refined as professional values. Participation in the workshop consists of observation and discussion of the Health Professional Conscience Interview and personal responses to select questions from the Conscience Autobiography for Psychiatrists. Implications of CCPE for approaching dilemmas in psychiatric ethics are described.

REFERENCES:

1. Stilwell B, Galvin M, Kopta SM, Padgett RJ: Moral valuation, a third domain of conscience functioning. J Am Acad Child Adolescent Psychiatry 1996;33:130–139.
2. Stilwell B, Galvin M, Kopta SM, Padgett RJ, Holt JW: Moralization of attachment: a fourth domain of conscience functioning. J Am Acad Child Adolescent Psychiatry. 1997;36(8):1140–1147.

Issue Workshop 104
UNDERSTANDING THE DYNAMICS OF ABUSIVE RELATIONSHIPS

Chairperson: Gary J. Maier, M.D., *Mendota Mental Hlth Institute, 301 Troy Drive, Madison WI 53704-1521*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) identify the need to diagnose couples involved in an abusive relationship, (2) identify a model that will differentiate an abusive fight from a fair fight, (3) identify control tactics used by an abuser to maintain power and control over a victim, (4) counsel an abused woman on the need to seek professional, therapeutic and legal help, (5) counsel an abuser on the need to seek professional help to identify and change the habit of abuse.

SUMMARY:

The goal of this workshop is to raise the consciousness of clinicians of the need for better diagnosis and treatment of battering men and battered women. Using a model that defines the stages of a fair fight so it can be contrasted with the stages of an abusive fight, the workshop leader will present examples of the differences so the participants can discuss the factors that must be considered when making the "diagnosis of abuse" (30 minutes).

In small groups, the participants will then discuss three cases of abuse and formulate a management plan, which will then be discussed with all participants. The cases will involve "couples" at different stages of abusive relationships. The treatment issues will range from no intervention through building a support group to legal remedies including the use of restraining orders and divorce (30 minutes).

Finally, the workshop leader will present a protocol for managing abusive relationships, enriched by the participant discussion. The participants will then discuss the practical implementation of the protocol as it applies to real abusive relationships in the context of the support system in their communities (30 minutes).

REFERENCES:

1. Maier GJ.: Understanding the Dynamics of Abusive Relationships, The Psychiatric Times, September, 1996.
2. Jones A, Schechter S: When Love Goes Wrong. New York, Harper Perennial, 1992.

Issue Workshop 105
EXECUTIVE DISTRESS: THREE TREATMENT MODELS

Chairperson: Jeffrey P. Kahn, M.D., *300 Central Park West, #1C, New York NY 10024-1513*
Participants: Kenneth Eisold, Ph.D., Miguel A. Leibovich, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand how to adapt psychotherapeutic evaluation and treatment approaches to the special concerns of business executives for their work environment. The participant should also be able to synthesize three different treatment models towards this end.

SUMMARY:

When business executives present for psychotherapy or coaching, they often have particular concerns about their careers and about the psychotherapeutic process. In addition, they are often well aware that their state of mind and behavior have significant effects on both corporate performance and subordinate morale. Psychotherapeutic understanding of these issues leads to improved evaluation and treatment approaches.

Presentation of a short case will be followed by guided audience discussion of three different clinical perspectives. The discussants are experienced in work with executive patients. An organizational psychologist will focus on work role perspectives. An occupational psychiatrist will facilitate a broad psychiatric perspective. A discussion of group process-based evaluation and treatment will be led by a psychiatrist leader of treatment groups for executives. These three complementary perspectives will permit a comprehensive synthesis of evaluation and treatment issues for executives. Greater understanding of the business issues discussed is also valuable in the treatment of any employed patient.

REFERENCES:

1. Obholzer & Roberts (Editors): The Unconscious at Work. London & New York: Routledge, 1994.

2. Kahn JP (Editor): Mental Health in the Workplace: A Practical Psychiatric Guide. New York: Van Nostrand Reinhold, 1993.

Issue Workshop 106
INTEGRATED CLINICAL SYSTEMS FOR PSYCHIATRIC CARE

Chairperson: Wesley E. Sowers, M.D., *Department of Psychiatry, St. Francis Medical Center, 400 45th Street, Pittsburgh PA 15201*
Participant: Gordon H. Clark, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize the need for and advantages of the development of efficiently organized clinical systems, which facilitate provider self management and maximize quality of services, and (2) demonstrate knowledge of systems assessment for the determination of possible inefficiencies in service delivery.

SUMMARY:

With the new emphasis on conservative management of scarce resources, clinical programs must be innovative in their attempts to eliminate redundancies and streamline documentation of services by professional staff. In this workshop, a clinical system will be presented that is based on the use of the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS), an instrument recently developed by the American Association of Community Psychiatrists. The use of the initial and periodic dimensional assessments to assist in level of care determinations and self management of resource utilization will be discussed with emphasis on the resulting minimization of administrative oversight and strengthening of clinician empowerment. The assessment's role in organizing individual and team treatment planning as well as its use for progress documentation will also be discussed. This process, in conjunction with the development of computer friendly, economic, and modular assessment documents to record psychiatric and personal histories will eliminate redundancies that currently exist in many systems and will maximize the quantity and quality of care being delivered. Participants will be encouraged to critique the systems presented and to share their own attempts to enhance quality by creatively addressing inefficiencies in their systems.

REFERENCES:

1. Santos AB, Henggeler SW, Burns BH, Arana GW, Meisler N: Research on field-based services: models for reform in the delivery of mental health care to populations with complex clinical problems. Am J Psychiatry 1995;152:1111–23.
2. Sowers W: Level-of-care determinations in psychiatry. Harvard Rev Psychiatry, September/October 1997;5:1–5 (in press).

Issue Workshop 107
PRESCRIBING FOR OTHER CLINICIANS

Chairperson: Lloyd I. Sederer, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont MA 02178-1048*
Participants: James M. Ellison, M.D., Catherine Keyes, J.D.

EDUCATIONAL OBJECTIVES:

At conclusion of this workshop, the participant should be able to (1) better define and understand consultative, collaborative, and supervisory relationships with other clinicians; (2) optimize communication among caregivers; (3) improve upon patient care in treatment involving multiple clinicians; and (4) enhance malpractice risk prevention.

SUMMARY:

Concerns abound about the high prevalence and medicolegal liability of psychiatrists who are prescribing medications for patients whose care is also provided by other physicians (psychiatrists as well as primary care and other specialty physicians), psychologists, social workers, and nurses. Division of responsibilities, ambiguity of roles, and inexact expectation for communication, information, emergency responsiveness, coverage, and the like, may affect the quality of patient care.

Lloyd I. Sederer, M.D., of McLean Hospital, James Ellison, M.D., MPH, of Harvard Pilgrim Healthcare, and Catherine Keyes, J.D., of the Harvard Risk Management Foundation established a task force and have developed "Guidelines for Prescribing Psychiatrists in Consultative, Collaborative, or Supervisory Relationships." These guidelines represent the first effort, to our knowledge, to define and provide guidelines for prescribing psychiatrists. We also anticipate they will serve as a template for other physicians (e.g., primary care physicians, pediatricians, obstetricians) whose practice involves other health professionals.

This workshop will use case examples and audience participation to identify potential clinical-practice problem areas and offer guidelines to improve upon patient care and reduce psychiatrists' liability.

REFERENCES:

1. Ellison JM, Smith JM: Intertherapist conflict in combined treatment. In The Psychotherapist's Guide to Pharmacotherapy. Edited by Ellison JM. Chicago, IL. Year Book Medical Publishers, 1989:96–115.
2. Sederer LI: The four questions. In Acute Care Psychiatry: Diagnosis and Treatment. Edited by Sederer LI, Rothschild AJ. Baltimore, MD. Williams & Wilkins, 1997; 3–14.

Issue Workshop 108
SPIRITUAL/RELIGIOUS ASSESSMENT: WHY AND HOW?

Co-Chairpersons: Francis G. Lu, M.D., *Department of Psychiatry, University of CA at SF, 1001 Potrero Avenue, San Francisco CA 94131*, James L. Collins, M.D., *6110 Executive Blvd., Ste 908, Rockville MD 20852*
Participants: David B. Larson, M.D., Christina M. Puchalski, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant should be able to recognize when and how to take a spiritual history, to diagnose and differentiate between the pathological and normal use of religion in patient assessments, and how to develop a treatment plan and use hospital chaplains in follow-up care.

SUMMARY:

As the U.S. population becomes more culturally diverse, the clinical psychiatric assessment is increasingly becoming more challenging to practitioners and medical educators. According to the APA Practice Guidelines on Psychiatric Evaluation of Adults and the DSM-IV Outline for Cultural Formulation, religion, spirituality, and other cultural issues need to be included in the clinical evaluation. This workshop will first demonstrate through a brief videotape presentation and discussion the methods of interviewing, case formulation, differential diagnosis, and developing a treatment plan, which illustrate the importance of spiritual, religious, and cultural issues presented in the patient's history. Secondly, a participant will conduct a brief interview with a workshop presenter acting as a simulated patient. The participants will critique the interview and discuss the applicability of religious/spiritual assessment to both their clinical work and the teaching of medical students and residents. Specific issues discussed will include the importance of respectful rapport;

the use of the DSM-IV Outline for Cultural Formulation to understand the patient's religious/spiritual identity, indigenous forms of healing (such as prayer) and social support; the DSM-IV diagnosis of religious or spiritual problem; and interventions such as request for chaplain consultation and referrals to religious/spiritual support groups.

REFERENCES:

1. Puchalski CM: Taking a Spiritual History, Videotape produced by The George Washington University Medical Center, 1997.
2. Model Curriculum for Psychiatric Residency Training Programs: Religion and Spirituality in Clinical Practice, Edited by Larson DB, Lu FG, Swyers JP: May 1996, revised, July 1997.

Issue Workshop 109
PRESERVING QUALITY IN OUTPATIENT PSYCHIATRY

Co-Chairpersons: David G. Krefetz, D.O., *Department of Psychiatry, UMDNJ - School of Osteo. Med., 2250 Chapel Avenue, West, #100, Cherry Hill NJ 08002,* Roberta R. Ball, D.O., *Department of Psychiatry, UMDNJ-SOM, 2250 Chapel Ave. West, #100, Cherry Hill NJ 08002-2000*
Participant: Geetha Kumar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) understand the increasing demands on an outpatient psychiatric practice, (2) develop creative strategies to maintain quality in the face of a changing health care system, and (3) communicate more effectively with referring physicians, other professionals, and managed care organizations staff.

SUMMARY:

The practice of outpatient psychiatry has been under assault by market forces. Over the last several years, these forces have tried to erode the autonomy of the psychiatrist and the doctor-patient relationship. We must adapt our practices to meet the demands of the changing health care system, while maintaining quality care for our patients. In the workshop, we will present the experiences of a suburban academic group practice to provide high quality outpatient services. We will focus on several issues: working with patients so that they can advocate for their needs within the system, redefining confidentiality, initiating and maintaining relationships with managed care providers, coordinating with other systems to provide comprehensive treatment, and working with nonpsychiatric physicians and other mental health professionals. We will address how to keep referring physicians aware of changes in access to psychiatric treatment. In addition, we will discuss how smaller groups and solo practitioners can adapt our experiences to meet their own needs. We will share some of the documents we have developed that provide communication to physicians, therapists, and managed care reviewers. We will invite the audience to share their own ideas and unique experiences and, together, formulate new strategies to provide high quality care and reduce frustration.

REFERENCES:

1. Schreter RK: Essential skills for managed behavioral health care. Psychiatric Services 1997;48:653–658.
2. Chipman A: Meeting managed care: an identity and value crisis for therapists. Am J Psychotherapy 1995;49:558–567.

Issue Workshop 110
SOCIAL AMNESIA: RESOCIALIZING PSYCHIATRIC RESEARCH

Chairperson: Carl I. Cohen, M.D., *Department of Psychiatry, SUNY Health Sciences Center, 450 Clarkson Avenue, Brooklyn NY 11203*
Participants: Cecile Rousseau, M.D., Kenneth S. Thompson, M.D., Carlos Mutaner, M.D., David Williams, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand why broadening and deepening our knowledge about psychosocial variables is essential for psychiatric research and practice. Several avenues for accomplishing this goal will be presented.

SUMMARY:

The dramatic expansion of biological psychiatric research has in part occurred at the expense of psychosocial research. Ironically, the proportionately greater funding for biological research has left investigators with inadequate theories and concepts to integrate social phenomena with biological findings. This has resulted in considerable distortions and inconsistencies in biological research. Among the topics that this workshop will address are the following: (1) how omission or simplification of social variables can cause an inflation in the explained variance of biological variables and/or large unexplained variances; (2) how commonly used social variables such as "race" or income may be proxies for more complex variables—e.g., access to goods and services, housing and environment, accumulated wealth, neighborhood wealth—that need to be developed as experimental variables; (3) the validity of the structural model of mental illness in which content (i.e., the sociocultural expression of the illness) is seen as an epiphenomenon, and consequently tends to be extruded from biological research; (4) the potential consequences of a nosology in which the differences of one subjective complaint may separate a case of disease from a socially caused type of human misery.

REFERENCES:

1. Mutaner C, Nieto FJ, O'Campo P: The bell curve: on race, social class, and epidemiological research. Am J Epidemiology 1996;144:531–536.
2. Cohen CI: The biomedicalization of psychiatry: a critical overview. Community Mental Health Journal 1993;29:509–521.

Issue Workshop 111
THE MAKING OF A BEHAVIORAL PREVENTIVE MEDICINE FELLOWSHIP

Chairperson: Michael A. Silver, M.D., *Department of Psychiatry, New Jersey Medical School, 630 First Avenue #28H, New York NY 10016*
Participants: Steven J. Schleifer, M.D., Martin E. Glasser, M.D., Lisa J.F. Miller, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop the participant should be able to recognize and effectively address issues involved in BHO/MHO's meeting NCQA standards in assuming leadership roles in a managed care environment and in developing academic/corporate collaborations for outcomes research.

SUMMARY:

Managed health care has challenged traditional vehicles of health care delivery. It has become increasingly important for behavioral health care organizations (BHO's) to work collaboratively with health maintenance organizations (HMO's) to develop programs and psychiatrically screen medical/surgical patients presenting to the primary care physician (PCP) with psychiatric and/or substance abuse concerns and symptoms. Merit Behavioral Care has developed one of the nation's first one-year research fellowships in preventative medicine in the managed behavioral health care industry.

It is the intent of this fellowship program that the BHO and HMO will help meet and exceed the prevention standards of NCQA, to help train psychiatrists and other MD's to work and relate in a managed care environment, prepare psychiatrists for leadership roles, train psychiatrists to function in and integrate in a medical/surgical HMO setting, and develop academic-corporate collaborations for outcomes research.

It is well known that 25% of primary care patients suffer from one or more mental disorders with 54% of patients with psychiatric disorders being cared for in the primary care setting and only one out of two patients with common mental disorders able to be diagnosed and treated by primary care practitioners. It is our plan that this research fellowship in behavioral preventative medicine will directly address those medical problems with HMO patients as well as be the template of collaboration for the managed care industry.

These collaborations also require novel approaches for both the academic organization, the BHO, and HMO, posing challenges in curricular definition, the melding of corporate and academic cultures, and fellowship funding.

The workshop will expand on our experiences from a variety of perspectives considering implications for such seamless collaborations. They include the BHO associate chief medical officer, a BHO executive medical director, the academic chair, and the behavioral preventive medicine fellow. Panel audience discussion will consider training program development, and BHO-HMO-department of psychiatry collaborations.

REFERENCES:

1. Schulberg HC, Burns BJ: Mental disorders in primary care: epidemiologic, diagnostic, and treatment research directions. Gen Harp Psychiatry 1988;10:79–87.
2. Regier DA, Narrow WE, Ras DS, et al: The de facto U.S. mental and addictive disorders services system: epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. Arch Gen Psychiatry 1993;50:85–94.
3. Anderson SM, Harthorn BH: The recognition, diagnosis, and treatment of mental disorders by primary care physicians. Med Care 1989 27:869–886.
4. Freeling P, Rao BM, Paykei ES, et al: Unrecognized depression in general practice. BMJ 1985; 290:1880–1883.

Issue Workshop 112
MENTAL HEALTH PEER ADVOCACY IN A GENERAL HOSPITAL EMERGENCY ROOM

Chairperson: Happy Scherer, M.A., *Department of Psychiatry, Ellis Hospital, 216 Lafayette Street, Schenectady NY 12305*
Participants: Lynne Davidson, M.S.W., Jeffrey D. DeLisle, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate a working knowledge of how a peer advocacy/support program was developed within a general hospital department of psychiatry to provide mental health consumers in the emergency room and in other crisis settings with support from individuals who have gone through the same experience themselves and have a unique perspective on the mental health recovery process.

SUMMARY:

In 1995, the newly hired director of psychiatry at Ellis Hospital in Schenectady, N.Y., had identified problems related to the experiences of mental health patients who came to the general hospital emergency room to be evaluated for crisis treatment and triage. Coincidentally, participants in a mental health consumer council had identified the need for real jobs to be created, which could build on their recovery skills. A grant was submitted to the van Ameringen Foundation to create a "Peer Advocacy and Support" program, which would train consumers to provide support and information to individuals who were seeking help in the hospital ER and throughout the inpatient diversion and crisis services.

The administrative director and chair of psychiatry, the director of the peer advocacy program (who is a mental health consumer and a CSW) and two to four peer advocates will present information about our first year's experience with this grant. We will provide information about recruitment of peer advocates, setting up and administrating a 60-hour training program, working within the system to create support and ownership for the program, pre- and post-evaluation tools that look at both the functioning of the peer advocates themselves and the changes in attitudes of emergency room staff toward psychiatric patients, as well as anecdotal information about the advocates' experiences working in the emergency room and in other settings.

Issue Workshop 113
COMPLIANCE: DIRECTLY OBSERVED THERAPY AND OTHER STRATEGIES

Chairperson: Michael M. Scimeca, M.D., *Department of Psychiatry, Harlem Hospital, 200 West 90th Street, Ste 11-H, New York NY 10024-1268*
Participants: Susan Stabinsky, M.D., Mary Alice O'Dowd, M.D., Harvey Stabinsky, M.D., David W. Preven, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the issues that underlie patients' unwillingness/inability/difficulties in complying with treatment and the parallels between the approaches to public health problems and psychiatric illnesses. The participant will receive specific suggestions for dealing with these problems in the chronically ill and substance abusing population.

SUMMARY:

The joint epidemics of HIV/AIDS and tuberculosis have engendered creative (fresh, novel) and effective ways to deal with chronic compliance problems. All medical patients may present problems in complying with appropriate treatment, even with taking possibly life-saving medications. Problems with compliance in psychiatric treatment may be more complex in difficulty because of added factors such as stigma and cognitive disorganization.

In this workshop we will invite discussion and active participation in reviewing the issues underlying patient noncompliance: fears of illness, sense of entitlement, disorganization in daily living, substance abuse, and denial. We will also explore ways that psychiatry can adapt techniques from public health so that mental illnesses and mentally ill patients can benefit from active, monitored, structured treatment approaches. Experiences with potentially more "user-friendly" approaches, such as stationing the psychiatrist in primary care clinics and providing services on-site to reach the multi-problemed individual, will be reviewed. A variant of directly observed therapy (as used in the treatment of TB) has proven very useful in monitoring psychotropic medication administration for substance

abusing, chronically psychotic patients. These models and other approaches and examples elicited from the audience will be reviewed and discussed.

REFERENCES:

1. Menninger WW: The Chronically mentally ill. Chapter 47.6. In Comprehensive Textbook of Psychiatry, Volume 2, 5th Edition. Edited by Kaplan, HI, Saddock, BJ. Baltimore, Williams and Wilkins, 1989.
2. Benet LZ: Principles of prescription writing and patient compliance instructions. In Goodman & Gilman's The Pharmacological Basis of Therapeutics, Ninth Edition, New York, McGraw Hill, 1996.

Issue Workshop 114
SEXUAL ABUSE CASE: PSYCHOTHERAPY AND NEUROBIOLOGY

Co-Chairperson: Patricia L. Gerbarg, M.D., *Boston Psychoanalytical, 86 Sherry Lane, Kingston NY 12401-4724,* Jose A. Saporta, Jr., M.D., *53 Beverly Road, Newton Highlands MA 02161-1112*

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should be able to integrate knowledge from different fields of inquiry: psychoanalysis, neurology, and psychopharmacology; correlate clinical observations with neurobiological research theories; develop more effective treatments for patients with a history of childhood sexual abuse and PTSD.

SUMMARY:

This workshop attempts to integrate psychoanalytic concepts with current neurobiological research in understanding the experiences and consequences of childhood sexual abuse. A highly interactive format will be used to explore the artwork of a woman with post-traumatic stress disorder, psychogenic amnesia, body dysmorphic disorder, and verbal inhibition. Her vivid drawings portray psychological processes involved in trauma, defense, character formation, and memory. Throughout the lecture, participants will be asked to share their thoughts and associations as they view slides of the patient's drawings.

We will also use the case to talk about disturbances in self-regulation and biological regulation and about how these disrupt coherent self-experience. Physiological processes, which contribute to memory disturbances in trauma, undermining coherent self-experience, will be discussed.

REFERENCES:

1. Van der Kolk BA: Traumatic Stress, New York, NY, The Guilford Press, 1996.
2. Laub D: Knowing and not knowing massive psychic trauma: forms of traumatic memory. Int J Psychoanalysis 1993; 74:287-300.

Issue Workshop 115
SUICIDE PREVENTION: NEW PUBLIC HEALTH PERSPECTIVES

Chairperson: Neal L. Cohen, M.D., *NYC Department of Mental Hlth, 93 Worth Street, New York NY 10013*
Participants: Peter M. Marzuk, M.D., Lloyd B. Potter, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize recent trends in the demographics and risk factors for suicide and potential strategies for suicide prevention facilitated by the emerging health care environment:

SUMMARY:

While the total national suicide rate has had minimal fluctuation in recent years, there remains significant variation in the demographics and chosen methods of suicide. Epidemiological and public health focus on suicide risk factors challenges policymakers to develop more effective preventive interventions.

The workshop presenters provide data on suicide risk factors prevalent in New York City and describe a new public health initiative created to target high-risk populations. The rapidly growing managed health care environment is seen as offering unique opportunities for wider linkage of at-risk individuals with mental health services in their communities. Managed care's emphasis and monitoring of treatment planning, documentation, and measureable outcomes give public health planners new tools to implement suicide prevention strategies. These public health strategies can be operationalized to complement the priorities of managed behavioral health care for lower-cost interventions that minimize chronicity and disability. Workshop attendees will be able to review a number of suicide prevention strategies and to propose refinements that are benefited by the emerging health environment.

REFERENCES:

1. Marzuk PM, Tardiff K, Leon AC, et. al.: Use of prescription psychotropic drugs among suicide victims in New York City. American Journal of Psychiatry, 1995;152(10):1520–1522.
2. Marzuk PM, Leon AC, Tardiff K., et. al.: The effect of access to legal methods of injury on suicide rates. Archives of General Psychiatry, 1992;49:451–458.

Issue Workshop 116
HIV AND HISPANICS: TREATMENT AND PREVENTION

Chairperson: Pedro Ruiz, M.D., *Department of Psychiatry, University of Texas, 1300 Moursund Street, Houston TX 77030*
Participants: Rodrigo A. Munoz, M.D., Lourdes M. Dominguez, M.D., Humberto L. Martinez, M.D., John G. Langrod, Ph.D.

EDUCATIONAL OBJECTIVES:

With the knowledge acquired in this workshop, the participants should be able to appropriately treat Hispanic patients suffering from HIV/AIDS. Also, they should be able to implement culturally relevant preventive strategies to combat the HIV epidemic among Hispanic populations.

SUMMARY:

In recent years, the HIV/AIDS epidemic has shifted toward the ethnic minority populations of this country, particularly Hispanics. Currently, Hispanics represent approximately 8.4% of the total U.S. population. However, as of December 1996, 27% of the adult/adolescent AIDS cases and 23% of the pediatric AIDS cases reported in this country have been among Hispanics. The intravenous use of drugs among Hispanics has greatly contributed to this new pattern of HIV infection. In this respect, Hispanic women have been seriously affected. The "machismo," with its impact on the pattern of sexual behavior among Latinos/Latinas, has much to do with the current trends of HIV/AIDS among Hispanic populations. In this workshop, we will address and discuss the most relevant sociocultural characteristics inherent among the Hispanic population of this country. Additionally, we will also focus on how to constructively use these sociocultural characteristics in the HIV/AIDS treatment setting, as well as with preventive interventions against HIV/AIDS. Hopefully, our presentations will help clinicians to more appropriately treat the

HIV/AIDS suffering Hispanic patient, and will also assist health providers in designing and implementing effective preventive strategies vis-à-vis Hispanic communities across the United States.

REFERENCES:

1. Fernandez F, Ruiz P, Bing EG: The mental health impact of AIDS on ethnic minorities. In Culture, Ethnicity and Mental Illness. Edited by Gaw AC. Washington, D.C., American Psychiatric Press, Inc., 1993, pp. 573–586.
2. Ruiz P, Fernandez F: Human immunodeficiency virus and the substance abuser: public policy considerations. Texas Medicine, 1994;90(5):64–67.

AIDS PROGRAM PART I

No. 1A
AIDS AND HIV DISEASE: A MEDICAL: UPDATE

Sharon Walmsley, M.D., *Toronto Hospital, Toronto General Division, Room 222, 200 Elizabeth Street, Eaton Wing, Toronto, ON, Canada M5G 2C4*

EDUCATIONAL OBJECTIVES:

To review the medical, epidemiologic, and treatment issues associated with AIDS and HIV infection.

SUMMARY:

At the time of this writing, more than one million people in the United States are thought to be infected with HIV, over 500,000 diagnosed with AIDS, and 250,000 people have died of AIDS-related conditions. To meet the challenges presented by this epidemic, psychiatrists need to understand the biomedical aspects of AIDS as well as patterns of HIV infection in special patient populations including women, children, ethnic minority groups, and the chronically mentally ill. This session is designed as an update on basic virology and immunology, epidemiology, clinical course and manifestations, opportunistic diseases resulting from HIV infection, and new treatment regimes, including protease inhibitors. The session will include a lecture and question and answer period allowing participants a forum for discussion of individual clinical problems.

REFERENCES:

1. Karon JM et al, Prevalence of HIV infection in the United States, 1984 to 1992, JAMA, 1996, 276(2): 126–31.
2. Bartlett, J. Protease inhibitors for HIV infection. Annals of Internal Medicine, Vol 124, No. 12, pgs 1086–1087, June 1996.
3. Moyle G, Gazzard, B. Current knowledge and future prospects for the use of HIV protease inhibitors. Drugs 1996 May: 51(5):701–712.

No. 1B
NEUROPSYCHIATRIC MANIFESTATIONS AND THEIR TREATMENTS—A REVIEW

Mark H. Halman, M.D., *Dept. of Psychiatry, The Wellesley Hospital Jones Building, 334-160 Wellesley Street East, Toronto, ON, Canada M4Y 1J37;* Francisco Fernandez, M.D., Stephen McDaniels, M.D.,

EDUCATIONAL OBJECTIVES:

To review the spectrum of neuropsychiatric conditions that often exist with HIV infection and the range of effective psychopharmacological treatment approaches.

SUMMARY:

Clinical experience and current research have yielded increasing evidence that HIV directly infects the brain, resulting in central nervous system (CNS) impairment and neuropsychiatric complications, including dementia, myelopathy, and delirium. Current studies estimate that as many as 65% of all AIDS patients present with symptomatic CNS consequences. During this presentation, panelists will discuss primary infection the central and peripheral nervous systems, cognitive-motor impairment, HIV-1 associated dementia, delirium and psychosis, and review effective psychopharmacologic interventions and palliative treatments. Panelists will also review the diagnosis and treatment of various clinical psychiatric conditions that often exist with HIV infection including anxiety, and depression, and highlight pharmacotherapy, psychotherapies, and other nonpharmacological interventions. The session will be divided into three discussions to include a review of neuropsychiatriatric complications, an overview of mood disorders, and a session on psychopharmacologic treatment and management. The session will include lecture, case discussion, and an open forum for discussion of individual clinical problems.

REFERENCES:

1. Goodkin K, Fernandez, F, McDaniel, S, et al. HIV-Related Neuropsychiatric Complications and Treatments. Commission on AIDS, American Psychiatric Association, Washington, DC, 1996.
2. Dana Consortium. Clinical confirmation of the American Academy of Neurology algorithm for HIV-1-associated cognitive/motor disorder. Neurology 1996;47:247–1253.
3. Ellis RJ, Deutsch R, Heaton RK, Marcotte T, McCutchan JA, Nelson J, Abramson I, Thal LJ, Atkinson JH, Wallace MR, Grant I, HNRC Group. Neurocognitive impairment is an independent risk factor for death in HIV infection. Arch Neurol 1997;54:416–424.

AIDS PROGRAM PART II

No. 2A
SPECIAL ISSUES OF WOMEN WITH AIDS AND HIV DISEASE

Cheryl Rowe, M.D, *207-348 Danforth Avenue, Toronto, ON, Canada M4K 2N8*

EDUCATIONAL OBJECTIVES:

To discuss the increased rate of HIV infection among women and the special needs presented by this population.

SUMMARY:

HIV is spreading more rapidly among women than among any other group in the United States. By 1993, AIDS had become one of the top five killers of American women of childbearing age. By the year 2000, most new HIV infections worldwide will be among women, according to the World Health Organization's Global Programme on AIDS. Most women with AIDS in the U.S. are either black or Hispanic, poor, and were infected via injectable drug use or sex with an IDU partner. Often they face multiple levels of prejudice—based on race or ethnicity, gender, drug use, poverty—which now are further complicated by the stigma associated with HIV/AIDS. During this program participants will examine a variety of issues of importance to the clinician including health, sexuality, addiction and recovery, relationships and dependency, caretaking, death and dying, as well as love and loss.

No. 2B
CHILDREN AND ADOLESCENTS

Arlette Lefebvre, M.D., *Dept of Psychiatry, 1st Floor, Elm Wing, Hospital for Sick Children, 555 University Avenue, Toronto, ON, Canada M5G 1X8*

OBJECTIVE:

To increase awareness of adolescents' heightened risk for HIV infection, review data on young people's sexual and drug using behavior, and to introduce intervention strategies for reducing HIV risk behaviors.

SUMMARY:

The number of adolescents with AIDS is increasing significantly. The problems that confront these teenagers and their families are

complex and manifold. During this session, faculty will advance a variety of issues of importance to psychiatrists in clinical practice. Participants will examine the role of impulsivity and prior risk-taking behaviors, report on substance abuse and its relation to sexual behavior among adolescents, describe issues involved in pre- and post-test HIV counseling for adolescents, and discuss opportunities and strategies for education and behavior change.

No. 2C
MULTICULTURAL ISSUES IN HIV/AIDS CARE

Joyce Y. Chung, M.D., *Department of Psychiatry, Georgetown University Medical School, 3750 Reservior Road, N.W., Washington, DC 20007*

SUMMARY:

AIDS and culture have been entwined from the beginning of the epidemic. Early on, AIDS appeared to select its victims from previously defined sub-cultural groups (homosexuals, hemophiliacs, intravenous drug addicts) and was seen as a disease of risk groups. A primary goal of HIV education and prevention efforts has been to undo static notions of culture by focusing on risk *behaviors* rather than risk *categories*. The message is that AIDS should not be viewed as a disease of the "other". Another way in which culture is associated with AIDS comes from the epidemiology of HIV infection in the U.S. that increasingly shows that the highest rates of new HIV infection and AIDS deaths occur in disadvantaged minority populations. Here, "culture" in the context of AIDS signifies persons or communities who are at higher risk for HIV infection because of skin color or ethnicity. I will argue that ethnic/racial grouping has little relevance for clinical care. Nonetheless, the concept of multiculturalism has value in understanding both the experience of HIV illness and its effective treatment. Multiculturalism refers to a process of acknowledgement and integration of cultural beliefs and practices in life situations. I propose to redefine culture in the arena of HIV/AIDS clinical care by describing how ethnographic methods can be used to elicit health beliefs and cultural values held by persons with HIV/AIDS. By use of techniques such as the "explanatory model", clinicians can incorporate culture into effective and sensitive treatment of their patients.

REFERENCES:

1. Kleinman, A. Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry. Berkeley: 1980, University of California Press.
2. Parker, R. Acquired Immunodeficiency Syndrome in Urban Brazil. 1987, Medical Anthropology Quarterly 1(2):155–175.
3. Pivnick, A, Jacobson, A, et al. Reproductive Decisions among HIV-Infected, Drug-Using Women: The Importance of Mother/Child Coresidence. 1991, Medical Anthropology Quarterly 5(2):153–169.

CLINICAL CASE CONFERENCES

1. NOT RECEIVED

2. PSYCHOTHERAPY WITH WOMEN WHO HAVE EXPERIENCED DOMESTIC VIOLENCE

Donna E. Stewart, M.D., *The Toronto Hospital, Women's Health, 200 Elizabeth Street, EN 1-222, Toronto, ON M5G 2C5, Canada,* Gail E. Robinson, M.D., Nada L. Stotland, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will become more knowledgeable about instrumental and psychodynamic issues in psychotherapy with women who have experienced domestic violence.

SUMMARY:

Domestic violence is epidemic in most societies. Violence against women, in this context, is perpetrated by intimate male partners or family members with whom the woman might reasonably expect a trusting, loving relationship. Differences in physical strength and power, as well as gender socialization frequently result in more serious injuries to women victims. This presentation will be chaired by Dr. Donna Stewart, who will discuss the psychologic sequelae of domestic violence and the general principles of psychotherapy with abused women. A psychotherapy patient who has experienced domestic violence will be presented by Dr. Gail Robinson. Dr. Nada Stotland will discuss the psychotherapy of this woman, with special attention to her abuse experiences. The expert panel will encourage comments from the audience during the discussion of the issues that are raised in psychotherapy practice with women who have experienced domestic violence.

REFERENCES:

1. Stewart DE, Robinson GE: Violence and Women's Mental Health. Harvard Review of Psychiatry 4:54–57, 1996.
2. Rose DF: Sexual assault, domestic violence and incest. In: Stewart DE, Stotland NL (eds): Psychological Aspects of Women's Health Care. Washington, DC: American Psychiatric Press, pp. 447–484, 1993.

3. PSYCHOTHERAPY WITH A PATIENT WITH MULTIPLE PERSONALITIES

Harold E. Bronheim, M.D., *1155 Park Avenue, New York, NY 10128-1209* Margaret Huntley, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to review and discuss the clinical psychotherapeutic management of a complex patient with many borderline traits and behaviors.

SUMMARY:

The purpose of this clinical case conference is to present and discuss a patient who offered complex diagnostic and management issues. The psychotherapeutic approach to the patient will be discussed from the standpoint of psychodynamic psychotherapy; especially with regard to therapeutic stance, transference-countertransference, and the larger question of the reliability of data emerging in therapy. The patient to be discussed met criteria for many Axis I disorders, and, in addition, had a history of sexually seducing several of her physicians including at least one psychiatrist.

REFERENCES:

1. Chessick RD: Intensive Psychotherapy of a Borderline Patient. Arch Gen Psych 29:413–419, 1982.
2. Bruer and Freud: Studies on Hysteria, Standard Edition Vol. 2, 1985.

4. PSYCHOTHERAPY WITH PERSONS WITH HIV CONSIDERING PROTEASE INHIBITORS

Warren M. Liang, M.D., *Department of Psychiatry, University of Cincinnati, PO Box 670559, Cincinnati, OH 45267* Francine Cournos, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will be able to examine the biopsychosocial issues that arise in psychotherapeutic work with HIV-seropositive patients.

SUMMARY:

The arrival of protease inhibitors into the therapeutic armamentarian used against HIV infection raises new challenges for psychiatrists working with patients with HIV. The dosing of these agents places high demands on the patient's lifestyle and one's sense of autonomy. Adherence to the medication regimen is a major area of concern as developing viral resistance is a very real danger when protease inhibitors are inconsistently taken even briefly. The long-term effectiveness of these agents is unknown as are the effects of these agents against HIV brain disease. And yet, many patients have shown dramatic improvements in their HIV illness. For some, these improvements have led to reexamination of life goals, relationships, and self-concept. These are expensive medications and access to them is highly variable. They have complex effects on cytochrome P450 and uncertain clinical interactions with commonly prescribed psychotropic medication. Experiences with zidovudine (AZT) monotherapy (where there was initial optimism, but subsequently a fair degree of disappointment) may leave patients, their family and friends, and care givers very cautious. These are just some of the factors that add to uncertainty in people's lives when faced with the consideration of taking protease inhibitors.

This session will include the presentation of a case of a patient with anxiety and depression for whom treatment with a protease inhibitor is appropriate based on viral load and CD4 count. The discussion of the case will highlight the factors mentioned above and their impact on psychotherapeutic work. It is expected that participants will also discuss their own work with patients for whom protease inhibitors have been considered.

REFERENCES:

1. Dilley JW, Forstein M: Psychosocial aspects of the human immunodeficiency virus (HIV) epidemic. In: Tasman A, Goldfinger S, Kaufmann C (eds): Review of Psychiatry Washington, D.C. American Psychiatric Press, Vol. 9, 631–655, 1990.
2. Markowitz JC, Rabkin JG, Perry SW: Treating Depression in HIV-Positive Patients. AIDS, 8:403–412, 1994.
3. Carpenter CCJ, Fischl MA, Hammer SM et al: Antiretrovial Therapy for HIV Infection in 1996: Recommendations of an International Panel. JAMA 276:146–154, 1996.

5. CONTINUOUS CLINICAL CASE CONFERENCE PART I AND II

Lisa A. Mellman, M.D., *Columbia University, NYS Psychiatric Institute, 722 West 168th Street, Box 63, New York, NY 10032,* Norman A. Clemens, M.D., *University Suburban Health Center, 1611 South Green Road, #301, Cleveland, OH 44121-4128,* Steven P. Hamilton,

M.D., Michael E. Thase, M.D., John C. Markowitz, M.D., Glen O. Gabbard, M.D., Deborah L. Kralick, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this two-day presentation, the participant will learn to evaluate patients to determine their suitability for psychotherapy, contrast and compare selection criteria for cognitive-behavioral, interpersonal, and long-term psychodynamic psychotherapy. In addition, participants will understand the similarities and differences in treatments conducted in each of these modalities.

SUMMARY:

In Part I, case material will be presented from a resident's clinical evaluation of a patient. The patient's suitability for psychotherapy will then be discussed by experts representing cognitive-behavioral, interpersonal, and long-term psychodynamic psychotherapy. In addition, an interpersonal psychotherapy treatment will be presented by a resident and discussed by the same experts.

In Part II, residents will present a clinical case treated in long-term psychodynamic psychotherapy and another treated in cognitive-behavioral therapy. Each case will be discussed by experts representing long-term psychodynamic, cognitive-behavioral, and interpersonal psychotherapy. Additionally, the discussants and chairpersons will discuss the acquisition by residents of psychotherapy skills and the work of the APA Commission on Psychotherapy.

REFERENCE:

1. Makover R: Overview of the Planning Process. In: Treatment Planning for Psychotherapies. Washington, DC: American Psychiatric Press, pp. 19–94, 1996.

DEBATE

RESOLVED: PHARMACEUTICAL SUPPORT FOR UNDERGRADUATE, GRADUATE AND POSTGRADUATE EDUCATIONAL PROGRAMS SHOULD BE ENCOURAGED

Moderator: Peter B. Gruenberg, M.D.
Affirmative: Michael A. Schwartz, M.D. and Paul C. Mohl, M.D.
Negative: Irwin N. Hassenfeld, M.D., and Myrl R.S. Manley, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant will learn about the social context within which pharmaceutical support for psychiatric education occurs and the benefits that have accrued. Learn about the ethical issues relevant to pharmaceutical support of psychiatric education and how to better advocate for pharmaceutical support of psychiatric education. The participant will also be able to list five different situations arising from pharmaceutical support of education that contain conflicts of interest for educators or students, define the terms "education" and "promotion," outline the differences between them, and discuss the ethical implications.

SUMMARY:

Affirmative:

Commercial support helped send Marco Polo to China and NASA to the moon. Societies work best when interest groups with complimentary, overlapping and sometimes even contradictory missions and goals try to work together to promote the common good. The process is intrinsically noble, although it may be fractious, perilous and often abused. The great strength of our American democracy is the system of checks and balances that founding Mothers and Fathers built into governing principles. The same systems of checks and balances are part of the processes that regulate pharmaceutical support for psychiatric education; they are an integral part of groups such as the ACCME. If these groups are not strong enough, they can be improved. Appropriately regulated pharmaceutical support for psychiatric education has made outstanding contributions in the past and can do even more in the years to come. Such support is especially needed now, given the present drying up of other funding sources. Given present-day circumstances, it would be unethical to fail to advocate for well-guided pharmaceutical support for psychiatric education. We should also encourage support from the managed care industry, a group that until now has done far less for education than their counterparts in the pharmaceutical industry.

Negative:

Pharmaceutical industry support for psychiatric education always poses a conflict of interest. It is well established in the literature that contact with pharmaceutical representatives influences clinicians' prescribing practices. Industry support risks blurring the distinction between education and promotion. Unlike industry support for research, there do not exist widely held, well-established, effective corrective restraints (requirements for disclosure, peer review, demand for replication) to offset potential bias in education. Continued reliance on pharmaceutical sponsorship decreases demand for other sources of funding, which in turn decreases the availability of those sources, and thereby, in a self-perpetuating fashion, the number of alternative sources continue to shrink. The substantial cost to pharmaceutical companies of underwriting educational programs such as symposia and all the associated food and entertainment, all expense paid special conferences at popular resorts, etc. is passed on to our patients and accounts, in part, for the high cost of new pharmacologic agents. Finally, accepting pharmaceutical industry funding betrays our responsibility to our trainees to encourage critical review and analysis, and to provide a moral compass for their personal and professional growth.

REFERENCES:

1. The American Psychiatric Association: Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, Washington, DC, The American Psychiatric Press, 1992.
2. Beauchamp TL, Childress JF: Principles of Biomedical Ethics, New York, Oxford University Press, 1989.
3. Lichstein PR, Turner RC, O'Brien K: Impact of Pharmaceutical Company Representatives on Internal Medicine Residency Programs. Arch Intern Med 152:1009–1013, 1992.
4. Bero L, Galbraith A, Rennie D: The Publication of Sponsored Symposiums in Medical Journals. New England J of Med 327:1135–1140, 1992.

FORUMS

1. WHAT'S REALLY GOING ON IN PSYCHIATRY? THE APA PRACTICE RESEARCH NETWORK

Chairperson: John S. McIntyre, M.D.
Participants: Harold Alan Pincus, M.D., Deborah A. Zarin, M.D., Terri L. Tanielian, M.A.

EDUCATIONAL OBJECTIVES

At the conclusion of this presentation participants will be able to understand the principles and rationale for practice-based research in psychiatry, design research studies for implementation within the PRN, discuss current psychiatric treatment practice patterns and relevant clinical information gathered through the Practice Research Network with relation to psychiatric patients.

SUMMARY:

The APA Practice Research Network (PRN) conducts clinical and services research. With funds from the MacArthur Foundation and CMHS, the PRN is expanding to a nationally representative network of 1,000 psychiatrists. This forum provides an update on the PRN and recent findings. Findings from the National Survey of Psychiatric Practice, a large national probability sample survey of APA members, will highlight critical clinical, financial, and other psychiatric issues of importance. This study collects nationally representative data on psychiatrists' professional activities, work settings, and patient caseloads. The study of psychiatric patients and treatments provides data systematically characterizing PRN members, their practices, patient caseloads, and clinical treatment patterns. It provides detailed clinical and diagnostic data on PRN patients and the specific types and combinations of treatments provided. Findings from the Child and Adolescent Pilot Treatment Study of ADHD will be presented highlighting patterns of medication use for children with ADHD and factors which are associated with variations in psychopharmacologic treatment patterns. Plans for a larger study investigating these issues will be discussed. Key findings from other PRN studies will also be presented along with related data on psychiatric practice from other national data bases.

REFERENCES:

1. Zarin D, Pincus H, West J, McIntyre J: Practice-Based Research in Psychiatry. American J of Psych 154:1199-1208, 1997.
2. Zarin D, Peterson B, West J, Suarez A, Marcus S, Pincus H: Characterizing Psychiatry: Findings from the 1996 National Survey of Psychiatric Practice. Submitted to American of Psych.

2. MEET THE APA MEDICAL DIRECTOR

Chairperson: Steven M. Mirin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will gain an appreciation of the American Psychiatric Association's (APA) activities in advocating on behalf of patients, improving clinical care, supporting psychiatric training and research and providing enhanced services to its members and to the profession.

SUMMARY:

As we enter the next millennium, psychiatry faces tremendous challenges. The restructuring of the nation's health care system has had profound effects on the financing and delivery of mental health care. In this context, patients have all too often been denied access to needed care, and psychiatrists have been increasingly marginalized as members of the treatment team. At the same time, projections about workforce needs in the next century threaten Federal Funding for the training of future psychiatrists.

The APA has taken a proactive stance in speaking out about the hazards posed by managed care practices that focus far more on cost containment than on insuring quality care for patients. Organized psychiatry must now move rapidly to develop clinical standards and promote legislation to insure that patients receive timely and appropriate mental health care. We must also continue to advocate for parity of insurance coverage for patients with mental illness (including those with substance use disorders), the preservation of patients confidentiality, and the ability of caregivers to exercise their best clinical judgment in the care of patients. These and other goals and APA initiatives will be discussed.

3. PSYCHIATRY: 25 YEARS SINCE DEPATHOLOGIZING HOMOSEXUALITY

Chairperson: Lowell D. Tong, M.D.
Co-Chairperson: James P. Krajeski, M.D.
Participants: Melvin Sabshin, M.D., Carolyn B. Robinowitz, M.D., Robert P. Cabaj, M.D., Diana C. Miller, M.D., Howard C. Rubin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the history of how homosexuality was removed from DSM in 1973, list the main gay and lesbian issues that have emerged in psychiatry since that time, and incorporate this knowledge into a better capacity to work with gays and lesbians.

SUMMARY:

In 1973, the American Psychiatric Association deleted homosexuality from its official nomenclature of mental disorders, the DSM-II. This played an important role in the advancement of mental health and many other aspects of the lives of gays and lesbians. In the subsequent 25 years there has been a significant evolution of psychiatric, social and political attitudes towards and understanding about homosexuality. This forum shall comprise brief presentations, followed by time for questions and discussion, on the following: a) history of the removal of homosexuality from DSM: b) how psychiatry has dealt with homosexuality since 1973; c) evolving psychoanalytic views about homosexuality; d) research and contemporary topics about homosexuality; and e) evolution of personal and professional attitudes towards homosexuality

REFERENCES:

1. Miller D. Magee M: Lesbian Lives: Psychoanalytic Narratives Old and New. The Analytic Press, Mahwah, NJ, 1997.
2. Cabaj R, Stein T (eds): Textbook of Homosexuality and Mental Health. America Psychiatric Press, Washington, DC, 1996.

4. TOWARD A NEUROBIOLOGY OF PSYCHOTHERAPY SPONSORED BY THE APA COMMISSION ON PSYCHOTHERAPY BY PSYCHIATRISTS

Chairperson: Bernard D. Beitman, M.D.
Participants: Barton J. Blinder, M.D., Ph.D., Glen O. Gabbard, M.D., Jerald Kay, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be able to foster the development of mind/brain thinking in psychiatric treatment

SUMMARY:

The Commission on Psychotherapy by Psychiatrists will present evidence from neuroscience to suggest the manner in which psychotherapy affects brain function. The purposes of this presentation are to help to accelerate concurrent clinical conceptualizing of the brain and mind during psychiatric treatment, and to connect psychotherapy theory to brain function. Presenters will describe a functional psychiatric neuroanatomy relevant to both pharmacotherapy and psychotherapy and review the effectiveness of psychotherapeutic interventions in well-established biological dysfunctional disorders including schizophrenia and recurrent depression. After describing several psychotherapeutic processes, the presenters will map several of them onto brain function including the following: the neurobiology of motivation, the neurobiology of neurotic patterns, neuroanatomical and cellular basis for learning and memory within the psychotherapeutic relationship, and the role of the prefrontal cortex in modulating internal and internal demands to reach judgment and decision making.

REFERENCES:

1. Quartz SR, Sejnowski TJ: The Neural Basis of Cognitive Development: A Constructivist Manifesto. Behavioral and Brain Sciences, in press.
2. Kandel ER: Cellular Mechanisms of Learning and the Biological Basis of Individuality: In Kandel ER, Schwartz JH, Jessel TM (eds): Principles of Neuroscience, Third Edition. New York, Elsevier, pp. 1009-1031, 1991.

5. THE FUTURE OF THE PSYCHIATRIC WORKFORCE

Chairperson: Allan Tasman, M.D.
Participants: Larry R. Faulkner, M.D., Gloria Pitts, D.O., Nyapati R. Rao, M.D., James H. Scully, Jr., M.D., Mary Kay Smith, M.D., Eva M. Szigethy, M.D., Sir David Paul Goldbert, D.M.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will understand the variety of forces at work which are influencing workforce issues in psychiatry. The participant will also be aware of the approach that the APA and other national organizations are using to address workforce needs in psychiatry.

SUMMARY:

Over the last several years, there has been significant national debate about the size of the needed workforce in medicine. The debate within psychiatry has paralleled with other specialties. When considering workforce projections, a variety of factors must be considered. These factors include the assumptions which underlie the various projections, access to quality care by members of various populations within the U.S., the scope of psychiatric practice, federal and state government policies regarding reimbursement for care and training, and the impact of professional and patient advocacy groups on the political debate. This forum will review all aspects of these issues by members of the APA Workforce Group and invited guests. Significant opportunity for audience interaction will be available.

REFERENCES:

1. 1. Faulkner, LF, Goldman CR: Estimating Psychiatric Manpower Requirements Based on Patients' Needs. Psychiatric Services 48(5): 666-670, 1997.
2. The Nation's Physician Workforce: Options for Balancing Supply Requirements. In: Lohr KN, Vanselow NA, Detmer DE (eds): Committee on the U.S. Physician Supply, Division of Health Care Services Institute of Medicine. National Academy Press, Washington, DC, 1996.

6. CHALLENGES IN TEACHING PSYCHIATRY IN THE NEXT CENTURY APA'S GEORGE TARJAN AWARD FORUM

Chairperson: Richard Balon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will understand old and new challenges that face academic psychiatry in the era of profound changes in health care.

SUMMARY:

In an era of diminishing resources, teaching psychiatry has gradually become the forgotten item on the agenda of academic psychiatry. However, it is necessary to challenge the wisdom of a decreased emphasis on teaching psychiatry during profound changes in health care. Poor teaching in psychiatry will not only undermine the quality of patient care, but will also threaten the level of excellence within the field of psychiatry. Inadequately prepared psychiatrists will not be able to face external (e.g., other mental health professions and managed care) and internal (e.g. rapidly emerging research findings) pressures. The teaching of psychiatry needs a re-evaluation on several levels: teaching psychiatry to medical students, psychiatry residents and other disciplines, and continuous education of practicing psychiatrists. There is also a lack of modern comprehensive text focused on teaching psychiatry. Finally, there is a need to focus on areas which have not been properly addressed in teaching psychiatry before, such as collaboration with other mental health professionals, managed care, organized medicine, patients' groups and organizations, and other related topics.

REFERENCES:

1. Yager J (ed): Teaching Psychiatry and Behavioral Science. Grune & Stratton, New York, 1982.

7. TRUST IN HUMAN SUBJECT RESEARCH

Chairperson: John M. Oldham, M.D.
Participants: Paul S. Appelbaum, M.D., Eva G. DeRenzo, M.D., Laurie M. Flynn, M.A., Robert J. Levine, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will have a greater appreciation of the complex issues and tensions regarding human subject research with vulnerable populations, including issues of risk versus benefit, public and consumer perceptions of research, and safeguards to ensure ethical and appropriate research.

SUMMARY:

National attention has been focused on ethical issues in human subject research, particularly research with vulnerable populations such as minors and adult subjects who lack capacity to provide informed consent. Critical questions include: 1) who should be authorized to provide surrogate consent for such research; 2) what level of risk can be justified in research with these patients; 3) should interventions or procedures that do not hold out the prospect of direct benefit to the patient be permitted with such populations; 4) how can public trust in research be projected in light of historical research abuses; (5) who should determine a patient's capacity to participate in informed consent and how; and 6) what degree of monitoring is appropriate for approved studies that include some risk. These and other questions have been considered in many states such as California, Maryland and New York, and they are under review by the Office of Research of the American Psychiatric Association, the National Institute of Health, the National Bioethics Advisory Commission and by other organizations. In this forum, panelists will

briefly review these issues followed by an interactive discussion with the audience.

REFERENCES:

1. Grisso T, Appelbaum PS: Comparison of Standards for Assessing Patients' Capacities to Make Treatment Decision. Am J Psychiatry 152: 1033-1037, 1995.
2. Keyserlingk EW, Glass K, Kogan S, Gauthier S: Proposed Guidelines for the Participation of Persons with Dementia as Research Subjects. Perspect Biol Med 38(2): 319-362, 1995.

8. THE IMPACT OF AMERICAN PSYCHIATRY ON THE DEVELOPMENT OF PSYCHIATRY IN ASIA
APA's Kun-Po Soo Award Forum

Chairperson: Robert O. Pasnau, M.D.
Co-Chairpersons: Roy W. Menninger, M.D., Ton-That Niem, M.D.
Participants: Ching-Piao Chien, M.D., Kyu-Hang Lee, M.D., Masahisa Nishizono, M.D., Zhang Mingyuan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will understand the role that American psychiatry has played in the development of modern psychiatry in Asian countries.

SUMMARY:

Four presentations will be made by leaders of psychiatry in four of the major Asian countries. All four leaders have played major roles in academic and organized medicine in their respective countries for the past four decades, and they have witnessed the increasing international cooperation and mutual assistance over these years. They will pay particular note to the role played by American psychiatry and the American Psychiatric Association, the Pacific Rim College of Psychiatrists, and the U.S. National Institute of Mental Health in the development of modern psychiatry in their countries. This includes public psychiatry, private hospital psychiatry, academic psychiatry including psychiatric medical school of residency education, psychiatric research, psychiatric consultation and liaison, child psychiatry, addiction and alcohol abuse and administrative psychiatry.

REFERENCES:

1. Gaw A (ed): Culture, Ethnicity and Mental Illness. American Psychiatric Press Washington DC, 1992.

9. WHO WILL PAY FOR THE TREATMENT OF SUBSTANCE ABUSE
Collaborative Session With The National Institute On Drug Abuse

Chairperson: Roger E. Meyer, M.D.
Participants: Jerome H. Jaffe, M.D., William H. Goldman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will be able to describe the challenges facing clinicians and patients in the area of addictive disorders in the context of major changes in health policy and financing of health care.

SUMMARY:

The efficacy of treatments for addictive disorders is comparable with the results found with other chronic disorders such as diabetes or asthma. Treatment of substance use disorders should be a high priority for the health care system because every $1 in treatment brings $4-$12 of cost savings. Funding for treatment has been seriously curtailed in the last few years in both the public and private sectors, and, where treatment is available, it tends to be too short-term to address the long-term issues of a chronic illness. Dr. Meyer will summarize some of these issues and address the panelists with the questions about what the federal government is doing and what corporate America is doing to deal with the treatment needs of persons with addictive disorders. Dr. Jaffe will describe what has been done in the past, and what is currently going on to address treatment needs in the 'War on Drugs.' Dr. Goldman will highlight the fact that corporate America's perspective differs depending upon whether the insured person is in a safety sensitive position (e.g., transportation), whether there are union considerations with bargained benefits, and/or whether there is total employer discretion on this issue. Managed behavioral health care is, to some extent, hostage to these different motives in corporate America.

REFERENCES:

1. O'Brien CP, McLellan AT: The Treatment of Addictive Disorders. Lancet 347:237-242, 1996.
2. Gerstein DR, Harwood HJ (eds): Treating Drug Problems. National Academy Press, Washington, DC pp. 154-167, 1990.

10. PRESCRIPTION OF MEDICINE BY NON PHYSICIANS: CONCERN FOR THE PUBLIC WELFARE AND POLITICAL PRESSURES

Chairperson: Ronald A. Shellow, M.D.
Participants: Jay B. Cutler, J.D., Rodrigo A. Munoz, M.D., Jeremy A. Lazarus, M.D., Michelle Riba, M.D., Scott D. Hagaman, M.D., Dudley M. Stewart, Jr., M.D., Maurice Rappaport, M.D.

SUMMARY:

The object of this presentation is to briefly examine issues about patient welfare in the complexity of prescription of medicine to persons suffering from psychiatric disorders. The panel will review efforts by non-physicians to obtain, through legislation, initiative, or regulation, the privilege to prescribe medicine. We will analyze issues such as accessibility and education of prescribers and needs of patients and discuss the politics of efforts in the various states and strategies to prevent injury to the public by putting prescribing in the hands of less well-trained people. Finally, we will try to assist those facing these issues in their home states.

INDUSTRY-SUPPORTED SYMPOSIUM 1—MAINTENANCE TREATMENT OF DEPRESSION: THE FINAL EPISODE
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The acute response to an antidepressant is but the beginning of treatment. After the patient is well for the rest of life, the task is staying well. Attendees will learn the long-term course, morbidity and mortality, and treatment of chronic and recurrent depression.

No. 1A
DEPRESSION IS A RECURRENT AND CHRONIC ILLNESS

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

SUMMARY:

Clinical depression represents a major medical disorder with significant public health consequences. While its high prevalence has been accepted for several decades, the high rate of recurrence (greater than 75%) in community-dwelling as well as treatment-seeking populations is now better appreciated. Recurrent mood disorders are present across the entire lifespan and can have their onset from the prepubertal years into the 60's, 70's, and 80's. With each recurrence, 10%–15% of subjects will develop chronicity or treatment refractoriness. The consequences of untreated or inadequately treated depression are felt not only by the person suffering from the disorder but by family members, friends, employers, and coworkers. Untreated depression may lead to greater physical morbidity as well, and between 10%–20% of depressed patients commit suicide. Epidemiologic studies and clinical trials have now pointed to the need to identify recurrent mood disorders, whether unipolar or bipolar, for long-term maintenance treatment.

No. 1B
MORBIDITY OF DEPRESSION: MAJOR CAUSES, TARGETED RESPONSES

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

SUMMARY:

Depression has always been a prevalent, pernicious disease, but its morbidity, mortality, and "costs" are only now receiving recognition. Depressive morbidity encompasses severe suffering, occupational impairment/absenteeism, deterioration of interpersonal/family relationships, physiologic dysfunction, worsening of comorbid diseases, direct/indirect financial costs, and even death (e.g., a 15% risk of suicide). Root causes of morbidity (often interactive) are: 1) disease-related (e.g., depression's recurrent course with worsening severity, longer duration with each new episode; 2) patient-related (e.g., failure to recognize symptoms; reluctance to seek treatment; noncompliance); 3) clinician and health system related (e.g., limited knowledge about treatment; lack of insurance parity); and 4) treatment related (e.g., starting medications too late; improper drug selection; subtherapeutic or excessive dosage; adverse drug reaction/interaction; failure to employ maintenance treatment).

If clinicians are to lead efforts to diminish morbidity, it will be necessary to "target" those key causes for which effective interventions are known. Recommendations include: starting psychopharmacologic treatment before chronicity or multiple recurrences and cycle acceleration have developed; selecting better-tolerated medications; actually using technological interventions (e.g., tailored personal digital computer messages, MEMS-Caps) to enhance compliance; and, especially, emphasizing extended maintenance treatment for patients at risk for relapse.

No. 1C
ANTIDEPRESSANT MAINTENANCE THERAPIES: IMPROVING OUTCOMES

A. John Rush, M.D., *Department of Psychiatry, University of Texas Southwestern Medical Center, 5959 Harry Hines Blvd, Suite 600, Dallas TX 75235-9070*

SUMMARY:

Long-term (maintenance) medication is used to prevent new episodes (recurrences) of depression. This presentation will review the efficacy of maintenance-phase treatments that have been the subject of multiple randomized trials. However, medication alone is often insufficient to obtain optimal individual outcomes. Helping patients and significant others to monitor symptoms and function, to identify and report early symptom worsening, and to anticipate and manage life events, antecedent general medical conditions, medication adjustments, etc. will all likely improve outcomes. Suggestions for long-term management of depression during maintenance-phase treatment based on clinical experience will be outlined. Procedures useful in the longer-term management of hypertension or diabetes will be discussed, as they often apply to depression. In addition, recommendations will be offered for service delivery system modifications that should result in early intervention for symptom worsening.

No. 1D
THE REALITY OF CURRENT ANTIDEPRESSANT MAINTENANCE TREATMENT

Ellen Frank, Ph.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh PA 15213-2593*

SUMMARY:

Studies completed in the 1980's and 1990's (Prien et al., 1984; Frank et al., 1990; Kupfer et al., 1992; Robinson et al., 1991) demonstrated the efficacy of full-dose antidepressant maintenance pharmacotherapy in midlife patients. Early results from a trial examining similar questions in 60- to 80-year-old subjects suggest similar outcomes for the elderly. All of these studies, however, examined the efficacy of tricyclic or MAOI antidepressant compounds, rarely used as first-line treatments today. To date there have been no true maintenance trials of the selective serotonin reuptake inhibitor (SSRI) antidepressants most commonly used in clinical practice at this point in time. This presentation will review the evidence for the efficacy of full-dose tricyclic maintenance strategies and will attempt to extrapolate from continuation treatment studies of SSRI's what might be expected in terms of their efficacy as truly long-term prophylactic treatments. Is there empirical evidence to substantiate the clinical impression that SSRI's may lose their efficacy with longer treatment duration? Are there any data to suggest that one of these newer compounds might be superior to another as a maintenance treatment? What algorithms might clinicians follow in making decisions about how to initiate and continue treatment in unipolar patients with a high probability of recurrence?

No. 1E
THE SSRI DISCONTINUATION SYNDROME

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

SUMMARY:

As with many classes of medications to which the body adapts, sudden interruption of treatment or abrupt discontinuation of antidepressants has been associated with the emergence of new symptoms related to perturbation of treatment cessation. In recent years, a number of spontaneous reports and published cases suggest that a discontinuation syndrome may occur with abrupt discontinuation of SSRIs and related drugs including new symptoms such as dizziness, ataxia, sleep and dreaming changes, flu-like symptoms, and nausea and vomiting. Psychological distress also may occur that mimics mood and anxiety symptom worsening. Frequency of reports suggests the risk of these events occurring is highest with shorter half-life agents and rare with those having longer half-lives. Recognition and awareness of the syndrome is critical to minimize patient distress by addressing compliance during treatment and gradually tapering medication at treatment termination. Controlled trials of treatment interruption support the hypothesis that half-life is a risk/protective factor for the syndrome, with discontinuation symptoms emerging during one-week interruption of paroxetine and sertraline therapy but not for fluoxetine. The long half-life SSRI fluoxetine was not associated with the syndrome after abrupt discontinuation over a one-week or six-week observation period.

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4. Thase ME, Kupfer DJ: Recent developments in the pharmacotherapy of mood disorders. Journal of Consulting and Clinical Psychology, 1996;64:646–659.
5. Zajecka J, Tracy KA, Mitchell S: Discontinutation symptoms after treatment with serotonin reuptake inhibitors: a literature review. J Clin Psychiatry, 1997;58:291–297.

INDUSTRY-SUPPORTED SYMPOSIUM 2—DEPRESSION AS A RISK FACTOR FOR CARDIOVASCULAR AND CEREBROVASCULAR DISEASE: EMERGING DATA AND CLINICAL PERSPECTIVES
Supported by SmithKline Beecham Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to describe the comorbid epidemiology of cardiovascular disease and depression and to outline the medical management of depression in cardiovascular patients; to understand the pathophysiologic relationship between depression, platelet dysfunction, and cardiovascular and cerebrovascular disease; to recognize the implications of heart rate variability in patients with mood and anxiety disorders; and to outline rational use of antidepressants in the cardiac patients.

No. 2A
THE CLINICAL COURSE AND MEDICAL MANAGEMENT OF DEPRESSED PATIENTS WITH ISCHEMIC HEART DISEASE

Christopher O'Connor, M.D., *Department of Cardiology, Duke University Medical Center, Box 3356, Room 740 IA, Durham NC 27710*

SUMMARY:

There is growing evidence that psychological stress in general and depression in particular predisposes to cardiovascular and cerebrovascular disease. Persons who experience mental stress during daily life are at twice the risk of myocardial ischemia following that stress. Depression following a myocardial infarction is associated with higher mortality compared with nondepressed controls. These data suggest a psychophysiologic mechanism underlying the vulnerability of depressed patients to ischemic heart disease. This presentation will review these data, including the seminal studies of Frasure-Smith and colleagues, that prospectively followed patients who had suffered a myocardial infarction and demonstrated that depression was associated with a much higher risk of both cardiovascular morbidity and mortality. Physicians should maintain a heightened level of clinical suspicion for depression and depressive disorders in patients at risk of ischemic heart disease, particularly those patients who are recovering from an acute ischemic event, such as a myocardial infarction. Depression should be aggressively treated in this at-risk population.

No. 2B
ARE PLATELETS THE LINK BETWEEN DEPRESSION AND ISCHEMIC HEART DISEASE?

Charles B. Nemeroff, M.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive, Suite 4000, Atlanta GA 30322*

SUMMARY:

Depression has been clearly linked to ischemic heart disease. Recent studies have demonstrated the role of major depression as an independent risk factor for, rather than a psychological response to, the progression of cardiovascular disease. The platelet response to psychological stress and/or depression is one hypothesis that has been explored in the study of this observed relationship. Inhibition of platelet function prevents coronary disease, but platelet activation leads to thrombosis and acute coronary events. Depressed patients exhibit exaggerated platelet reactivity compared with nondepressed subjects, which may be one mechanism underlying depression as a risk factor for ischemic events. Increased susceptibility to platelet activation may be one mechanism by which depression increases the risk for ischemic heart and cerebrovascular disease and fatal events after myocardial infarction.

No. 2C
DEPRESSION AS A CONTRIBUTING FACTOR IN CEREBROVASCULAR DISEASE

K. Ranga Rama Krishnan, M.D., *Department of Psychiatry, Duke University, 3018 South Hospital, Rm. 3352, Durham NC 27710*

SUMMARY:

The relationship between stroke and depression has been well established. Depressive disorders are common following stroke and are often related to the location of the lesion. Recent studies demonstrated that the presence of depression complicates recovery from stroke and may indeed increase mortality. Of particular interest is emerging data from the SHEP (systolic hypertension in the elderly) study that depression and anxiety may be risk factors for stroke. This coupled with data that depression and anxiety may also be risk factors for hypertension suggests that the depression may be a factor in both the occurrence of stroke as well as recovery following stroke. Since subcortical stroke (often without localizing findings) is common in late-life depression, it will be interesting to speculate whether similar mechanisms operate in these patients; i.e., whether there is an increase in mortality and whether presence of depression in these patients increases the risk for worsening of cerebrovascular disease.

No. 2D
HEART RATE VARIABILITY IN DEPRESSIVE AND ANXIETY DISORDERS

Jack M. Gorman, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York NY 10032;* Richard Sloan, Ph.D., Peter A. Shapiro, M.D.

SUMMARY:

Considerable evidence indicates that loss of the normal autonomic nervous system control of heart rate and rhythm is an important risk factor for adverse cardiovascular events. For example, following myocardial infarction, reduction in beat to beat heart period variability (HPV), a measure of cardiac autonomic innervation by the brain, is a strong predictor of death. Normally, heart rate varies on a beat basis because of parasympathetic innervation to the heart, transmitted from the brain via the vagus nerve. With loss of vagal innervation, as is seen in severe neuropathy and in cardiac heart transplant patients, there is loss of heart period variability. It is speculated that such decrease in parasympathetic innervation leaves the heart entirely prone to the unbalanced stimulatory effects of sympathetic nerves. This makes the heart vulnerable to arrhythmia and sudden death and also accelerates the development of atherosclerotic coronary artery disease. Several studies now suggest that patients with mood and anxiety disorders as well as individuals prone to dysphoric emotional states may have increased risk of cardiovascular disease. Following myocardial infarction, depressed patients have higher mortality rate than nondepressed patients. Prospectively, depression appears to entail a higher risk of cardiac disease. Men with "phobic anxiety," a construct that appears to overlap substantially with panic disorder also have higher rates of sudden cardiac death and coronary artery disease than control populations. Evidence now also suggests that reduction in autonomic nervous system control to the heart may be the link between psychopathology and heart disease. Although tricyclic antidepressants reduce heart period variability, SSRI antidepressants do not, and at least one study has suggested that paroxetine treatment of panic disorder patients normalizes heart period variability. Hence, there is potential for psychiatric treatment to positively affect the development of heart disease.

No. 2E
CONSIDERATIONS FOR THE USE OF ANTIDEPRESSANTS IN PATIENTS WITH ISCHEMIC HEART DISEASE

Steven P. Roose, M.D., *Clinical Psychopharmacology, New York State Psychiatric Institute, 722 West 168th Street, PI 98, New York NY 10032*

SUMMARY:

There is strong evidence that patients with depression more frequently develop symptomatic and fatal ischemic heart disease and that patients with manifest ischemic heart disease who are also depressed have an increased mortality rate. It is unknown whether treatment of depression will prevent the development of ischemic disease or reduce the associated increase in cardiac mortality. However, before this question can be studied, it needs to be established that there is a safe and effective antidepressant therapy for patients with cardiac disease.

Although at one point it was believed that tricyclic treatment was a relatively "safe" therapy with a favorable risk/benefit ratio in patients with heart disease, recent data have mandated a significant revision of this conclusion. Studies have established that, specifically in post-myocardial-infarction patients with ventricular arrhythmia and probably in patients with ischemic heart disease in general, drugs with a class 1A or 1C antiarrhythmic action are associated with an increased mortality rate compared with placebo. Since tricyclics have class 1A antiarrhythmic action, it is both reasonable and prudent to assume that tricyclic treatment carries the same risk.

The obvious question is whether the SSRIs are a safe and effective alternative. There are data from two studies available on the use of SSRIs in this patient population: 1) a double-blind randomized trial comparing paroxetine to nortriptyline in depressed patients with ischemic heart disease and 2) an open trial of sertraline in the treatment of depression in the immediate post MI period. The limited data available suggest that the SSRIs have a relatively benign cardiovascular profile and do not carry the same risks as the tricyclics when used in patients with ischemic disease.

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INDUSTRY-SUPPORTED SYMPOSIUM 3—MANAGEMENT OF IATROGENIC SEXUAL DYSFUNCTION
Supported by GlaxoWellcome Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize antidepressant-induced sexual dysfunction either by clinical interview or questionnaire. The participant also should be able to either manage the patient with SSRI-induced sexual dysfunction or utilize SSRI's to treat selected primary sexual dysfunctions.

No. 3A
ETIOLOGY AND INCIDENCE

R. Taylor Segraves, M.D., *Department of Psychiatry, Case Western Reserve University, 2500 Metro Health Drive, Cleveland OH 44109-1998*

SUMMARY:

Large clinical series, double-blind controlled studies, and post-marketing surveillance have all consistently reported a high incidence of antidepressant-induced sexual dysfunction, especially problems with orgasm and ejaculation. These difficulties have occurred with monoamine oxidase inhibitors, tricyclic antidepressant, and serotonin reuptake inhibitors. Current evidence suggests that these problems may occur in excess of 30% of patients and be an unspoken cause of treatment noncompliance. These problems appear especially common with the serotonin reuptake inhibitors and uncommon with buproprion, nefazodone, and mirtazapine. Among the serotonin reuptake inhibitors, fluvoxamine appears to have a lower incidence than the other drugs in this class. The most widely accepted hypothesis is that antidepressant drugs mainly interfere with sexual function by stimulating the 5HT2 receptor.

No. 3B
ASSESSMENT OF SEXUAL FUNCTIONING

Anita L.H. Clayton, M.D., *Department of Psychiatry, University of Virginia, 2955 Ivy Road, Suite 210, Charlottesville VA 22903*

SUMMARY:

A number of factors contribute to difficulties obtaining information regarding sexual functioning including patient issues, physician-related factors, and the need for a standardized assessment tool. Phase-specific function (desire, arousal, and release) for both sexes must be evaluated with regard to premorbid psychosexual adjustment, illness effects, and medication-related changes in both clinical and research settings. Comorbid medical conditions and concurrent medications affecting sexual functioning should also be documented. The Changes in Sexual Functioning Questionnaire (CSFQ) is a brief instrument (35 questions for females, 36 questions for males), given as a structured interview or as a self-report, developed to measure sexual function changes accompanying illness or the administration of medications. A series of studies will be presented to demonstrate the validity and reliability of the Changes in Sexual Functioning Questionnaire, specifically, internal consistency, concurrent validity with the Derogatis Interview for Sexual Functioning, test-retest reliability, and the ability of the CSFQ to differentiate between clinical (depressed) and nonclinical samples on total CSFQ score, as well as on five subscales (desire/frequency, sexual pleasure, sexual desire/interest, arousal, and orgasm).

No. 3C
MANAGEMENT OF SRI-INDUCED SEXUAL DYSFUNCTION

Adam K. Ashton, M.D., *Department of Psychiatry, Buffalo Medical Group, 295 Essjay Road, Williamsville NY 14221*

SUMMARY:

Serotonin reuptake inhibiting antidepressants (SRI's) have revolutionized the treatment of depressive and anxiety disorders since their United States release in the late 1980's. Unfortunately, sexual dysfunctions have been reported to be common side effects of this class of drugs. According to the DSM-IV, sexual dysfunctions are defined as any clinically significant alteration in desire, arousal, or orgasm resulting in marked distress or interpersonal difficulty.

Several strategies for management of SRI-induced sexual dysfunction have been offered. These include waiting for spontaneous remission, dose reduction, change in antidepressant, drug holiday, and augmentation with another pharmacologic agent. Augmentation strategies have included yohimbine, amantadine, cyproheptadine, bupropion, stimulants, buspirone, bethanechol, nefazodone, and ginkgo biloba.

This presentation will delineate clinically relevant techniques for determining the optimal intervention for subsets of patients. Suggestions will be based upon the largest published study of SRI-induced sexual dysfunction as well as a recently completed study of bupropion as an augmenting agent. Yohimbine, effective in 80% of patients, was a superior augmenting agent when compared with amantadine and cyproheptadine. In addition, bupropion was effective in reversing SRI-induced sexual dysfunction in 66% of patients. Efficacy, advantages, and disadvantages of all proposed treatment strategies will be reviewed.

No. 3D
SSRI'S IN PREMATURE EJACULATION AND PARAPHILIAS

Richard Balon, M.D., *Department of Psychiatry, University Psychiatric Center, 2751 East Jefferson, Suite 200, Detroit MI 48207*

SUMMARY:

Premature ejaculation is the most prevalent sexual dysfunction among males, with estimates of prevalence up to 40 percent. It is defined as a persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes. The pause maneuver, pause-squeeze technique, and stop-start method have been standard treatments for this condition for a long time. However, serotonergic antidepressants have emerged as an effective treatment for premature ejaculation. Recent studies have demonstrated the efficacy and safety of clomipramine, fluoxetine, paroxetine, and sertraline in the treatment of premature ejaculation. SSRI's seem to be a logical treatment of choice especially in cases of failed psychological treatment, when psychological treatment rejected, or the partner is unwilling to cooperate.

The essential feature of paraphilias is recurrent, intense sexually arousing fantasies and urges. Paraphilias have been described as impulse disorders, obsessive-compulsive spectrum disorders, or affective spectrum disorders. SSRI's, namely fluoxetine, demonstrated efficacy in the treatment of impulse disorders, obsessive compulsive disorder, and mood disorders. Fluoxetine also reduced paraphilias and nonparaphilic sexual addictions in one study. This presentation will review the efficacy, management strategies, and advantages and disadvantages in the treatment of premature ejaculation and paraphilias with SSRI's.

REFERENCES:

1. Segraves RT: Overview of sexual dysfunction complicating the treatment of depression. Monograph, J Clin Psychiatry 1992;10:4–10.
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INDUSTRY-SUPPORTED SYMPOSIUM 4—COGNITION IN SCHIZOPHRENIA: THE NEW THERAPEUTIC GOAL
Supported by U.S. Pharmaceuticals, Pfizer Inc

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the dimensions of cognitive dysfunction in schizophrenia, its etiology in neuropathology, the value of imaging to identify abnormal cognitive mechanisms, the role of drug therapy to remediate it, and its importance for work and social function.

No. 4A
DIMENSIONS OF COGNITIVE DYSFUNCTION IN SCHIZOPHRENIA: THE KRAEPELINIAN LEGACY

Philip D. Harvey, Ph.D., *Department of Psychiatry, Mt. Sinai Medical Center, One Gustave L. Levy Place, New York NY 10029*

SUMMARY:

Cognitive impairment in schizophrenia is present before, during, and after active psychotic episodes of illness. Individuals who have not yet developed schizophrenia perform considerably more poorly

in childhood than their siblings and peers who do not develop the illness. Patients in their first episode of illness have impairments that are as severe on average as patients with several years of illness, although patients with a poorer overall outcome are consistently more impaired in their cognitive functions. Many different domains of cognitive functioning are impaired in schizophrenia, with the most severe deficits in areas of memory, including memory span, serial learning, and delayed recall. Many aspects of memory and attentional functioning are performed as much as 2 or 3 standard deviations below expectations based on age and educational attainment. At the same time, there is a gradient of impairment across cognitive functions, with aspects of long-term memory often essentially unimpaired. The severity of negative symptoms is consistently found to be related to the overall severity of cognitive impairments, while positive symptom severity is typically found to be related only to a few indices of attentional functioning. Analyses of the profile of memory impairment have suggested that it resembles that seen in subcortical conditions, although some poor outcome patients have deficits in cortical functions that are as severe as those seen in progressive dementing conditions, much as Kraepelin suggested. The cognitive performance profile suggests several possible neurological causes of these impairments and possible intervention directions, which will be discussed in other presentations in this symposium.

No. 4B
CORTICAL CIRCUITRY AND COGNITION IN SCHIZOPHRENIA

David A. Lewis, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, W1651, Pittsburgh PA 15213-2593*

SUMMARY:

Certain disturbances in cognition in schizophrenia appear to be related to dysfunction of the prefrontal cortex (PFC), and this dysfunction is thought to be the consequence of a diminished substrate for neuronal connectivity in this region. For example, levels of synaptophysin, a critical protein in synaptic transmission, are decreased in the PFC of schizophrenic subjects. Understanding the relationship between these abnormalities and the cognitive disturbances of schizophrenia requires an appreciation of the specific components of PFC circuitry that are affected. The results of preliminary studies suggest that the density of dendritic spines, markers of excitatory synaptic inputs, is selectively decreased on certain populations of pyramidal neurons in the PFC of schizophrenic subjects. In addition, we quantified the density of axon terminals immunoreactive for GABA transporter-1, a marker of inhibitory synapses. These studies revealed a significant 40% decrease in the number of GAT-1-immunoreactive axon terminals arising from the chandelier class of GABA neurons. Since the axons of chandelier cells selectively target the axon initial segment of pyramidal neurons, these findings suggest that this type of potent inhibitory control over pyramidal cell activity is altered in schizophrenia. In summary, these findings suggest that the dysfunction of the PFC in schizophrenia is associated with a decrease in synaptic connectivity in this region, and that these changes may preferentially affect the regulation of pyramidal cell activity.

No. 4C
FUNCTIONAL MRI STUDIES OF COGNITIVE FUNCTION IN SCHIZOPHRENIA

Daniel R. Weinberger, M.D., *National Institute of Mental Health, St. Elizabeths Hospital, 2700 Martin Luther King, Jr. Avenue, SE, Washington DC 20032-2698;* Venkata Mattay, M.D., Joseph H. Callicott III, M.D., Kathryn J. Kotria, M.D., Attanagoda Santha, Ph.D., Peter Van Gelderen, Ph.D., Jeff Duyn, Ph.D.

SUMMARY:

fMRI has unique potential in the study of psychiatric patients, particularly in characterizing individual variations and changes over time. Patients with schizophrenia have been studied with various fMRI acquisition protocols: (1) 3-D echo-shifted FLASH, a multishot volumetric approach; (2) 3-D PRESTO, a hybrid of multishot and echo-planar imaging (EPI) methods that also acquires true volumetric data; and (3) a whole-brain isotropic, multislice EPI technique during cognitive and other activation procedures. In general, patients show normal sensorimotor activation responses, although motor cortical activation tends to be less completely lateralized. Prefrontal activation during working memory tends to be reduced in patients with schizophrenia even when performance is normal. A major potential confound in studying this patient population with fMRI is the effect of motion. We propose several methodological standards to address this problem, including comparisons of motion corrections parameters, voxel variances, and the use of an "internal activation standard."

No. 4D
EFFECT OF ANTIPSYCHOTIC DRUGS ON COGNITION IN SCHIZOPHRENIA

Herbert Y. Meltzer, M.D., *Department of Psychiatry, Psychiatric Hospital at Vanderbilt University, 1601 23rd Ave. South, Suite 306, Nashville TN 37212;* Susan R. McGurk, Ph.D.

SUMMARY:

Varying degrees of cognitive impairment are present in virtually all patients with schizophrenia from the first episode of schizophrenia onwards; lesser impairment may be present during the premorbid period. Typical neuroleptic drugs have been found to have minimal effects on improving cognition. Those agents with strong anticholinergic properties may worsen some types of memory. There is a growing literature that indicates that some atypical antipsychotic drugs have the ability to improve some domains of cognition. In particular, clozapine has been found to improve attention, semantic memory, and recall memory in a number of studies. It does not affect executive function as assessed by the Wisconsin Card Sorting Test. Risperidone has recently been found to improve spatial working memory, while clozapine did not improve verbal working memory. Melperone, another atypical antipsychotic of the 5-HT/DA series, also improves some types of cognition. Studies with olanzapine and ziprasidone, two other new atypical antipsychotic drugs, will be reported. These effects on cognition are independent of effects on psychopathology. These preliminary findings suggest that the choice of which antipsychotic drug to chose may be based on their efficacy with regard to their cognitive effects and major impairments in cognition specific patients.

No. 4E
COGNITIVE IMPAIRMENT AND PSYCHOPATHOLOGY AS DETERMINANTS OF ABILITY TO WORK IN SCHIZOPHRENIA

Susan R. McGurk, Ph.D., *Department of Psychiatry, Vanderbilt University, 1601 23rd Avenue South, #306, Nashville TN 37212;* Herbert Y. Meltzer, M.D.

SUMMARY:

Ability to work up to the level of premorbid functioning is absent in 60%–80% of patients with schizophrenia, despite control of positive symptoms with antipsychotic medications. There is some published evidence that cognition influences the capacity to work (e.g., Green, 1996). We have conducted two studies that have further examined these issues. In the first study, 116 schizophrenia subjects who were

treated with clozapine were evaluated at baseline and employment status was followed for 12 months. Baseline performance on measures of executive functioning, verbal working memory, verbal learning and memory, and verbal fluency differentiated those subjects whose employment status changed from unemployed to employed (N = 33) from those subjects who remained unemployed (N = 61) but not from those who remained employed (N = 22), whereas negative and positive symptom clusters did not. These findings validate the roles of executive functioning and verbal learning and memory in vocational outcomes in schizophrenia and extend them to include a role for verbal working memory and fluency. Similar results were found in regard to cognition in a second study of 30 schizophrenia subjects treated with a variety of antipsychotic medications who had maintained a stable working status (full time, part time, and not working) for a minimum of one year. A forward selection regression procedure indicated that premorbid cognitive functioning, executive functioning, and negative symptoms were the strongest predictors of employment status adjusted for workload complexity. We conclude that cognition, especially prefrontal function, is the main predictor of vocational functioning in schizophrenia.

REFERENCES:

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2. Gold JM, Harvey PD: Cognitive deficits in schizophrenia. Psychiatric Clinics of North America 1993;295–312.
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INDUSTRY-SUPPORTED SYMPOSIUM 5—OCD SUBTYPES: FROM CLINICAL TO MOLECULAR GENETICS
Supported by Solvay Pharmaceuticals, Inc. and Pharmacia & Upjohn Company, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participants will have greater understanding of the importance of making clear diagnostic distinctions in order to better define phenotype. In addition, they will have up-to-date knowledge on current findings in the genetics of OCD.

No. 5A
PHENOTYPIC COMPONENTS OF OCD

David Pauls, Ph.D., *Department of Child Studies, Yale University, 230 South Frontage Road, New Haven CT 06520*

SUMMARY:

Modern genetic studies of complex behavioral traits have relied on dichotomous phenotypes of affected/unaffected. Multiple components contribute to the assignment of an individual's affected status. Recent analytic trends include efforts to find biologically meaningful substrates of the affected/unaffected phenotypes in the hope of discovering homogeneous subgroups. Such subgroups are typically defined by ad hoc attempts at subclassification of a disorder based on symptomatic differences. A more deliberate approach to symptomatic subclassifications could use factor and/or cluster analytic techniques to discern any underlying phenotypic constructs. Factor analysis extracts information from the full range of available symptom data and reduces it to a handful of statistically significant factors, each of which is comprised of a group of nonoverlapping symptoms. We have recently completed two studies: a symptom factor analysis on a sample of 98 OCD probands and 82 OCD-affected first-degree relatives for whom complete symptomatic data were available from a family study of OCD; and a cluster analysis on a sample of 32 individuals with Gilles de la Tourette's syndrome and obsessive compulsive disorder. Results suggest that separate factors/cluster comprising subcomponents of OCD are heritable. These are not "subtypes" of OCD, but clusters of behaviors representing component parts of the disorder.

No. 5B
ARE OCD SPECTRUM DISORDERS DIFFERENT PHENOTYPES OF OCD?

Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustave Levy Place, Box 1230, New York NY 10029;* Cheryl M. Wong, M.D., Charles Cartwright, M.D., Concetta M. DeCaria, Ph.D., Bonnie A. Aronowitz, Ph.D., Lisa Margolin, Ph.D., Tomer Begaz, B.A.

SUMMARY:

An OCD spectrum has been proposed that includes a group of disorders that share certain features with OCD, including clinical symptoms, associated features, neurobiology, and preferential response to antiobsessional treatments, as well as family history in some cases. In this presentation, we explore whether the different OCD spectrum phenotypes represent different expressions of the same or closely related OCD genotypes. We have identified three clusters within the OCD spectrum that share phenotypic features. These include: 1) disorders with heightened focus on body image and body sensations, including body dysmorphic disorder, eating disorders, and hypochondriasis, 2) neurologically based disorders with repetitive behaviors, including autism, Tourette's syndrome, and Sydenham's chorea, and 3) disorders with impulsively driven repetitive behaviors, including pathological gambling, sexual impulsivity, compulsive shopping, kleptomania, and self-injurious behavior. We present and contrast phenomenology, neurobiology, and pharmacologic treatment response in body dysmorphic disorder, autism, and pathological gambling as examples of these three clusters. Specific biological factors appear to cut across these disorders and specifically correlate with severity of repetitive behaviors. For example, D8/17 positivity, a B cell marker present in rheumatic fever, Sydenham's chorea, Tourette's syndrome, and obsessive compulsive disorder, is also present in 78% of autistic patients vs. 21% of matched controls and strongly correlates with the severity of repetitive behaviors in autistic subjects ($r = .86$, $p = .007$). Likewise, increased anterior cingulate metabolic activity by PET is found in both OCD and autism and correlates with severity of repetitive behaviors. These findings support the notion that various phenotypic expressions may stem from common brain mechanisms, and perhaps genetic factors.

No. 5C
OCD AND SCHIZOPHRENIA: DIAGNOSTIC AND TREATMENT CONSIDERATIONS

Joseph Zohar, M.D., *Department of Psychiatry, Chaim Sheba Medical Center, Tel Hashomer 52621, Israel*

SUMMARY:

About 15% of chronic schizophrenic patients also suffer from obsessive compulsive disorder (OCD). The increased prevalence of OCD in schizophrenia compared with that in the general population (2%) has raised intriguing questions about association between the two. While identifying obsessive-compulsive (OC) symptoms in schizophrenia may be a diagnostic challenge, many schizophrenic patients can indeed differentiate the ego-dystonic OC symptoms, perceived as originating from within, from ego-syntonic delusions perceived as introduced from the outside. Long-term follow-up studies demonstrate diagnostic stability over the years and suggest that the presence of OCD in schizophrenia predicts a poor prognosis. Several studies among schizophrenic patients with OCD in which either an antiobsessive medication, such as clomipramine, or selective serotonin reuptake inhibitors were added to ongoing antipsychotic medications, showed a significant decrease in OC symptoms. In some cases they were also associated with an improvement in psychosis. Preliminary data also suggest a role for atypical neuroleptics such as clozapine and olanzepine in treating this subset of patients. The poor prognosis of schizo-obsessive patients, preliminary data regarding their response to the unique combination of antipsychotic and antiobsessive medications, along with the high prevalence of this presentation suggest that a schizo-obsessive subcategory may be of value.

No. 5D
MOLECULAR GENETICS OF OCD AND RESPONSE TO SRI'S

James L. Kennedy, M.D., *Neurogenetics, Clarke Institute, 250 College Street, Toronto, ON, M5T 1R8, Canada*

SUMMARY:

Obsessive compulsive disorder (OCD) is a common illness, characterized by anxiety-provoking thoughts and the need to perform rituals. OCD is most commonly treated with serotonin reuptake inhibitors (SRIs), which block the reuptake of serotonin (5-HT) into the presynaptic neuron, a process mediated by the serotonin transporter (5HTT). The successful use of SRIs in OCD has led to the hypothesis that the 5-HTT may play a pivotal role in the pathogenesis of OCD. We tested this hypothesis from a genetic perspective, based on evidence from family and twin studies. The 5-HTT gene has a 44bp insertion/deletion polymorphism in the promoter region. We typed 72 OCD patients and 72 matched controls, and found no statistically significant difference between the two groups ($X2 = 4.319$, $p = 0.115$, 2df). We observed, however, a trend towards increased homozygosity in the patient group. We also rated the patients' responses to SRIs. No association was observed between response and the polymorphism in the 5-HTT gene. Given the pharmacological evidence favoring a role for 5-HTT in SRI response, further genetic evaluation of the serotonin transporter in OCD is indicated.

At the end of this presentation, the participant should be able to understand the rationale for genetic etiology in OCD, the methods used in genetic association studies, and the potential importance of the serotonin transporter gene as a risk factor.

No. 5E
AUTOIMMUNITY AND OCD

Mark H. Rapaport, M.D., *Department of Psychiatry, University of California San Diego School of Medicine, 8950 Villa Jolla Drive, #2243, La Jolla CA 92037*

SUMMARY:

Husby and colleagues first reported in 1976 that there was a correlation between the presence of antibrain antibodies and Sydenham's chorea. They demonstrated that the course of Sydenham's chorea paralleled the antibrain antibody titers in these children. In the 1980s Dr. Susan Swedo and colleagues performed a series of epidemiological, clinical, and basic research studies that have developed a convincing body of evidence suggesting that some children who develop symptoms of obsessive compulsive disorder may indeed have an autoimmune mediated pediatric disorder. In parallel efforts, Goodman and colleagues and Leckman and Pauls, established that the presence of tics and Tourette's syndrome, obsessive compulsive symptoms, and obsessive-compulsive disorder may be causally related. The confluence of these data plus recent findings by both Drs. Swedo and Goodman's groups suggest that certain forms of obsessive compulsive disorder may be associated with an antigenic determinant that has been commonly found on peripheral β-lymphocytes, D8/17. Zabriskie and colleagues have shown this antigenic marker is far more prevalent in individuals at risk of developing rheumatic fever and rheumatic endocarditis. Swedo and Goodman have demonstrated an increased prevalence of this antigenic determinant in selected groups of individuals with obsessive compulsive disorder. This presentation attempts to unify these findings into a cogent argument that some individuals with early onset of obsessive compulsive disorder may have an autoimmune mediated process. By the end of this presentation participants should understand the epidemiological, genetic, and immunological data supporting this hypothesis.

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INDUSTRY-SUPPORTED SYMPOSIUM 6—PHARMACOTHERAPY OF BIPOLAR DISORDER: NEWEST ADVANCES Supported by Abbot Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) understand rapid stabilization strategies for acute mania, (2) recognize treatment approaches for bipolar depression, (3) understand the latest advances in maintenance treatment, and (4) recognize and treat comorbid substance use disorders.

No. 6A RAPID LOADING STRATEGIES IN THE TREATMENT OF ACUTE MANIA

Paul E. Keck, Jr., M.D., *Biological Psychiatry, University of Cincinnati, 231 Bethesda Avenue, Cincinnati OH 45267;* Susan L. McElroy, M.D.

SUMMARY:

Data from two open and one randomized, controlled trials suggest that rapid loading of divalproex (20mg/kg/day) may produce rapid antimanic effects with good tolerability. In addition, this strategy may also ameliorate psychosis in patients with psychotic mania. Two open studies also suggest that lithium formulations may be able to be administered with larger initial doses to produce more rapid antimanic activity. The results of a recently completed prospective, double-blind, controlled trial comparing lithium and divalproex administered via gradual titration vs. divalproex rapid loading in the treatment of patients with acute mania will be presented. The potential pharmacoeconomic implications of these various loading strategies will be discussed.

No. 6B BIPOLAR DEPRESSION

John M. Zajecka, M.D., *Department of Psychiatry, Rush-Presbyterian Medical Center, 1725 West Harrison, Suite 955, Chicago IL 60612*

SUMMARY:

The management of depression in bipolar disorder is among the most challenging treatment strategies. Clinical guidelines for the management of bipolar depression frequently depend upon several factors, including the type of bipolar disorder, subtype of depression, concomitant illness, prior response/failure, propensity of treatment and/or individual patient toward cycle acceleration, and duration of treatment. The currently available treatment options for bipolar depression will be presented, including the management of depression in rapid cycling bipolar disorder, and "resistant depression" in bipolar disorder.

No. 6C MAINTENANCE TREATMENT IN BIPOLAR DISORDER

Charles L. Bowden, M.D., *Department of Psychiatry, University of Texas, Health Sciences Center, 7703 Floyd Curl Drive, San Antonio TX 78284-7792;* Joseph R. Calabrese, M.D., Susan L. McElroy, M.D., Robert M.A. Hirschfeld, M.D., Frederick Petty, M.D., Laszlo Gyulai, M.D.

SUMMARY:

Maintenance treatment of bipolar disorder is for most patients the most crucial component of treatment for overall degree of recovery and function. Whereas studies of a quarter century ago yielded highly successful results with lithium-based maintenance therapy, studies of the past decade, mostly naturalistic in format, have yielded much more limited evidence for lithium's effectiveness. These studies have stimulated several well-designed, prospective, randomized maintenance phase drug trials in bipolar disorder. Results from a uniquely large study comparing lithium, divalproex, and placebo in a blinded one-year study will be presented and compared with other relevant studies. Patients treated with divalproex had fewer relapses into mania or depression than patients treated with either lithium or placebo. Divalproex was similarly effective in patients with initial pure or mixed manic episodes. Lithium was less effective in patients whose initial manic episode was pure or elated in subtype, and in particular provided no protection against depressive symptomatology in such patients. Among patients initially treated successfully with divalproex for acute mania, divalproex was more effective during maintenance than lithium or placebo. In contrast, successful treatment of acute mania with lithium did not predict a better outcome with lithium than divalproex or placebo during maintenance treatment.

No. 6D SUBSTANCE ABUSE COMPLICATING MANIC DEPRESSION

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

SUMMARY:

Alcohol and substance use disorders are common in the United States today, and are particularly common in individuals who also have psychiatric disorders. Data from the most recent epidemiologic survey, the National Comorbidity Study, indicate that individuals with mania are at a considerably enhanced risk for also having a substance use disorder when compared with the general population (odds ratio 6.8) (Kessler et al., 1996). Data from this study also indicate that the onset of the psychiatric disorder usually precedes the onset of the substance use disorder. In this presentation, data on the course and development of comorbid drug and alcohol use in bipolar disorder will be presented. Differential outcomes, possibly suggesting different treatment emphasis for individuals with primary versus secondary bipolar disorder, have been suggested (Winokur et al, 1995). Ongoing treatment studies are investigating both pharmacotherapeutic and psychotherapeutic strategies for the treatment of individuals with this comorbid bipolar disorder and substance use disorders. Preliminary data from these studies will be presented. Data from a recently completed study of 171 cocaine-dependent individuals stratified by the presence or absence of affective disorder indicate that carbamazepine, an anticonvulsant mood stabilizing agent, was significantly more effective than placebo in decreasing cocaine use in the group with bipolar affective disorder.

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treatment of acute psychotic mania. J Clin Psychiatry 1996;57:142–146
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INDUSTRY-SUPPORTED SYMPOSIUM 7—MOOD DISORDERS IN SCHIZOPHRENIA: UNITED STATES AND EUROPEAN PERSPECTIVES

Supported by the International Academy for Biomedical and Drug Research

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to be familiar with the characteristics of mood symptomatology and disorders observed during the course of schizophrenia. Data will be presented to clarify the interface between mood and schizophrenic disorders and to provide useful treatment algorithms for managing mood symptomatology in schizophrenic patients both through the use of new antipsychotic medications and/or adjunct mood-stabilizing drugs.

No. 7A
DEPRESSIVE SYMPTOMATOLOGY IN SCHIZOPHRENIA: COMORBID DISORDERS OR NEGATIVE SYMPTOMS?

Lewis L. Judd, M.D., *Department of Psychiatry, University of California San Diego School of Medicine, 9500 Gilman Drive, La Jolla CA 92093-0603*

SUMMARY:

One of the most difficult symptom clusters to treat effectively in schizophrenic patients is negative symptoms (i.e., social withdrawal, apathy, inertia, blunted or paucity of affect, etc.). However, the development of new atypical psychotic medications have provided clinicians with effective therapeutic tools to reduce negative symptomatology. It has been assumed and partially established that the ability of the new neuroleptics to decrease negative symptoms is due to the effect on the serotinergic nervous system, in addition to their effect on the dopaminergic system of the brain. This has raised the question of whether negative symptoms of schizophrenia are symptoms inherent to the schizophrenic process itself or are symptoms of a separate comorbid depressive disorder. This issue has important implications for treatment of schizophrenia, since therapeutic strategies may be quite different if negative symptoms are actually those of a depressive disorder. If true, this may help explain why negative symptoms have been so difficult to treat using traditional neuroleptic drugs. This presentation will focus on detailed analyses of comorbidity patterns between schizophrenia and all of the depressive subtypes of unipolar major depressive disorders. It will also involve fine-grained analyses of the symptom structure and characteristics of negative symptomatology and the potential overlap with unipolar depressive symptomatology. In addition, meta-analyses of controlled treatment studies of negative symptoms in schizophrenic patients comparing novel and traditional antipsychotics, as well as use of new antidepressant medications as treatment adjuncts. These data will be presented with the goal of providing new clinical insights into the interface of schizophrenic and mood disorders and their implications for treatment.

No. 7B
THE INTERFACE BETWEEN BIPOLAR AND SCHIZOPHRENIC DISORDERS: THE UNITED STATES APPROACH

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

SUMMARY:

Although some authorities consider schizophrenia, even process schizophrenia, to be a brain-damaged variant of bipolar disorder, most U.S. researchers and clinicians consider bipolar and schizophrenic disorders to be distinct from etiologic, clinical, and therapeutic perspectives. The situation is complicated by the emergence of clinically significant depression in the course of well-established schizophrenia and the occurrence of mood incongruent features in manic and sometimes psychotic depressives. Most U.S. clinicians today, when in doubt, consider that an affective diagnosis should take precedence over schizophrenia, because potentially more harm can come from misdiagnosis of an affective illness as schizophrenia than the reverse. A schizoaffective diagnosis, in the author's opinion, should not be made until such complicating factors as concurrent alcohol and substance abuse and complex partial seizures are excluded. Recent data that the author has collected in collaboration with John Downs (unpublished) raise the provocative possibility of supersensitivity psychosis in affectively ill patients inappropriately treated with neuroleptics. Although the use of neuroleptics could in theory prevent the occurrence of rapid-cycling, suicide and tardive dyskinesia represent other unacceptable complications of mood disorders treated as schizophrenia. A user-friendly clinical approach to the differential diagnosis of these disorders that goes beyond DSM-IV will be presented.

No. 7C
THE INTERFACE BETWEEN BIPOLAR AND SCHIZOPHRENIC DISORDERS: THE EUROPEAN APPROACH

Helmut Beckmann, M.D., *Department of Psychiatry, Fuechlein Strasse 16, Wuerzburg 97080, Germany*

SUMMARY:

Present classification systems of functional psychoses (ICD-10 and DSM-III-R) attempt a synthesis of Kraepelin's prognosis-oriented concept with Bleuler's symptomatology-oriented classification thus continuing all unsettled debate of almost one century. Schizoaffective psychoses of Kasanin (1933) would be classified according to Bleuler's more cross-sectional view as schizophrenia and according to Kraepelin as manic-depressive illness (MDI) because of the presence of affective symptoms and the potentially favorable outcome. The concept of schizoaffective psychoses, however, has never been defined with sufficient accuracy. Its genetic and prognostic validity as well as its usefulness in predicting the response to various therapy regimens remain uncertain.

The clinical description of cycloid psychoses dates back to Wernicke and Kleist and has been meticulously elaborated by Karl Leonnard. One important characteristic of the cycloid psychoses in comparison to the schizoaffective psychoses is their favorable outcome.

They completely remit even if some phases last for a long time, possibly years. They are divided into "anxiety-happiness psychosis." "excited/inhibited confusion psychosis," and "hyperkinetic/akinetic motility psychosis." Perris, Brockington (1981), Maj (1990), Beckmann et al. (1990), Franzek and Beckmann (1995), have shown evidence that these are psychoses of their own with characteristic phenomenology, morbidity risk, environmental stressors, prognosis, and therapy response different from "true" schizophrenia and MDI. This has been corroborated in several studies applying modern imaging techniques, EEG, family investigations, and systematic twin research by Franzek and Beckmann (1996).

It is hypothesized that these cycloid psychoses form the interface between MDI and schizophrenia. In addition they are rigorously defined and often distinct from schizoaffective psychoses.

No. 7D
NEW THERAPEUTIC APPROACHES IN THE MANAGEMENT OF MOOD DISORDERS IN SCHIZOPHRENIA

W. Wolfgang Fleischhacker, M.D., *Biological Psychiatry, Innsbruck University, Annichstrasse 35, Innsbruck A6020, Austria;* Armand Hausmann, M.D.

SUMMARY:

A significant number of patients with schizophrenia develop mood disorders at some time during the course of their illness. Both manic and depressive symptoms have been found. While the former have received relatively little attention in the scientific literature, the latter have been the subject of numerous reports. They have been considered both as an integral part of schizophrenia as well as a psychological reaction to the disorder. An antipsychotic-induced etiology is also discussed. The differential diagnosis includes negative symptoms and drug-induced akinesia. Manic symptoms accompanying schizophrenia are usually treated by increasing the dose of generally low potency antipsychotics. This is based on clinical experience rather than formal, clinical trials. For many years, European psychiatrists tended to shy away from using antidepressants to treat depressive symptoms in schizophrenic patients because it was believed that these could exacerbate psychotic symptoms. This belief was probably based on early clinical experience when tricyclic antidepressants were used in depressive patients with schizophrenia without antipsychotic protection, as well as on the depressive hypothesis of schizophrenia. Most European psychiatrists choose to combine antidepressants and antipsychotics in these patients after a careful evaluation of the nature of the depressive syndrome. Interestingly, this is based on very few controlled clinical trials for tricyclic antidepressants and even fewer for SSRIs. ECT is also considered for treatment of refractory patients. Whether some of the newer antipsychotics exclusively available in Europe, such as zotepine, which is also a powerful NA reuptake inhibitor, will offer advantages over classical compounds in this respect must remain the subject of further study, just as is the impact of psychosocial measures on depressive features often encountered during rehabilitation efforts.

No. 7E
NEW THERAPEUTIC APPROACHES IN THE MANAGEMENT OF MOOD DISORDERS IN SCHIZOPHRENIA: UNITED STATES PERSPECTIVES

William T. Carpenter, Jr., M.D., *Department of Psychiatry, Maryland Psychiatric Research Center, P.O. Box 21247, Baltimore, MD 21228*

SUMMARY:

Depression is observed in most initial psychotic episode patients, does not adhere to DSM-IV time sequence criteria, and is, therefore, of little diagnostic significance. Depression improves in the context of effective antipsychotic therapy, thus muting treatment relevance. Depression has confounded negative symptom ratings, thus contributing to confusion regarding direct therapeutic effects on primary negative symptoms.

The presence or absence of depression in persons with schizophrenia is critically important in four instances: 1) absence of depression in circumstances where expected, reflecting limited capacity for emotional arousal; 2) persevering depression during neuroleptic therapy; 3) depressive episodes emerging while psychosis remains stable; and 4) associated clinical features such as suicide and substance abuse. Treatment considerations in these four circumstances will be discussed.

No. 7F
THE USE OF NEW ANTIPSYCHOTICS IN THE TREATMENT OF SCHIZOAFFECTIVE DISORDER

Mario Maj, M.D., *Department of Psychiatry, Naples University, Largo Madonna Delle Grazie, Naples, Italy 80138*

SUMMARY:

The DSM-IV definition of schizophrenia consists of a symptomatological criterion, a chronological criterion, a functional criterion, and some exclusion criteria. The first three criteria, taken together, do not characterize schizophrenia as a syndrome (all of them, in fact, may be fulfilled by several cases of dementia, major depression, and bipolar disorder), so that the exclusion criteria become decisive for the diagnosis. Should the schizophrenic syndrome be really diagnosed by exclusion? Does this syndrome not have a character? The possible answers to these questions are at least four: 1) what we currently call schizophrenia is simply a heterogeneous group of nonaffective psychoses of unknown etiology (in this case, a diagnosis by exclusion would be appropriate); 2) the schizophrenic syndrome does have a character, but its essence is not translatable into operational terms; 3) the schizophrenic syndrome does have a character, but the DSM-IV criteria fail to catch one or more clinical aspects that are essential for the diagnosis; 4) the schizophrenic syndrome does have a character and all its essential elements are actually present in the DSM-IV definition, but these elements are not sufficiently qualified.

The DSM-IV definition of schizoaffective disorder is difficult to apply in clinical practice, and its interrater reliability is poor. The usefulness of retaining this diagnostic category in its present formulation is uncertain.

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INDUSTRY-SUPPORTED SYMPOSIUM 8—NOVEL ANTIPSYCHOTICS: USE IN NONPSYCHOTIC DISORDERS ACROSS THE LIFE CYCLE

Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to present clinical evidence that several nonpsychotic disorders appear to improve with the novel antipsychotic agents. These disorders include behavioral disturbances in children, dementia in adults, and includes Axis I, II, and III disorders.

No. 8A
NOVEL ANTIPSYCHOTICS IN CHILDREN AND ADOLESCENTS

Herman A. Tolbert, M.D., *Department of Psychiatry, Ohio State University, 1670 Upham Drive, Suite 460, Columbus OH 43210-1250;* Henry A. Nasrallah, M.D., Noelle K. Gehm, B.S., Nicholas A. Votolato, R.Ph.

SUMMARY:

The medical records of all consecutive child and adolescent admissions to our department's inpatient unit who received risperidone over the previous three years were reviewed: A total of 39 cases were included in this study. Of 15 preadolescents identified, (13 male and two female), 11 were Caucasian and four African American, mean age was 9.4 years with a range of 5–12 years. Mean dose received was 1.25 mg/day with a range of 0.5–4 mg with a mode of 1 mg/day. Of adolescents who received risperidone, 13 were female and 11 were male, 17 were Caucasian and seven were African American. Mean age of the sample was 15.8 years, with a range of 13–18 years. Mean dose received was 4.02 mg/day with a range of 0.5–10 mg/day.

Of the preadolescents 60% showed good improvement, 27% showed partial improvement, and 13% did not improve. Symptoms that improved included anxiety, depression, paranoia, inappropriateness, impulse control, hallucinations, bizarre behavior, and aggression. There were no side effects documented in 10/15; sedation, EPS, cramps and QTC/QRS abnormalities were rare.

A total of 71% of the adolescents improved partially or significantly; 13% showed no response. Risperidone was discontinued in 21% due to side effects (but one of these patients had shown good response). The side effects included sedation, EPS, and orthostatic hypotension. Improved symptoms included paranoia, thought disorder, and manic and depressive symptoms. In several patients, improvement of negative symptoms such as interactiveness, appropriateness, insight, or social withdrawal were documented.

These results indicate the usefulness of novel antipsychotics in the management of psychiatrically hospitalized child and adolescent inpatients with various types of psychopathology.

No. 8B
NOVEL ANTIPSYCHOTICS IN PERSONALITY DISORDERS

Larry J. Siever, M.D., *Department of Psychiatry, Mount Sinai School of Medicine, 1 Gustave L. Levy Place, New York NY 10029*

SUMMARY:

While severe and persistent psychosis is more associated with the Axis I disorders such as schizophrenia or bipolar disorder, psychotic-like symptoms may also occur in Axis II personality disorders. Persistent cognitive perceptional distortions including suspiciousness, illusions, and magical thinking are prominent features of schizotypal personality disorder (SPD). Transient psychotic-like episodes marked primarily by paranoia and dissociative symptoms are characteristic of many patients with borderline personality disorder. In personality disorder patients, particularly patients with schizotypal personality disorder, psychotic-like symptoms are significantly correlated with increased concentrations of plasma and cerebrospinal fluid (CSF) homovanillic acid (HVA). SPD patients also show impaired cognitive function and alterations in brain structure and function by PET and MRI. Trials with neuroleptic medications suggest reductions in psychotic-like symptoms in both borderline and schizotypal personality disorder patients. New data from a treatment trial with risperidone in SPD and its effect on cognitive function will also be presented, and implications for psychosocial interventions addressed.

No. 8C
EFFICACY OF NOVEL ANTIPSYCHOTICS IN BASAL GANGLIA DISORDERS

Henry A. Nasrallah, M.D., *Department of Psychiatry, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216*

SUMMARY:

Novel or "atypical" antipsychotic medications' main advantages over the conventional or "typical" antipsychotic drugs are a broader efficacy and a better safety profile. However, since the introduction of clozapine in 1990, risperidone in 1993, olanzapine in 1996, and quetiapine in 1997, it has become apparent to clinicians and researchers alike that the novel antipsychotics exert therapeutic benefits in several nonpsychotic disorders. There now exists a substantial body of literature reporting improvement with novel antipsychotics in several disorders that are associated with basal ganglia pathology. These include reports of 1) reduction of chronic motor tics (using the Yale Global Tic Severity Scale or YGTSS), 2) improvement in Tourette syndrome using the YGTSS, 3) reduction of treatment in resistant or refractory obsessive-compulsive symptoms (using the Yale Brown Obsessive Compulsive Scale or YBOCS), 4) significant reduction of persistent tardive dyskinesia (using the Abnormal Involuntary Movement Scale or AIMS), 5) improvement in L-DOPA-induced psychosis in parkinsonism and other akinetic-rigid syndromes and 6) reduction or remission of stuttering. The published data related to the above findings will be presented and discussed. The utility of novel antipsychotics in nonpsychotic clinical syndromes may help provide new leads regarding the neurobiological mechanisms of these disorders and may generate additional insights about the neurochemical effects of the various novel antipsychotics.

No. 8D
ROLE OF NOVEL ANTIPSYCHOTICS IN TREATMENT OF MOOD DISORDERS

Donna A. Wirshing, M.D., *Department of Psychiatry, West Los Angeles Veterans Affairs Medical Center, 11301 Wilshire Blvd. (B151-H), Los Angeles CA 90073*

SUMMARY:

The new antipsychotic agents clozapine, olanzapine, quetiapine, risperidone, sertindole, and ziprasidone may all play a role in the treatment of patients with mood disorders. These agents, by virtue of their favorable EPS profile, may be better tolerated when used to treat symptoms of psychosis in this population. There also may be some mood-altering properties of these medications themselves. These mood-altering and/or stabilizing properties are most likely mediated by the novel antipsychotic agents' effects on the serotonin system. I will first review prospective data that demonstrate these agents' impact on depressive symptoms within schizophrenic populations. I will then review all of the research that utilizes novel antipsychotic agents in mood disorders.

No. 8E
USE OF ATYPICAL ANTIPSYCHOTICS IN DEMENTIA AND DELIRIUM

Prakash S. Masand, M.D., *Department of Psychiatry, SUNY Health Sciences Center, 750 East Adams Street, Syracuse NY 13210;* Henry A. Nasrallah, M.D.

SUMMARY:

Conventional antipsychotics like haloperidol still represent the most commonly prescribed antipsychotics in patients with dementia and delirium. Unfortunately, the conventional antipsychotics have several adverse effects in the elderly, including higher rates of EPS, tardive dyskinesia, sedation, anticholinergic side effects, and orthostatic hypertension. The newer antipsychotics like risperidone, clozapine, olanzapine, quetiapine, and sertindole represent viable alternatives to the conventional antipsychotics in the treatment of the elderly patient with dementia and delirium. The talk will address the use of the conventional and atypical neuroleptics in this population. The cognitive effects of the conventional and atypical neuroleptics, which are of particular importance in the elderly patient with dementia and delirium, will also be discussed.

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INDUSTRY-SUPPORTED SYMPOSIUM 9—ESTROGEN ENHANCEMENT OF MOOD AND MEMORY IN POSTMENOPAUSAL WOMEN
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participants should be able to demonstrate a knowledge of the central effects of gonadal hormones, specifically estrogen. They will recognize the interactions between hormonal deficiency symptoms and psychiatric pathology, which will result in an increased ability to provide adequate treatment to postmenopausal women.

No. 9A
ESTROGENS AND SYNAPSES: BASIC NEUROBIOLOGY OF OVARIAN STEROIDS

Bruce S. McEwen, Ph.D., *Neuroendocrinology, Rockefeller University, 1230 York Avenue, Box 165, New York NY 10021*

SUMMARY:

Ovarian steroids have numerous effects on the brain throughout the lifespan, beginning during gestation and continuing on into senescence. One of these is regulating synapse turnover in the CA1 region of the hippocampus during the 4–5d estrus cycle of the female rat. Formation of new excitatory synapses is induced by estradiol and involves NMDA receptors, whereas down-regulation of these synapses involves intracellular progestin receptors. There are developmentally programmed sex differences in hippocampal structure that may help to explain differences in the strategies that male and female rats use to solve spatial navigation problems. During the period of development when testosterone is elevated in the male, aromatase and estrogen receptors are transiently expressed in hippocampus, and recent data on behavior and synapse induction strongly suggest that this pathway is involved in the masculinization or defeminization of hippocampal structure and function. Ovarian steroids also have widespread effects throughout the brain on catecholaminergic neurons and serotonergic pathways and the basal forebrain cholinergic system. Regulation of the serotonergic system appears to be linked to the presence of estrogen and progestin sensitive neurons in the midbrain raphe, whereas the ovarian steroid influence upon cholinergic function involves induction of choline acetyltransferase and acetylcholinesterase according to a sexually dimorphic pattern. Because of the widespread influences of these various neuronal systems, ovarian steroids have measurable effects on affective state as well as on cognition, with implications for dementia.

No. 9B
SEXUAL DIMORPHISM, MEMORY, AND MENOPAUSE

Marjorie L. Shuer, M.D., *P.O. Box 354, Youngtown AZ 85363-0354*

SUMMARY:

The brain's sexually dimorphic nature has long fascinated scientists. Their manipulations of gonadal hormones in the animal model during critical periods of development have demonstrated evidence of significant neural plasticity. Patient populations with abnormal gonadal hormone levels have illustrated cognitive and memory profiles that differ from their biological sex, suggesting possible modulation of neural mechanisms. These findings indicate aberrant hormone levels may significantly impact cognitive skills in both directions. Thus, specific cognitive skills appear to be dependent on hormonal milieu and may indicate that the organizational and activational effects of gonadal hormones are more fluid than previously thought.

In the nonpatient population, psychometric studies have demonstrated sex-specific cognitive patterns. Verbal memory and visual/spatial studies illustrate significant variations between and within the sexes. Evidence for within sex variability in performance has been linked to hormonal assays.

The effect of hormonal milieu on brain function is significant, and the implications of current research with regards to the postmenopausal patient have not been translated into clinical practice. These findings suggest that patients would benefit from a reassessment of traditional hormone replacement therapy. Hopefully this new ap-

proach will encompass a treatment paradigm emphasizing cognitive, memory, and mood symptom resolution.

No. 9C
ESTROGEN AND COGNITION IN POSTMENOPAUSAL WOMEN

Barbara B. Sherwin, Ph.D., *Department of Psychology, McGill University, 1205 Dr. Penfield Avenue, Montreal, PQ, H3A 1B1, Canada*

SUMMARY:

Findings from basic neuroscience have described numerous mechanisms that explain how estrogen influences brain chemistry and morphology in areas known to be important for memory. Prospective, controlled studies of estrogen administration to postmenopausal women consistently show that estrogen maintains and/or enhances verbal memory and the capacity for new learning in these middle-aged women. In healthy, independently living 65-year-old women, estrogen users had higher verbal memory scores compared to nonusers. In 72-year-old healthy women, those who had been taking estrogen since their menopause had higher scores on a test of attention and short-term verbal memory compared with age-matched estrogen nonusers. Finally, in a recent study of young women, "add-back" estrogen reversed the deficits in verbal memory that had been induced by treatment with a gonadotropin-releasing hormone agonist alone. Taken together, these findings strongly suggest that there may be a specificity of the estrogenic effect on cognitive functioning such that the hormone enhances or maintains verbal memory but has little effect on visual memory in adult women.

No. 9D
HORMONE-REPLACEMENT THERAPY: COGNITION AND ALZHEIMER'S DEMENTIA

Uriel Halbreich, M.D., *Department of Behavioral Health, State University of New York, 462 Grinder Street, BB170, Buffalo NY 14215*

SUMMARY:

Hormonal replacement therapy (HRT) is quite widely used for prevention of cardiovascular disorders as well as osteoporosis. It is also used for treatment of hot flashes and other symptoms. Recent data suggest that HRT has a positive effect on cognition of postmenopausal women and their well being. There are also epidemiological and indirect data suggesting a positive role of estrogen on cognition of patients suffering from dementia of Alzheimer type (DAT).

Our own data show a selective relative impairment of some cognitive functions of postmenopausal women compared with women of reproductive age. Treatment with estradiol transdermal patches (0.1 mg) or conjugated estrogens (1,25 mg) for 60 days selectively improved most of the impaired cognitive functions. This treatment also influenced the hormonal response to the serotonergic stimulus m-cpp, 5-HT2 binding, α 2 and imidazoline receptors binding, and decreased monoamine oxidase activity in platelets.

These results support the suggestion that an indication for ERT for improvement of cognition of postmenopausal women and prevention or delay of DAT is quite promising. The use of estrogen as an adjunct therapy to conventional antidepressants is also suggested.

No. 9E
PRACTICAL IMPLICATIONS OF HORMONE-REPLACEMENT THERAPY: USING NATURAL HORMONES

Joel T. Hargrove, M.D., *820 Hatcher Lane, Columbia TN 38401*

SUMMARY:

There is a mounting body of evidence supporting the use of hormone replacement therapy (HRT) in most postmenopausal women for relief of menopausal symptoms, improvement of quality of life, and prevention of cardiovascular disease, osteoporosis, and possibly Alzheimer's disease. The optimum program for replacing the deficient steroids attendant with the menopause is controversial. Described in this presentation is the view that holds estradiol and progesterone as known to be the principal female sex steroids secreted by the premenopausal ovary and that these steroids do in fact become deficient after the menopause. This deficiency is readily demonstrable by measurement in serum at almost any clinical lab. These steroids are available for use in restoring the deficiencies of the menopause; adequate replacement can be titrated and verified by measurement of serum levels and further confirmed by clinical response in relief of symptoms. The oral route of administration is satisfactory for the majority of patients. Because of the extensive metabolism of estrogen by the cytochrome P450 class of enzymes in the liver, about 25% of patients will require transdermal administration to avoid the first pass hepatic phenomenon. This HRT method individualizes therapy and provides objective evidence of the adequacy of treatment.

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INDUSTRY-SUPPORTED SYMPOSIUM 10—WOMEN AND PSYCHOSIS: FROM LAB BENCH TO CLINICAL PRACTICE Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand how differences in brain structure, sensitivity to gonadal steroid, and neuroendocrine effects of antipsychotic treatment may contribute to what is seen clinically in women who suffer from psychotic symptoms associated with a variety of psychiatric disorders. The participant should also understand sex differences in response to treatment and sequalae of treatment-convergent hypoprolactinemia as seen with typical and atypical antipsychotics.

No. 10A
EFFECTS OF GONADAL STEROIDS ON BRAIN AND BEHAVIOR

David R. Rubinow, M.D., *BEB, National Institute of Mental Health, Building 10, Room 3N238/10, Center Drive, Bethesda MD 20892;* Peter J. Schmidt, M.D.

SUMMARY:

Gonadal steroids function as major neuroregulators and presumably underlie gender-related differences (sexual dimorphisms) in

brain structure and function. In animals, gonadal steroids modulate neurotransmitter receptor ontogeny, distribution, and activity as well as create capacities for behaviors in adulthood. Further, recent studies have identified groups of persons who are differentially susceptible to mood destabilization by gonadal steroids. For example, estrogen administration precipitates depression in women with menstrual-cycle-related mood disorders, has no effect on mood in women lacking a history of menstrual-cycle-related mood disorder, and displays antidepressant efficacy in women with perimenopausal depression. Similarly, the beneficial effects of estrogen on verbal memory are far more apparent in perimenopausal women than in young women with experimentally induced hypogonadism. Thus, while gonadal steroids create a context that shapes development, their activational/neuromodulatory effects are highly context dependent. These observations, culled from a variety of hormone-manipulation studies in both male and female rats and humans (which will be described in this presentation), suggest that increased attention to the role of gonadal steroids in modulating human behavior will help answer a critical question in psychiatric research: Why do different individuals respond differently to what is ostensibly the same stimulus?

No. 10B
SEX AND BRAIN ABNORMALITIES IN SCHIZOPHRENIA

Jill M. Goldstein, Ph.D., *Department of Psychiatry, Harvard Medical School, 74 Fenwood Road, Boston MA 02115;* Larry J. Seidman, Ph.D., Julie M. Goodman, Ph.D., Nikos Makris, M.D., David Kennedy, Ph.D., Verne Caviness, M.D., Stephen V. Faraone, Ph.D.

SUMMARY:

The impact of sex on brain structure and function in schizophrenia has become a popular topic of debate. This talk will review normal sexual dimorphism and whether or how schizophrenic men and women differ. Data will be presented from our current studies of sex differences in brain abnormalities in schizophrenia. Thirty DSM-IV schizophrenics, matched within sex to 28 normal controls, were systematically ascertained from an urban catchment area to assess brain structure and cognitive function. T1-weighted SPGR images from a 1.5 GE Tesla magnet were segmented into white matter, subcortical, and 48 cortical brain areas. ANCOVA tested the effects of sex, group, and their interaction on brain areas, adjusted for total cerebrum. Results showed that sex differences were pervasive across the brain. Men had larger ventricular regions and women had larger cortical brain areas, particularly frontal and medial paralimbic. The effect of group was greater than the effect of sex in subcortical regions. Sex differences in normals were attenuated in patients. Results suggest that normal sexual dimorphism may help to "protect" schizophrenic women from some of the more severe cognitive consequences of brain abnormalities associated with schizophrenia. Findings from our cognitive studies of these subjects supports this.

No. 10C
SEX AND NEUROENDOCRINE DIFFERENCES FOLLOWING TREATMENT WITH TYPICAL AND ATYPICAL ANTIPSYCHOTICS

Lee S. Cohen, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 815, Boston MA 02114;* Jill M. Goldstein, Ph.D., Hang Lee, Ph.D., Mauricio Tohen, M.D., Scott Andersen, M.S., Gary D. Tollefson, M.D.

SUMMARY:

Sex-based differences in psychiatric illnesses such as schizophrenia continue to gain increasing attention. Factors that distinguish risk for onset or relapse of illness between men and women who suffer from schizophrenia are yet to be entirely understood. Sex-based differences in response to typical and atypical antipsychotics as well as neuroendocrine differences following treatment with these older and newer agents are areas in need of further investigation. This presentation will review sex differences in response to treatment with both typical and atypical neuroleptics. Specifically, data will be presented from a large international clinical trial of olanzapine versus haloperidol in which sex-based differences in response to treatment are described. In addition, changes in prolactin concentration following treatment with olanzapine or haloperidol will be described, taking into account factors such as chronicity of illness (as measured by number of previous episodes) and pre- versus post-menopausal status. Delineation of the precise impact of hyperprolactinemia on end organ function and the secondary effects of induction of a hypoestrogenic state seen with prolactin elevation is an important area of study. Clarification of the effects of hyperprolactinemia on end organ function will facilitate refinement of treatment guidelines for women who suffer from psychotic illness.

No. 10D
WOMEN, PROLACTIN, AND THE NEW NEUROLEPTICS

Ruth A. Dickson, M.D., *Department of Psychiatry, Calgary General Hospital, 841 Center Avenue East, Calgary, AB, T2E 0A1, Canada*

SUMMARY:

Clinical sequelae of NIHP in women have received scant attention in recent psychiatric literature. While the medical side effects, including amenorrhea, galactorrhea, and sexual dysfunction, have been known since the advent of antipsychotic therapy, these side effects have (1) been undervalued, (2) not been the target of new drug development, and (3) often ignored in psychiatric clinics. Serendipitously, some of the new neuroleptics, including clozapine, olanzapine, and quetiapine, do not elevate prolactin levels as do the traditional neuroleptics and risperidone. Review of cases across the reproductive cycle illustrate biological and psychological consequences of resolution of hyperprolactinemia.

Traditional treatment of NIHP, i.e., lowering antipsychotic dose or prescribing dopamine agonists, has changed with the introduction of prolactin-sparing neuroleptics. Prevention of sexual and reproductive side effects secondary to antipsychotics is a significant therapeutic advance for women.

No. 10E
ATYPICAL ANTIPSYCHOTICS IN WOMEN WITH BIPOLAR AND OTHER PSYCHIATRIC DISORDERS

Susan L. McElroy, M.D., *Department of Psychiatry, University of Cincinnati College of Medicine, 231 Bethesda Avenue, ML 559, Cincinnati OH 45267-0559*

SUMMARY:

Evidence from a number of open trials suggests that clozapine is effective in the treatment of patients with bipolar disorder who do not respond to standard mood stabilizers. These findings have suggested, in turn, that clozapine may exert thymoleptic as well as antipsychotic activity. The emergence of new antipsychotics, each with unique pharmacologic profiles e.g., olanzapine, risperidone, quetiapine, sertindole, and ziprasidone, raises the possibility that these agents may also exert thymoleptic effects. Data from available studies examining the antidepressant and antimanic activity of these agents will be presented. The studies include the response to treatment of affective symptoms in patients with schizophrenia, schizoaffective disorder, psychotic depression, and bipolar disorder. Data

from recently completed clinical trials of these agents in patients with bipolar disorder will be reviewed in detail, including analyses of response and side effects by sex.

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INDUSTRY-SUPPORTED SYMPOSIUM 11—NEW TREATMENTS FOR ANXIETY DISORDERS: CLINICAL APPROACHES FOR SUCCESSFUL OUTCOMES Supported by SmithKline Beecham Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to describe the comorbid and complicated presentation of panic disorder, social phobia, obsessive compulsive disorder, and post-traumatic stress disorder; to recognize gender differences in the epidemiology, treatment, and outcome of anxiety disorders; to understand current therapeutic strategies for management of anxiety disorders in patients with traditional presentations, comorbid medical and psychiatric conditions, and complicated courses.

No. 11A GENDER DIFFERENCES IN THE EPIDEMIOLOGY AND TREATMENT OF ANXIETY DISORDERS

Teresa A. Pigott, M.D., *Department of Psychiatry, University of Texas Medical Branch at Galveston, 4442 Graves Building, 301 University Boulevard, Galveston TX 77555*

SUMMARY:

Women have a substantially higher risk of developing anxiety disorders then men. Large-scale epidemiological studies suggest that women in comparison to men have a two- to three-fold increase in the occurrence of panic disorder, post-traumatic stress disorder, or generalized anxiety disorder, as well as a 1.5 times greater risk of developing obsessive-compulsive disorder or social phobia. Elevated morbidity and mortality rates, frequent comorbid psychiatric diagnoses, and substantial psychosocial impairment are associated with the anxiety disorders. Pharmacotherapy is an important and highly effective treatment for anxiety. Significant gender differences in the metabolism of psychotropic medications have been identified. For example, significant increases in the expected plasma half-lives of various anxiolytic and antidepressant medication have been reported in women. Despite the fact that women are the greatest consumers of psychotropic medication, there are surprisingly few systematic data available concerning the clinical relevance of these differences. With this in mind, it is not surprising that adverse drug reactions are most commonly encountered in the elderly in general, and women in particular. The potential effects of the menstrual cycle, pregnancy, exogenous estrogen, and menopause are also likely to have a substantial and potentially significant impact on the course and treatment of women with anxiety disorders. This presentation will provide a brief overview of these important issues and their clinical relevance in the treatment of women with anxiety disorders.

No. 11B CURRENT CONCEPTS IN THE TREATMENT OF PANIC DISORDER

David V. Sheehan, M.D., *Department of Psychiatry, University of South Florida, 3515 East Fletcher Avenue, Tampa FL 33613-4706;* Kathy Harnett-Sheehan, Ph.D., Ashok Raj, M.D.

SUMMARY:

In the 1990s several new classes or new formulations of older medications have been studied in panic disorder. These include the selective serotonin uptake inhibitors, the serotonin norepinephrine uptake inhibitors, the tricyclic antidepressant clomipramine, the triazolopyridines, the monocyclic bupropion, the nonbenzodiazepine anxiolytics like buspirone, gepirone, and ritanserin, and the betacarbolines like ZK112-119 and sustained-release formulations of benzodiazepines. Studies on all these medications are in varying stages of completion and are of varying quality. Clinicians have had an opportunity to use several of them in their practices. It is now possible to review our experience with many of them. The emerging data favor the use of SSRIs as the first-line treatment for most patients with panic disorder. Although the data supporting the use of SSRIs in the treatment of major depression are well known, the data on SSRIs in panic disorder are much less familiar to most clinicians.

The majority of patients with panic disorder are now treated first with antipanic medications. A minority receive tricyclic antidepressants either alone or in combination with a benzodiazepine, and fewer than 10% get MAO inhibitors.

This presentation will review the efficacy and safety of the data on these treatments, their relative merits and disadvantages, and will assist the practicing clinician in choosing among them and in tailoring the treatment to each patient's needs.

No. 11C UPDATE ON THE DIAGNOSIS AND TREATMENT OF SOCIAL PHOBIA

Michael R. Liebowitz, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 722 West 168th Street/MB #120, New York NY 10032-2603;* Richard G. Heimberg, Ph.D., Frank Schneier, M.D.

SUMMARY:

Social phobia is best conceptualized as having two distinct subtypes, which appear to differ in terms of symptoms, course of illness, morbidity, comorbidity, and pathophysiology. With regard to treatment, both pharmacological and cognitive behavioral approaches

are being found effective, and the two modalities appear to have complementary strengths.

The standard MAOIs have well-demonstrated efficacy, with several controlled trials showing marked acute benefits, even in highly disabled patients with generalized social phobia. The high-potency benzodiazepine clonazepam also appeared effective in one trial. SSRI's have also shown substantial acute efficacy in recent trials and are emerging as a first-line treatment for social phobia. However, results with the reversible, selective inhibitors of monoamine oxidase have been more variable. A limitation of all pharmacotherapies studied is the substantial relapse seen even after prolonged treatment.

Cognitive behavior therapy (CBT) also has substantial acute efficacy, although somewhat less than the MAOI phenelzine in one trial. However, there appears to be less relapse following CBT discontinuation than is seen with medication treatment. This provides a potent rationale for assessing the acute and long-term effects of combined CBT and medication.

No. 11D
OCD: DIAGNOSIS AND TREATMENT

Wayne K. Goodman, M.D., *Department of Psychiatry, University of Florida, P.O. Box 100256, Gainesville FL 32610*

SUMMARY:

This presentation will provide an update on the medical management of OCD, ranging from guidelines for use of serotonin reuptake inhibitors (SRIs) to novel approaches for treatment-refractory cases. The backbone of pharmacological treatment of OCD is a 10–12 week trial with an SRI in adequate doses. What constitutes an adequate dose depends upon the drug in question. In most cases, treatment should be initiated with a selective SRI (e.g., fluvoxamine or paroxetine) because of its superior safety/tolerability but equivalent efficacy compared with clomipramine. Available data will be reviewed regarding the long-term management of OCD including how long treatment should be continued and whether it is advisable to reduce dosing to maintenance levels.

Options in dealing with the SRI-resistant OCD patient include switching to a different SRI, combining another medication (or behavior therapy) with the SRI, considering novel or experimental drug treatments, or employing nonpharmacological biological approaches such as ECT, neurosurgery, or repetitive transcranial magnetic stimulation. None of the SRI drug combination approaches to treatment-resistant OCD can be viewed as firmly established. Intravenously administered or oral pulse loading of clomipramine may have a place in the management of treatment-resistant OCD. The treating physician should be cognizant of current evidence regarding the possible role of stereotactic neurosurgery in severe refractory OCD.

No. 11E
MANAGEMENT OF PTSD: DIAGNOSTIC AND THERAPEUTIC ISSUES

Jonathan R.T. Davidson, M.D., *Department of Psychiatry, Duke University Medical Center, Box 3812, Durham NC 27710*

SUMMARY:

Although the hallmark symptoms of PTSD are clear, PTSD is not always properly diagnosed. Reasons include comorbidity (false and real), patient denial or minimization, and too high of a diagnostic threshold by the provider. Data also suggest that subjects with PTSD are more frequent visitors to primary care physicians and rarely see mental health providers.

Treatment challenges include the following: PTSD populations may not all respond to drug therapy in the same way, and it is unclear whether this relates to gender, trauma, or some other factor; do some subjects require higher doses and how does dose in general relate to outcome? Antidepressants seem to be the most effective form of drug therapy while benzodiazepines are of limited value at best. What is the role of neuroleptics and anticonvulsants? Some forms of psychosocial therapy (CBT, stress inoculation training) are effective, while others that are widely used (e.g., EMDR) are unproven. Are combined psychosocial-psychopharmacological approaches the best? What is the relapse rate in PTSD?

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INDUSTRY-SUPPORTED SYMPOSIUM 12—INTERVENTION FOR REFRACTORY BIPOLAR DISORDER
Supported by Glaxo Wellcome Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants will be able to offer better treatment to patients with treatment-refractory bipolar depression, mania, and rapid cycling; understand the role of cognitive behavioral interventions for managing bipolar mood disorder; recognize potential adverse consequences of antidepressant medications for bipolar patients; and understand the role of practice guidelines in the management of refractory bipolar patients.

No. 12A
BIPOLAR DISORDER: EXPERT CONSENSUS SURVEY RESULTS

David A. Kahn, M.D., *Department of Psychiatry, Columbia University/Presbyterian Hospital, 180 Ft. Washington Avenue, Harkness Pavillion, New York NY 10032*

SUMMARY:

Synthesis of expert opinion is an important component of treatment guidelines, especially for clinical questions where research evidence is uncertain, such as sequencing treatments, head-to-head comparisons, or roles for new treatments. The Expert Consensus Guidelines for the Treatment of Bipolar Disorder surveyed 68 nationally recognized psychopharmacologists on 81 key treatment decisions. Using both continuous and categorical analyses of appropriateness ratings on a nine-point scale, treatment recommendations were derived. Intraclass correlations showed very reliable group mean ratings. Recommendations were consistent with current evidence, but more specific in sequencing of first, second, and some third steps in the progression from straightforward to treatment-resistant patients. Differential recommendations were found for the use of mood stabilizers in subtypes of mania, for selection of adjunctive medications, and for subsequent steps and their timing in partial or total nonresponders. For bipolar depression, bupropion and SSRI's were first-line, in

conjunction with differential pathways for use of mood stabilizers, psychotherapy, antipsychotics, and ECT in bipolar I and II disorders, with and without psychosis. Recommendations also emerged for various patterns of relapse during maintenance treatment. Strengths of the survey technique are its reliability in representing a broad group of experts, its rapidity of development to assess the perception of new treatments, and its ability to characterize the best practice standards of physicians on the front lines of health care.

No. 12B
MANAGEMENT OF TREATMENT-REFRACTORY BIPOLAR DEPRESSION

Gary S. Sachs, M.D., *Bipolar Clinic, Massachusetts General Hospital, 15 Parkman Street, WACC-815, Boston MA 02114*

SUMMARY:

The high risk of suicide in depressed bipolar patients presents a compelling need for antidepressant treatment, but risk of poor outcome is high. Response rates to standard antidepressant medications appear substantially lower in bipolar patients than in those with unipolar depression. Furthermore, standard antidepressant medications may worsen the course of bipolar illness. Use of antidepressants is complicated by the risk of mania during the course of treatment and during withdrawal of treatment. In addition, Altshuler et al. have shown antidepressant medications may accelerate cycling even without induction of abnormal mood elevation. Therefore, clinicians treating bipolar depression face a dilemma as they balance the risks and benefits of treatment with antidepressant medication.

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

No. 12C
OPTIONS FOR TREATMENT-REFRACTORY RAPID CYCLING

Joseph R. Calabrese, M.D., *Department of Psychiatry, Case Western Reserve University, 11400 Euclid Avenue, Suite 200, Cleveland OH 44106-3986*

SUMMARY:

The rapid-cycling variant of bipolar disorder appears to account for 13%–20% of all patients with bipolar disorder, and as many as 72%–82% of these patients exhibit a poor response to lithium. Dunner and Fieve (1976) first coined the term *rapid cycling* in a landmark paper that summarized double-blind placebo-controlled data designed to evaluate clinical factors associated with lithium prophylaxis failure, and Kukopulos (1980) and colleagues replicated and extended these findings in 1980. Rapid cycling is now viewed as a phenomenon that modifies or specifies the natural history or course of bipolar disorder and is believed to be associated with a greater mortality and morbidity. In recent studies, it has been noted that bipolar rapid cycling is often accompanied by comorbidity on Axis I (substance abuse and anxiety disorders), Axis II (borderline personality disorder), and Axis III (hypothyroidism). The phenomenon of rapid cycling tends to appear late in the course of the disorder when cycles have become circular and occurs more frequently among females. This presentation will review various treatment options for refractory rapid cycling, including data regarding the spectrum of efficacy of lamotrigine in treatment-refractory bipolar rapid cycling.

No. 12D
ALTERNATIVE TREATMENT FOR REFRACTORY MANIA/CYCLING

Robert M. Post, M.D., *Biological Psychiatry Branch, National Institute of Mental Health, 10 Center Drive, MSC-1272, Bethesda MD 20892;* Mark A. Frye, M.D., Kirk D. Denicoff, M.D., Timothy A. Kimbrell, M.D., Robert T. Dunn, M.D., Gabrielle S. Leverich, M.S.

SUMMARY:

Lithium, carbamazepine, valproate, and their combination have become the core antimanic/cycling treatments. In the past several decades, high-potency benzodiazepines and typical neuroleptics have been the adjunctive measures for agitation, dysphoria, and dyscontrol and, particularly, neuroleptics for refractory psychotic/aggressive components of the illness. Several new potential approaches have emerged, including the dihydropyridine calcium channel blockers for ultra-rapid and ultradian cycling and thyroid augmentation strategies with replacement doses of T_3, T_4, or ultra-suppressive doses of T_4. Third-generation mood-stabilizing anticonvulsants appear highly promising, including lamotrigine, with approximately 50% response rates in refractory bipolar patients, and gabapentin, with approximately 40% response rates, and potentially higher rates for both when used adjunctively. The atypical neuroleptics clozapine and its close relative planzapine, may have a unique niche in the treatment of refractory, dysphoric, psychotic, or cyclic mania. Preliminary evidence suggests that nimodipine, gabapentin, and lamotrigine responders have decreased blood flow/metabolism at baseline, while carbamazepine responders may be hypermetabolic. The relative efficacy of these approaches, their potential clinical and biological markers of response, and optimal sequences and algorithms to be used initially and in the face of treatment refractoriness are all critical areas in great need of further research and NIMH funding.

No. 12E
COGNITIVE-BEHAVIORAL STRATEGIES FOR BIPOLAR PATIENTS

Noreen A. Reilly-Harrington, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, Harvard Medical School, 15 Parkman Street, WACC-812, Boston MA 02114*

SUMMARY:

Historically, bipolar disorder has been conceptualized as a biologically driven form of mental illness. Therefore, the majority of research on bipolar disorder has explored genetic and biochemical diatheses and pharmacological treatments. However, limitations to pharmacotherapy alone are indicated by a five-year relapse rate of 73% even for patients with favorable acute responses to medication and adequate maintenance treatment. Furthermore, a growing number of studies suggest that life stressors and psychological variables, such as negative cognitive styles, contribute vulnerability to bipolar mood episodes. Cognitive-behavioral therapy (CBT) is a structured, active, and present-oriented psychotherapy that has the potential to augment the efficacy of pharmacotherapy, improve quality of life, and lower rates of relapse. This presentation will focus on adjunctive, cognitive-behavioral techniques for the control and management of treatment-refractory hypomania and depression. Specialized strategies for modifying dysfunctional thinking and behavior, identifying and coping with triggers for relapse, and improving medication compliance will be discussed. Suggestions for regulating activities, minimizing circadian rhythm disruptions, charting mood fluctuations, and recognizing early warning signs of episodes will also be pre-

sented. The importance of psychoeducation and family involvement will be addressed, and recent data supporting the application of adjunctive CBT will be reviewed.

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INDUSTRY-SUPPORTED SYMPOSIUM 13—INDIVIDUALIZING THE TREATMENT OF PSYCHOSES
Supported by Zeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to review management practices for patients with a spectrum of psychotic disorders.

No. 13A
IMPACT OF PHASES AND SEVERITY OF ILLNESS ON TREATMENT DECISIONS ACROSS THE AGE SPECTRUM

Robert L. Findling, M.D., *Division of Child Psychiatry, Case Western Reserve University, 11100 Euclid Avenue, Cleveland OH 44106;* S. Charles Schulz, M.D., Mahmoud A. Parsa, M.D.

SUMMARY:

Schizophrenia is a common disorder in adolescence and early adulthood. Unfortunately, not all patients in the early stages of schizophrenia receive adequate amelioration of symptoms from the first medication prescribed. Moreover, younger patients may be more prone to antipsychotic-induced extrapyramidal side effects than adult patients. For these reasons, effectiveness and tolerability have a major impact on treatment compliance and clinical stabilization for patients in the early stages of schizophrenia.

For many adult patients, maintaining stabilization is the paramount issue in their pharmacotherapy. Although tolerability and effectiveness of a medication are important issues, medication acceptability can enhance a patient's desire to comply with ongoing treatment and allow the patient to successfully participate in multimodal therapy.

In the elderly, new issues, including comorbid medical illnesses, neuropsychiatric conditions, and greater sensitivity to side effects, can complicate the treatment of a psychotic illness. Age-related changes in biodisposition and biotransformation can also affect pharmacotherapy in the elderly.

Different issues become particularly relevant during different phases of life for patients with schizophrenia. Awareness of these concerns can be important to tailoring the appropriate medication and dosage to the needs of the individual patient.

No. 13B
MANAGEMENT OF PSYCHOTIC ASPECTS OF SCHIZOAFFECTIVE DISORDER

Stephen M. Strakowski, M.D., *Department of Psychiatry, University of Cincinnati College of Medicine, 231 Bethesda Avenue, Suite 7005, Cincinnati OH 45267-0559*

SUMMARY:

Schizoaffective disorder is characterized by concurrent affective and psychotic syndromes in which neither affective nor psychotic symptoms are clearly dominant. The boundaries of this diagnostic category have been widely debated, and it remains unclear whether schizoaffective disorder represents a truly separate diagnostic entity or is either a combination of severe affective disorders or schizophrenia associated with concurrent affective syndromes. Regardless, patients with schizophrenia commonly present to treatment settings.

Treatment of schizoaffective disorder has traditionally involved combinations of thymoleptic and antipsychotic agents. Unfortunately, there are few controlled clinical trials to validate this approach. Moreover, the introduction of atypical antipsychotic agents may alter how these patients are treated. Specifically, several of the atypical antipsychotics may also possess clinically meaningful thymoleptic activity. Additionally, recent studies suggest that patients with psychotic mood and schizoaffective disorders exhibit better responses to these agents than do patients with schizophrenia. The newer atypical antipsychotics have favorable side-effect profiles that may lead to improved treatment compliance, which is a critical factor in the good outcome of patients treated for combined affective and psychotic symptoms. We have developed a preliminary algorithm for incorporating these new medications.

No. 13C
TREATING SYMPTOMS COMORBID WITH PSYCHOSES IN SCHIZOPHRENIA

Jeffrey A. Lieberman, M.D., *Department of Psychiatry, University of North Carolina School of Medicine, 7025 Neurosciences Hospital, CB716, Chapel Hill NC 27599*

SUMMARY:

Schizophrenia is associated with many comorbidities. In the psychiatric realm, depression occurs in at least 25% of patients above and beyond that associated with antipsychotic-induced akinesia and akathisias, relapse prodrome, negative symptoms, and substance abuse. Other less common psychiatric comorbid disorders are OCD and panic disorder. There is also a very high rate of substance abuse, including alcohol abuse or dependence (33%) and illicit drug use (27.5%), which contributes to more severe psychiatric symptoms, reduced medication compliance, higher rates of rehospitalization, poorer treatment response, increased violent behavior, and greater use of emergency services. Fifty percent to 90% of patients with schizophrenia smoke cigarettes. When schizophrenia is complicated by other psychiatric or medical illnesses, the life span is shortened by 10 or more years and the rate of mortality is two to three times that of the general population. Patients with schizophrenia have increased risk of cardiovascular disorders, inappropriate antidiuretic hormone production, polydipsia, hyponatremia, and increased susceptibility to infection, especially tuberculosis. The treatment of patients with comorbid illnesses must be specifically tailored to the patient's clinical needs.

No. 13D
TREATMENT ISSUES WITH THE USE OF ANTIPSYCHOTIC MEDICATIONS

Sharon G. Dott, M.D., *Department of Psychiatry, University of Texas, 1114 Graves Bldg., Route D28, Galveston TX 77555-0428*

SUMMARY:

The psychotic-spectrum disorders now possess major advances in pharmacologic management. Many patients treated with novel or atypical antipsychotic agents have achieved much greater control of their illness than during previous treatment with traditional antipsychotics. These patients have experienced relief from both positive and negative symptoms of schizophrenia. Equally important, the side-effect profiles promise marked improvement. However, while our armamentarium of medications increases, the expertise for clinical implementation lags far behind. Few studies have been done to address the practical issues of initiating treatment with these novel antipsychotics in various patient populations. This review will cover the clinical experiences in the literature and practical treatment issues addressing the challenges of prescribing atypical antipsychotics. Other clinical issues will be covered such as indications and contraindications for switching antipsychotics, patient selection in the choice of atypical antipsychotics, and crossover techniques with depot antipsychotics. Considerations for outpatients on maintenance therapy and inpatients in acute settings will be discussed separately since the clinical needs differ with the treatment setting.

No. 13E
AFTER RESPONDING: WHAT HAPPENS NEXT?

Peter J. Weiden, M.D., *Department of Psychiatry, St. Luke's/Roosevelt Hospital, 411 West 114th Street Suite 3B, New York NY 10025;* Ralph Aquilla, M.D., Laura J. Dalheim, M.D.

SUMMARY:

Introduction: Many patients switched to one of the newer atypical antipsychotics experience dramatic symptom reductions. However, with symptom improvements come new challenges. This presentation is based on observations made during follow-up of cohort of outpatients with schizophrenia who were successfully switched to one of the newer atypical antipsychotics.

Observations: We observed that many responders went through one of the following phases:

1) a "honeymoon" period where the patient (and caregiver) are taken aback by the degree of symptom improvement. This is a period where the patient may become overconfident, or the caretakers may become too easy-going,
2) a "flooding" phase when the patient is overwhelmed by recollections of illness experiences, losses experienced, or by painful emotions formerly numbed by the illness or medication,
3) a "testing" phase where the patient may test out new situations that were previously unthinkable before switching medication,
4) a "setback" phase where the patient is overwhelmed by the emotional flooding or testing experiences described above.

Discussion: Moving through these phases often leads to a critical crisis, which can be mistaken as being from loss of efficacy of the new medication. However, the crisis may really be from *adapting* to the medication response, and is not a *loss* of response. How the crisis resolves often seems to depend on nonpharmacologic factors, such as the person's intrinsic psychologic strengths or the perseverance and skills of the caregivers.

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INDUSTRY-SUPPORTED SYMPOSIUM 14—ALZHEIMER'S DISEASE: PRACTICAL TREATMENT APPROACHES
Supported by Novartis Pharmaceuticals Corporation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the importance of communication with the Alzheimer's disease patient and family and the role of therapeutic interventions.

No. 14A
THE NATURAL HISTORY OF ALZHEIMER'S DISEASE AND THE EVOLUTION OF PSYCHIATRIC SYMPTOMS

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

SUMMARY:

This presentation will focus on the progression of Alzheimer's disease from its theoretical beginnings (cellular changes). The disease will be described as its patients move through various stages. Specific emphasis will be placed on the appearance and development of various psychiatric symptoms.

No. 14B
THE ALZHEIMER'S DISEASE PATIENT AND FAMILY: COMMUNICATION, EVALUATION, AND MANAGEMENT ISSUES

Steven H. Ferris, Ph.D., *Department of Psychiatry, New York University Medical Center, Aging Center, THN312B, 550 First Avenue, New York NY 10016*

SUMMARY:

This presentation will deal with the evaluation and treatment of the disease. Specific focus will be on the various tools utilized to diagnose the disease and evaluate its progress. In addition, a review of current and potential future therapies will be presented with emphasis on their impact and the expectation for the patient and caregiver.

No. 14C
THE PSYCHIATRIST'S ROLE IN DAY-TO-DAY MANAGEMENT

Peter V. Rabins, M.D., *Department of Psychiatry, Johns Hopkins Hospital, 600 N. Wolfe Street/Meyer 279, Baltimore MD 21287-7279*

SUMMARY:

This presentation will discuss the day-to-day role of the psychiatrist for Alzheimer's patients. Special consideration will be given to the identification of techniques that allow the caregiver to provide more efficient patient care. The possible impact of those caregiver interventions will be highlighted.

No. 14D
THE APA PRACTICE GUIDELINES: IMPLICATIONS FOR THE PRACTITIONER

Elsa M. Zayas, M.D., *Department of Psychiatry, St. Louis University, 1221 South Grand Boulevard, St. Louis, MO 63104*

SUMMARY:

The recently published guidelines by the American Psychiatric Association on the treatment of Alzheimer's disease and related disorders will be discussed. The focus will be on the practical application of these guidelines in day-to-day practice. Particular emphasis will be placed on patient diagnosis, treatment and coordination with caregiver efforts, and how these might be measured. Comparisons will be made with the AAGP/GPA Consensus Statement.

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INDUSTRY-SUPPORTED SYMPOSIUM 15—CHRONIC DEPRESSION: OPTIMIZING LONG-TERM TREATMENT
Supported by Bristol-Myers Squibb

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: better recognize chronic major depression; optimally select treatment approaches; improve compliance; and understand how combined therapy provides symptom relief.

No. 15A
EPIDEMIOLOGY AND CLINICAL COURSE OF CHRONIC DEPRESSION

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

SUMMARY:

Whether depression is a single disease that varies from mild to severe, with varying episode durations and different course patterns, or whether it is an umbrella diagnosis representing depressive subtypes with different psychological and biological characteristics has been debated by clinicians and researchers for many years. However, most scientists now agree that understanding the heterogeneous subtypes of depression allows for greater accuracy in describing and differentiating patients' suffering from depression and, therefore, greater precision in developing and testing the efficacy of new treatments, as well as prescribing the most efficacious treatment plan.

This presentation will review: 1) the epidemiology and clinical course of depression; 2) the distinctions between unipolar major depression, double depression and dysthymia; and 3) the history of the DSM classifications for these "subtypes" of depression. The presentation will also discuss the fact that, despite a lack of scientific validation of the subtypes of major depressive disorder, clinicians and researchers continue to subclassify major depression, particularly, for the purpose of testing the efficacy of new psychopharmacologic and psychosocial treatments.

There continues to be a need for future research to more clearly establish the predictive value in terms of course, recovery, rates of relapse, and treatment in regard to distinguishing types of depression as well as to validate the current nosology.

No. 15B
ENHANCING COMPLIANCE WITH ANTIDEPRESSANT TREATMENT: IDENTIFICATION AND MANAGEMENT OF SIDE EFFECTS

John M. Zajecka, M.D., *Department of Psychiatry, Rush-Presbyterian Medical Center, 1725 West Harrison, Suite 955, Chicago IL 60612*

SUMMARY:

Optimal recovery from chronic depression requires adherence to the treatment throughout the acute, continuation, and maintenance phases of treatment. Poor compliance with treatment is among the most common reasons for inadequate treatment. Compliance issues may arise throughout any phase of treatment; however, studies show that a significant percentage of patients stop their antidepressants during the acute treatment phase, often for reasons that could have been prevented through appropriate clinical intervention. Intolerable side effects are among the most common reasons for patients to stop their antidepressant prematurely.

Several clinical interventions will be presented that may enhance compliance throughout the various phases of treatment with antidepressants. Identification and intervention strategies will be reviewed for the common early and long-term side effects that affect compliance with antidepressants, including anxiety, insomnia, asthenia, weight gain, and sexual dysfunction.

No. 15C
CHRONIC DEPRESSION: MANAGING EMERGING BIPOLAR SYMPTOMS

David L. Dunner, M.D., *Center for Anxiety and Depression, University of Washington, 4225 Roosevelt Way, NE, #306, Seattle, WA 98105-6099*

SUMMARY:

Growing evidence suggests that a majority of patients with chronic depression will achieve substantial symptomatic improvement, often full-blown remission, upon treatment with full-dose antidepressant drug therapy. As always in treating depression with antidepressant agents, in a small percentage of patients the mood state will switch beyond euthymia to states of euphoria or elation. In such circumstances, the clinician must first consider a differential diagnosis. In many such cases, the antidepressant agent will have unmasked a latent bipolar-spectrum disorder. If that diagnosis best fits available clinical information, the practitioner may manage the patient as per accepted guidelines for the presenting condition: e.g., hypomania or mania, with or without psychosis. The speaker will review pros and cons of the varying approaches for acute treatment and for long-term maintenance in this event. *#306, Seattle, WA 98105-6099.*

No. 15D
GENDER ISSUES IN CHRONIC DEPRESSION: IMPLICATIONS FOR TREATMENT

Susan G. Kornstein, M.D., *Department of Psychiatry, Medical College of Virginia, Box 980710, MCV Station, Richmond VA 23298;* Alan F. Schatzberg, M.D., Michael E. Thase, M.D., Alan J. Gelenberg, M.D., Gabor I. Keitner, M.D

SUMMARY:

The recent emphasis on women's health issues has brought needed attention to gender differences in the prevalence, presentation, and treatment response of various medical and psychiatric disorders. In the area of depression, gender has been shown to be a major risk factor, with both major depression and dysthymia being twice as common in women as in men. In addition to the difference in prevalence of depression, recent studies suggest gender differences in presentation, course of illness, and treatment response to both medications and psychotherapy. Because of the exclusion of women from clinical trials in the past and the lack of data analysis by gender, our knowledge in this area is limited but growing rapidly.

This presentation will increase awareness and understanding of gender issues in the evaluation and management of patients with depressive disorders. Data from studies of gender differences in chronic depression and treatment response to various antidepressants will be reviewed. Recommendations will be given for gender-specific assessment and treatment of chronic depression.

No. 15E
COMBINING PHARMACOTHERAPY WITH PSYCHOSOCIAL TREATMENTS

Gabor I. Keitner, M.D., *Department of Psychiatry, Rhode Island Hospital, 593 Eddy Street, Providence RI 02903*

SUMMARY:

The presentation will review evidence for the effectiveness of combining antidepressant drugs with psychotherapy and family therapy in patients with depression. The focus will be on the advantages, disadvantages, and indications for combined therapy as opposed to pharmacotherapy alone.

The main ingredients of effective psychotherapies (cognitive therapy, interpersonal therapy, the problem-centered systems therapy of the family) will be highlighted with a special emphasis on the treatment of chronic depression.

Preliminary data from a multicenter study of chronically depressed patients comparing the effectiveness of an antidepressant alone to cognitive-behavioral therapy alone and the combination of the two treatments will be presented.

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3. Kornstein SG: Gender differences in depression: implications for treatment. J Clinical Psychiatry, 1997:58(suppl), in press.
4. Miller IW, Keitner GI: Combined medication and psychotherapy in the treatment of chronic mood disorders. Psychiatric Clinics of North America 1996;19:151–171.

INDUSTRY-SUPPORTED SYMPOSIUM 16—ISSUES IN THE LONG-TERM MANAGEMENT OF DEPRESSION
Supported by Organon Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

This symposium will provide practical information for the clinician on the long-term nature of depression and management of its treatment during the maintenance phase, including compliance, side effects, "blips," "poop-out," and other issues.

No. 16A
LONG-TERM NATURE OF DEPRESSION

Michael E. Thase, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh PA 15213*

SUMMARY:

Many if not most people with depression are at high risk for developing recurrent and potentially chronic disorders with deleterious effects on vocational, social, and family functioning. Recent evidence suggests that recurrent episodes of severe depression may induce changes in brain function that further heighten vulnerability and severity. The best way to deal with these sobering problems is prevention via vigorous treatment of the index episode to produce complete remission and broader use of longer-term models of prophylactic therapy. This presentation will focus on the four "arms" of preventative treatment: psychoeducation, pharmacotherapy, adherence, and psychotherapy. Management of common side effects, problems with apparent "tolerance" of therapeutic effects, and antidepressant discontinuation syndromes also will be discussed. Like the treatment of hypertension, a conscientious and integrated approach to preventative therapy will save lives and have profoundly beneficial effects for our patients and their loved ones.

No. 16B
NEW DEVELOPMENTS IN ACUTE TREATMENT OF DEPRESSION

Stuart A. Montgomery, M.D., *19 St. Leonard's Road, London, W13 8PN, United Kingdom*

SUMMARY:

Much new research has been directed towards developing antidepressants with a faster onset of action than conventional antidepressants, which have a delay before response is reliably seen. Pindolol augmentation strategies have shown a faster onset for pindolol plus fluoxetine and paroxetine compared with SSRI's alone. The paroxetine study showed accelerated response in primary care but not in hospital-based practice where secondary referral of more chronic or recurrent cases occurred. The accelerated response was also associated with a superior response at the end of acute treatment.

Not all depressions are the same. Recurrent brief depression, characterized by short episodes, normally two to four days, but recurring erratically mostly some 18 times a year, is not thought to respond to conventional TCA or SSRI treatment. Bipolar depression, where major depression is part of a cyclical disorder with mania or hypomania in the history, differs from unipolar major depression in the response to drugs. Bipolar patients are often provoked into an episode of hypomania by TCAs, which are therefore contraindicated. SSRIs, which appear less prone to provoke switches, may be preferred. Mood stabilizers such as sodium valproate or to a lesser extent lithium may also be used. The development of antidepressants that also treat mania would be an important advance. The search for superior efficacy should lead to newer antidepressants, some of which may be targeted to subgroups of depression that have been poorly treated.

No. 16C
ANTIDEPRESSANT DRUG MECHANISMS OF ACTION: RELATIONSHIP TO EFFICACY

Dennis S. Charney, M.D., *Department of Psychiatry, Yale University, 25 Park Street, New Haven CT 06519*

SUMMARY:

There is accumulating knowledge from preclinical and clinical research laboratories indicating that there are numerous possible mechanisms of action of antidepressant drugs. This is due, in part, to our increasing understanding of the role of the various serotonin and norepinephrine receptors and involvement of other neuronal systems besides monoamines that regulate mood and are potential targets for antidepressant drugs. This presentation will review the major hypotheses regarding the mechanisms of action of antidepressant treatments in the context of the efficacy and potency of both available and putative antidepressant drugs.

No. 16D
MANAGEMENT ISSUES IN MAINTENANCE TREATMENT

A. John Rush, M.D., *Department of Psychiatry, University of Texas Southwestern Medical Center, 5959 Harry Hines Blvd, Suite 600, Dallas TX 75235-9070*

SUMMARY:

Maintenance therapy aims at preventing a new episode (recurrence) of depression. Optimally, maintenance therapy also provides a totally symptom-free state with minimal or no side effects and subsequent functional restoration. Maintenance medication cannot protect against life's stresses, although it may better prepare patients to deal with them. In some patients, the secondary complications of depressive illness may also be reduced (e.g., substance abuse, marital discord, suicidal actions). The long-term management of chronic or recurrent depressions (those needing maintenance treatments) can be usefully modeled after the management of diabetes or hypertension, each of which involves lifestyle revisions, medication adjustments, long-term adherence, symptom- or disorder-specific physiological self-monitoring, at least intermittent reporting by "significant others," and treatment delivery system contingencies that facilitate early and timely interventions when the disorder worsens.

This presentation will evaluate the empirical evidence for these promised benefits and offer clinically based suggestions for how best to deal with common clinical obstacles to optimal outcomes. Such obstacles include adherence, failure to optimally dose, ongoing untoward life events, continuing interpersonal difficulties, stigma, intercurrent general medical conditions, grief, and other major life events (e.g., marriage, childbirth). In addition, the key elements in symptom self-monitoring and patient and family education will be highlighted.

No. 16E
MANAGEMENT OF SEXUAL SIDE EFFECTS OF ANTIDEPRESSANT THERAPY

Robert M.A. Hirschfeld, M.D., *Department of Psychiatry, University of Texas, 1200 Graves Building, Route D-29, Galveston TX 77555-0429*

SUMMARY:

Sexual dysfunction occurs in over one-third of the general population and has many causes including psychosocial, general medical illness, nonpsychiatric medication, psychiatric disorders, and psychotropic medications. Psychosocial causes are the most prevalent, but many frequently used medications, such as diuretics, beta blockers, and H_2 blockers, can also cause sexual dysfunction. Sexual dysfunctions occur in many psychiatric disorders, including mood disorders, schizophrenia, substance abuse, and anxiety disorders. In addition, over half the patients with major depression will have some sexual dysfunction.

Although much attention has been paid to sexual dysfunction associated with the SSRIs, many other commonly used psychotropics are associated with a variety of sexual dysfunctions, including haloperidol, benzodiazepines, stimulants, and drugs of abuse. With regard to the SSRIs, sexual dysfunction occurs in 50 percent or more of patients taking them, which is substantially higher than the rates reported in the PDR. The reason for this is that patients will not spontaneously report sexual problems, which must be elicited by direct inquiry.

A variety of strategies exist to manage antidepressant-induced sexual problems, including waiting, reducing the antidepressant dose, use of drug holidays, use of adjunctive pharmacotherapy, and switching antidepressants. Use of an antidepressant with a low prevalence of sexual side effects, such as bupropion, nefazodone, and mirtazapine may also be considered.

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INDUSTRY-SUPPORTED SYMPOSIUM 17—JUVENILE MOOD DISORDERS: FROM RESEARCH TO CLINICAL PRACTICE Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to learn differences and similarities between juvenile and adult mood disorders; to gain familiarity with clinical characteristics, course, treatment, and genetic factors of juvenile mood disorders; to learn management strategies of comorbid substance abuse and juvenile mood disorders; to learn pharmacotherapy guidelines for MDD and bipolarity in children and adolescents.

No. 17A ADHD AND JUVENILE MANIA: AN OVERLOOKED COMORBIDITY?

Joseph Biederman, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, ACC-725, Boston MA 02144*

SUMMARY:

Dr. Biederman will describe findings from his four-year follow-up study. Psychiatric, cognitive, and functional correlates of ADHD children with and without comorbid bipolar disorder (BPD) were compared. Eleven percent of ADHD children at baseline were diagnosed BPD and an additional 12% at four-year follow-up. ADHD children with comorbid BPD at either baseline or follow-up assessment had significantly higher rates of additional psychopathology, psychiatric hospitalization, and severely impaired psychosocial functioning than other ADHD children. The clinical picture of bipolarity was mostly irritable and mixed. ADHD children with comorbid BPD also had a very severe symptomatic picture of ADHD as well as prototypical correlates of the disorder. Comorbidity between ADHD and BPD was not due to symptom overlap. ADHD children who developed BPD at the four-year follow-up had higher initial rates of comorbidity, more symptoms of ADHD, worse scores on the CBCL, and a greater family history of mood disorder compared with non-BPD ADHD children. Dr. Biederman will discuss the importance of these findings in understanding the complex picture of bipolar disorder in juveniles.

No. 17B MANIA-LIKE SYMPTOMS SUGGESTIVE OF CHILDHOOD-ONSET BIPOLAR DISORDER IN CLINICALLY REFERRED CHILDREN

Janet Wozniak, M.D., *12 Field Road, Lexington MA 02173-8015*

SUMMARY:

Dr. Wozniak will describe her work on the characteristics and correlates of mania among clinically referred children age 12 or younger. Dr. Wozniak systematically compared children age 12 or younger who satisfied criteria for mania (N = 43) with ADHD children without mania (N = 164) and non-ADHD controls (N = 84). A clinical picture fully compatible with the DSM-III-R diagnosis of mania was found in 16% of referred children. All but one of the children meeting criteria for mania also met criteria for ADHD. Compared with ADHD children without mania, manic children had significantly higher rates of major depression, psychosis, multiple anxiety disorders, conduct disorder, and oppositional defiant disorder as well as evidence of significantly more impaired psychosocial functioning. In addition, 21% of manic children had been psychiatrically hospitalized at least once. These results suggest that mania may be relatively common among psychiatrically referred children. The clinical picture of childhood-onset mania is very severe and frequently comorbid with ADHD and other psychiatric disorders. Dr. Wozniak will discuss the importance of identifying both ADHD and bipolar disorder in a substantial percentage of referred prepubertal children.

No. 17C ADHD WITH BIPOLAR DISORDER: A FAMILIAL SUBTYPE?

Stephen V. Faraone, Ph.D., *Department of Child Psychiatry, Massachusetts General Hospital, 15 Parkman Street, ACC 725, Boston MA 02114-3954*

SUMMARY:

Dr. Faraone will discuss a family genetic study of children with ADHD and bipolar disorder (BPD). Using blind raters and structured psychiatric interviews, we examined children with ADHD (N = 140), non-ADHD comparisons (N = 120), and their first-degree relatives (N = 822). After stratifying our ADHD sample into those with and without BPD, we found that: 1) relatives of both ADHD subgroups were at significantly greater risk for ADHD than relatives of non-ADHD controls, 2) the two subgroups did not significantly differ from one another in their relatives' risk for ADHD; 3) a five-fold elevated risk for bipolar disorder was observed among relatives when the proband child had BPD but not when the proband had ADHD alone; 4) an elevated risk for major depression with severe impairment was found for relatives of ADHD + BPD probands; and 5) both ADHD and BPD occurred in the same relatives more often than expected by chance alone. Our data suggest that ADHD comorbid with BPD is familially distinct from other forms of ADHD and may be related to what others have termed childhood-onset BPD.

No. 17D JUVENILE BIPOLAR DISORDER AND THE RISK FOR SUBSTANCE ABUSE

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

SUMMARY:

Recent research suggests that bipolar (BPD) and substance use disorders (SUD) in adults co-occur more often than expected by chance, and that BPD, which develops in young adulthood, appears to influence the course of SUD. To evaluate the developmental relationship of BPD to SUD, we systematically assessed 219 children and adolescents with BPD using structured psychiatric interviews. Whereas adolescents with onset of their BPD during early childhood (BPD onset <12 yrs) were at minimal risk for SUD, adolescent-onset BPD cases (BPD onset ≥13 years) were at very high risk for SUD. Adolescent-onset BPD youth were five times more likely to develop a SUD than those with childhood-onset BPD ($p < 0.003$). This elevated risk of SUD in adolescent-onset BPD was not accounted for by conduct disorder or other psychiatric disorders. Hence, this study coupled with others strongly supports adolescent-onset BPD as a major risk factor for SUD. Identification and aggressive psychiatric treatment of the BPD in these comorbid, severely im-

paired adolescents may improve both the BPD and SUD. Strategies for assessment and treatment of these youths will be presented.

No. 17E
THE NATURALISTIC COURSE OF PHARMACOLOGIC TREATMENT OF CHILDREN WITH MANIC-LIKE SYMPTOMS: A SYSTEMATIC CHART REVIEW

Thomas J. Spencer, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, ACC 725, Boston MA 02114*

SUMMARY:

Since childhood mania is frequently comorbid with depression, anxiety, and/or ADHD, manic youth are likely to receive multiple medications in combination with mood stabilizers. Combined use of antidepressants and stimulants may increase the risk for exacerbation of mania. Unfortunately, there are no rigorously controlled studies of the pharmacotherapy of childhood mania. Dr. Spencer will present original data on the effectiveness of antipsychotics and mood stabilizers in juvenile mania as well as the impact of antidepressants and the anti-ADHD aramamentarium in the management of the manic child.

In subjects who met diagnostic criteria for mania, we reviewed both the course of manic-like symptoms and all medications prescribed at each follow-up visit. Survival analyses were used to determine the effect of antipsychotics, mood stabilizers, and other medications on the course of manic-like symptoms. Of the 59 subjects meeting criteria for mania, 44 (75%) exhibited evidence of manic-like symptoms during follow-up. The occurrence of manic symptoms significantly predicted the subsequent prescription of mood stabilizers, and mood stabilizers predicted decreases in manic symptoms. Dr. Spencer will discuss various approaches to treatment in complex manic children.

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INDUSTRY-SUPPORTED SYMPOSIUM 18—THE DEPRESSED WOMAN: CONTEMPORARY TREATMENTS
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to provide the latest information on the treatment with both drugs and psychotherapy of depressed women.

No. 18A
TREATMENT OF PSYCHIATRIC ILLNESS DURING PREGNANCY AND THE POSTPARTUM PERIOD

Lee S. Cohen, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 815, Boston MA 02114*

SUMMARY:

While the postpartum period has typically been described as a time of risk for development of affective disorder, pregnancy is frequently considered a time of well being for women, providing "protection" against emotional disturbance. A growing literature suggests that at least some women continue to manifest symptoms of depression during pregnancy. Women with histories of depression may be more likely to experience depression during pregnancy and are at particular risk for postpartum worsening of mood. Identification of women "at risk" for development of depression during pregnancy and the postpartum period allows for thoughtful treatment planning, which may include either pharmacologic and/or nonpharmacologic interventions and potential prophylactic strategies during the puerperium.

This presentation will review risks associated with antidepressant use during pregnancy as well as those of untreated maternal psychiatric disorder. Data regarding risk of prenatal exposure to psychotropics, perinatal toxicity, and long-term neurobehavioral sequelae will be discussed. Treatment guidelines for psychotropic drug use during pregnancy will be presented. In addition, the spectrum of postpartum depressive syndromes will be described as will appropriate screening instruments for puerperal mood disturbance. Treatments for postpartum depression will also be discussed in the context of matching therapies for "at risk" women.

No. 18B
INTERPERSONAL PSYCHOTHERAPY FOR ANTEPARTUM DEPRESSION

Margaret G. Spinelli, M.D., *Department of Psychiatry, Columbia University, 722 West 168th St. Box 14, New York NY 10032*

SUMMARY:

Antenatal depression, a substantial risk factor for postpartum depression, occurs in 10% of pregnant women, but no clinical treatment trials of antenatal depression exist. In an effort to establish treatment guidelines for depression during pregnancy, the author reports on a treatment program using interpersonal psychotherapy for antepartum depression. A 16-week open pilot trial was conducted with 13 pregnant women who met DSM-III-R criteria for major depression. The women's mean depression ratings decreased significantly from week 0 to week 16 of the treatment program. Interpersonal psychotherapy for antepartum depression appears to be an effective alternative to pharmacotherapy in pregnancy. This study served as a pilot for an ongoing controlled clinical treatment trial.

No. 18C
THE TREATMENT OF DEPRESSED WOMEN AND THEIR CHILDREN

Myrna M. Weissman, Ph.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 14, New York NY 10032-2603*

SUMMARY:

The increased rate of major depression in women has been well established in numerous studies across diverse cultures. The peak age of first onset is in childbearing years and recurrence occurs across the life span. The offspring of depressed women are at particularly high risk for depression. Our 10-year follow-up found that the depressed offspring of depressed as compared with nondepressed parents had more serious and recurrent depression, were more socially and vocationally impaired, and over the 10-year follow-up period were less likely to go for treatment. We reasoned that successful treatment of parental depression may provide primary prevention in offspring by reducing the symptoms of depression that impair parenting. This presentation will describe new data on a recently initiated study of the treatment of depressed mothers of depressed children to test this hypothesis.

No. 18D
PREVENTING RECURRENCE OF DEPRESSION IN WOMEN

Ellen Frank, Ph.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh PA 15213-2593*

SUMMARY:

For over a decade, we have been interested in the maintenance treatment of recurrent depression using drugs and psychotherapy (Frank et al., 1990; Frank et al., 1991; Frank et al., 1993; Kupfer et al., 1990). We have also had a sustained interest in the treatment needs of women, particularly during the childbearing years. In the Pittsburgh study of maintenance therapies for recurrent depression, we conducted a three-year randomized clinical trial of patients with recurrent depression. Although numbers of males in each of the five conditions were relatively small, limiting power to detect gender differences, no such differences were observed. We later observed that highly specific (i.e. interpersonally focused) IPT was associated with significantly different ($p \leq .001$) survival time, leading us to design a trial in which women in the childbearing years were treated acutely with IPT alone and then randomly assigned to various "doses" (weekly, biweekly, monthly) of maintenance interpersonal psychotherapy. Early results suggest that while frequency of therapy contact is not directly related to treatment specificity, treatment specificity is, once again, related to the prophylactic efficacy of interpersonal psychotherapy. Overall, the results of this trial have been highly encouraging in that fewer than 20% of the women who entered maintenance treatment have thus far experienced a recurrence of illness. This presentation will update the findings and present new data on the treatment of the depressed older woman.

No. 18E
NEW TREATMENTS FOR PREMENSTRUAL DYSPHORIC DISORDER

Kimberly A. Yonkers, M.D., *Department of Psychiatry, University of Texas Southwestern Medical Center, 5959 Harry Hines Boulevard, #520, Dallas TX 75235-9070*

SUMMARY:

The addition to DSM-III-R and DSM-IV of clinical criteria for premenstrual dysphoric disorder (PMDD) has facilitated research into possible effective treatments. Active investigation using these criteria have shown that some, but not all, psychotropics are useful in the treatment of PMDD. Selective serotonin reuptake inhibitors, the dual reuptake inhibitor venlafaxine, and the anxiolytics buspirone and alprazolam have been evaluated in large randomized placebo-controlled trials. Results using these psychotropics show that approximately 60% of women on active treatment will substantially improve. On the other hand, approximately 35% of women given placebo will feel somewhat or greatly improved. These promising results, and the substantial difference between active treatment and placebo, contrast with the results of trials using progesterone or oral contraceptives as active treatments for premenstrual dysphoria. The majority of trials using progesterone or oral contraceptives have failed to show benefit beyond what is found with placebo. In this presentation, information from the latest clinical trials on the treatment of premenstrual dysphoria will be presented. Other issues including dosing strategies, timing of drug administration, and duration of treatment will be discussed.

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INDUSTRY-SUPPORTED SYMPOSIUM 19—NEW FRONTIERS IN THE MANAGEMENT OF SOCIAL PHOBIA: DIAGNOSIS, TREATMENT AND CLINICAL COURSE
Supported by SmithKline Beecham Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to appreciate the economic and societal impact of social phobia, describe the typical presentation of a patient with social phobia, discuss relevant psychiatric comorbidity, understand sex differences in the presentation and management of social phobia, and develop a treatment strategy for social phobia.

No. 19A
THE DIFFERENTIAL DIAGNOSIS OF SOCIAL PHOBIA

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

SUMMARY:

Social phobia has recently garnered recognition as a distinct anxiety disorder. In fact, although social phobia is definitely distinguishable from other psychiatric disorders, there are several areas where this distinction is not straightforward. Furthermore, social phobia is typified by considerable comorbidity with other disorders, which may render differential diagnosis a challenging endeavor. In this presentation, Dr. Stein will review those disorders from which social phobia must be differentiated in order to arrive at the appropriate diagnosis. These include panic disorder, major depression, obsessive-compulsive disorder, and body dysmorphic disorder. In addition, DSM-IV provides specific examples of disorders (e.g., verbal dysfluency [stuttering], Parkinson's disease) in the context of which social phobia is *not* to be diagnosed. Dr. Stein will review several studies that challenge the wisdom of this decision rule. Social phobia is also frequently comorbid with an Axis II disorder, avoidant personality disorder. Interestingly, this may represent a prime example of "comorbidity by committee" in that it is growing increasingly clear that avoidant personality disorder as defined in DSM-IV merely denotes a severe subgroup of patients with generalized social phobia. Data supportive of this conclusion will be presented.

No. 19B
GENDER DIFFERENCES IN THE PRESENTATION AND MANAGEMENT OF SOCIAL PHOBIA

Lisa S. Weinstock, M.D., *Department of Psychiatry, Cornell University Medical Center, 21 Bloomingdale Road, White Plains NY 10605*

SUMMARY:

Social phobia is a common psychiatric disorder often associated with severe impairment in social and occupational functioning. Epidemiologic studies of social phobia suggest it is more common in women than men. A number of biological and psychosocial factors may contribute to gender differences in the presentation and management of social phobia. Changing societal expectations regarding gender roles may contribute to sex differences in clinical characteristics of social phobia. During the menstrual cycle, pregnancy, and the postpartum period, there are significant changes in serum levels of progesterone and its anxiolytic metabolite 3-alpha-dihydroxyprogesterone. These changes may impact on severity of anxiety symptoms in women with social phobia. Oral contraceptives can affect serum levels of many of the psychopharmacologic agents used in the management of social phobia. Women planning a pregnancy have concerns about continuing pharmacotherapy while trying to conceive and during pregnancy. Treatment strategies for women with social phobia must be designed to take into account individual variables such as pregnancy status, oral contraceptive use, and specific nature of anxiety and avoidant symptoms.

No. 19C
COGNITIVE-BEHAVIOR THERAPY FOR SOCIAL PHOBIA: THEORY, OUTCOME, AND FUTURE DIRECTIONS

Michael W. Otto, Ph.D., *Clinical Psychopharmacology, Massachusetts General Hospital, 15 Parkman Street, WACC-815, Boston MA 02114*

SUMMARY:

Cognitive-behavioral treatments for social phobia have typically emphasized cognitive-restructuring and exposure interventions, delivered alone or in combination, in either individual or group formats. Treatment programs emphasizing these interventions have met with consistent success. In this presentation, the nature and application of these interventions will be reviewed in relation to a cognitive-behavioral model of the development and maintenance of social phobia. Strategies and mechanisms of treatment change will be discussed as will outcome findings, with attention to both individual studies and meta-analytic reviews of the outcome literature. Data on acute treatment outcome will be complemented by discussion of the maintenance of treatment gains and consideration of "next step" strategies for patients who do not respond to initial interventions.

No. 19D
SOCIAL PHOBIA: DESIGNING A PHARMACOLOGIC TREATMENT STRATEGY

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

SUMMARY:

The growing appreciation of the prevalence and morbid sequelae of social phobia has focused increasing interest on the treatment of this disorder. A number of pharmacologic interventions including the MAOI's, RIMA's, benzodiazecpines, beta blockers, and SSRI's have demonstrated efficacy for the treatment of social phobia. The choice of initial treatment depends on a number of factors including comorbidity, treatment history, patient preference, and side-effect profile. In this presentation we will examine evidence for the efficacy of the various pharmacologic agents for social phobia, discuss considerations in the long-term management of the disorder, and review strategies to optimize treatment in patients partially or completely unresponsive to initial treatment approaches.

No. 19E
COMORBID SOCIAL ANXIETY AND BODY DYSMORPHIC DISORDER: MANAGING THE COMPLICATED PATIENT

Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustave Levy Place Box 1230, New York NY 10029;* Charles Cartwright, M.D., Bonnie A. Aronowitz, Ph.D., Cheryl M. Wong, M.D., Concetta M. DeCaria, Ph.D., Tomer Begaz, B.A., Jee Kwon, B.A.

SUMMARY:

Social anxiety is a prominent component of body dysmorphic disorder (BDD), the distress of imagined ugliness. These patients have an obsessive preoccupation with an imagined body defect, compulsive mirror checking, and frequently repetitive cosmetic surgery to correct the perceived defect in appearance. However, the resultant social anxiety itself can markedly impair social functioning, resulting in avoidance of social situations, occupational and academic impairment, and in some cases causing the patient to become housebound. Depression and suicide are also frequent complications of BDD.

Patients with BDD have a selective response to potent SRI's and SSRI's. For example, patients do not respond to the norepinephrine reuptake inhibitor desipramine, but significantly improve with the serotonin reuptake inhibitor clomipramine, as well as the selective serotonin reuptake inhibitors. In addition to improvement in the obsessive preoccupation and urge to have cosmetic surgery, the social anxiety also improves with SSRI's. A group cognitive-behavioral approach to BDD is also helpful.

Patients presenting with prominent social anxiety should be carefully screened to elicit symptoms of BDD. Also, patients with BDD need to be queried for the presence of comorbid social phobia.

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INDUSTRY-SUPPORTED SYMPOSIUM 20—NICOTINE: AN ENEMY OR AN ALLY? Supported by Glaxo Wellcome Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

Attendees will learn the potentially beneficial effects of nicotine for various psychiatric patients and how these effects complicate cessation efforts at the same time that they improve our understanding of the pathophysiology of both depression and schizophrenia. Cessation programs specific to psychiatric patients will be presented.

No. 20A DEPRESSIVE RELAPSE PROVOKED BY SMOKING CESSATION

Alexander H. Glassman, M.D., *Clinical Psychopharmacology, New York State Psychiatric Institute, 722 West 168th Street, New York NY 10032-2603;* Toby A. Cohen, M.S.

SUMMARY:

Ten years ago, we first reported a strong association between major depression and both cigarette smoking and smoking cessation. These relationships existed not only in individuals who were presently ill, but even in those who only had a history of major depression. These observations have now been replicated over and over again and led to the trials of antidepressant drugs as aids to smoking cessation.

For the psychiatrist, this relationship between smoking and depression has revealed a serious problem. Euthymic patients with a history of recurrent depression who are smokers have a significant risk of relapsing if they successfully stop smoking. This depression is not just a withdrawal symptom, like anxiety or irritability, that will disappear in a week or two. The increased risk of a serious relapse continues for weeks, even months, after smoking cessation. This would seem to be strong evidence that nicotine actually has antidepressant activity. While smoking cessation clearly carries special risks for the patient with depression, it also seems to reveal a new class of potentially antidepressant drugs.

No. 20B A NICOTINIC RECEPTOR DEFICIT IN SCHIZOPHRENIA

Robert Freedman, M.D., *Department of Psychiatry, University of Colorado, 4200 E. Ninth Avenue, Box C268-71, Denver CO 80262;* Lawrence E. Adler, M.D., Ann Olincy, M.D., Herbert T. Nagamoto, M.D., Sherry Leonard, Ph.D., Paula Bickford, Ph.D., Karen Stevens, Ph.D.

SUMMARY:

Schizophrenia likely has multiple genetic and environmental causes, which confounds attempts to learn its basic biology. One strategy for dissecting various pathogenic factors is to identify elementary physiological deficits that occur in patients and their relatives. Such deficits might have a more direct relationship to a single genetic abnormality and its corresponding neuronal dysfunction than is apparent from studies of the illness itself. Loss of the inhibitory gating of the auditory evoked response to repeated stimuli is one such deficit, which may underlie some of the patients' well-known distractibility and difficulties with attention. Normals quickly diminish the response to repeated sounds, whereas schizophrenics do not. Neurobiological and genetic investigations provide convergent evidence that this trait may reflect a deficit in alpha7-nicotinic receptor subunit gene, which codes for one of the brain's nicotinic cholinergic receptors. Schizophrenics are among the heaviest abusers of tobacco products. Furthermore, nicotine transiently reverses several of their physiological deficits. The dose of nicotine required is high and the effects are quickly lost, which is consistent with the biological properties of the alpha7-nicotinic receptor. It is possible, therefore, that patients' psychosis and their heavy use of tobacco reflect a genetically determined deficit in the same neuronal mechanism.

No. 20C THE NEUROBIOLOGY OF NICOTINE DEPENDENCE

George F. Koob, Ph.D., *Neuropharmacology, The Scripps Research Institute, 10550 Torrey Pines Road, CVN 7, La Jolla CA 92037;* Shelly Watkins, M.A., Mark Epping-Jordan, Ph.D., Ana Maria Basso, Ph.D., Athina Markou

SUMMARY:

Nicotine dependence is one of the most prevalent drug addictions, and as such, shares many of the behavioral effects of other major drugs of abuse in animal models of drug addiction. Nicotine is readily self-administered intravenously by animals, which indicates that acute nicotine administration produces reinforcing effects. The acute reinforcing effects of nicotine appear to be mediated by actions at nicotine acetylcholine receptors in the central nervous system that activate the mesolimbic dopamine system. By contrast, the nicotine withdrawal syndrome is characterized not only by somatic signs but also behavioral changes that may reflect negative emotional states. Nicotine withdrawal in rodents, following chronic nicotine administration, is accompanied by robust decreases in brain reward function that can last for several days. Similar decreases in reward can be precipitated by administration of nicotinic acetylcholine receptor antagonists in nicotine-dependent animals. Neuropharmacological studies have implicated decreases in dopaminergic and opioidergic function in nicotine withdrawal, as well as increases in the function of the stress neurotransmitter, corticotropin releasing factor. These neurochemical changes observed with chronic nicotine administration are similar to those observed with cocaine and heroin, and these similarities suggest that chronic nicotine may be altering the function of the same major neurochemical reward circuits that are associated with dependence on other major drugs of abuse. These same neural circuits may be important for normal emotional function in humans.

No. 20D TREATING HEAVILY DEPENDENT AND COMORBID SMOKERS

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

SUMMARY:

Over 10 million smokers have failed group behavior therapy or nicotine gum or patch. This talk presents data that show that simple retreatment is unlikely to be successful. The talk also presents data that those who have failed several attempts are likely to be either severely dependent on nicotine (e.g., have continued withdrawal despite gum/patch) or have psychiatric comorbidity (especially depression and alcohol/drug abuse). The talk proposes that if the former occurs, medications such as combined gum plus patch therapy, buproprion plus nicotine patch, nicotine nasal spray, or nicotine inhaler should be considered. If the latter occurs, treatment of psychiatric comorbidity and individual behavior therapy for smoking cessation should be considered. The talk presents data showing that severe nicotine dependence and psychiatric comorbidity are associated such that many failures will need both types of therapy. Such intensive therapy may appear unusual, but it must be remembered that for smoking cessation to be preventative it must occur early. Finally, the talk proposes that psychiatrists are in a unique position to provide such therapy and gives concrete examples of achieving reimbursement for such therapy.

No. 20E
NICOTINE DEPENDENCE IN ALCOHOLICS

Richard D. Hurt, M.D., *Internal Medicine, Mayo Clinic, Rochester MN 55905*

SUMMARY:

Smoking among alcoholics is two to three times that of the general population, and heavy smoking is a predictor of unrecognized alcoholism. Tobacco-related diseases account for more than 50% of deaths in patients previously treated for alcoholism. Nicotine dependence treatment has not been fully incorporated into the treatment of alcoholism and other drugs of dependence. Evolving evidence shows a higher rate of abstinence from alcohol among recovering alcoholics who successfully quit smoking after treatment for alcoholism. Nicotine dependence treatment has been successfully carried out during inpatient treatment for alcoholism without causing an increase in relapse to drinking. In a smoking cessation trial involving recovering alcoholics, the relapse to alcohol was 4% during the 12-month follow-up. Nicotine gum and patch trials show that recovering alcoholic smokers are more dependent on nicotine, and recovering alcoholic smokers were less likely to stop smoking than nonalcoholic subjects. In a nicotine patch trial (n = 382) smoking cessation rates were significantly lower in recovering and active alcoholics compared with the nonalcoholics at end of treatment (58%, 41.7%, and 34%, respectively) and at six months (26.7%, 25%, 15.1%, respectively). Research is needed on how to increase the efficacy of nicotine-dependence treatment for this group of high-risk smokers.

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INDUSTRY-SUPPORTED SYMPOSIUM 21—NEW ATYPICALS: DATA VERSUS CLINICAL EXPERIENCE
Supported by Zeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: demonstrate the ability to differentiate between antipsychotics as to indications, efficacy, and side-effect profiles.

No. 21A
THERAPEUTIC IMPLICATIONS OF ETIOLOGICAL RESEARCH

Robin M. Murray, M.B., *Institute of Psychiatry, Kings College Hospital, De Crespigny Park, London, SE5 8AF, United Kingdom*

SUMMARY:

Recent research suggests that both abnormal genes and early environmental hazards such as infection and hypoxic-ischaemic damage to the frontal/neonatal brain contribute to the form of schizophrenia characterized by neurodevelopmental impairment, poor childhood function, and insidious onset. Adverse life events and a family history of affective disorder are associated with more acute schizoaffective illnesses. This implies that treatment with antipsychotics should be seen in the context of the limitations imposed by neurodevelopmental impairment and that there is a major role for mood stabilizers. Functional brain imaging is now demonstrating the physiology that underlies psychotic symptoms: for example, the dysfunctional frontotemporal connectivity that causes the sufferer to misperceive his/her own inner speech as external voices. MRI can therefore be used to monitor the effect of antipsychotics on the dysfunctional connectivity. Two other new techniques can help to monitor the effects of antipsychotics: 1) Neuroreceptor imaging can be used to understand the different clinical effects of both traditional and atypical antipsychotics. 2) The genotyping of psychotic patients can help to predict an individual's response to antipsychotics; e.g., variation in 5HT2A receptor gene appears to partly determine response to clozapine.

No. 21B
ATYPICAL ANTIPSYCHOTICS: HOW WELL DO THEY REALLY WORK?

Rajiv Tandon, M.D., *Department of Psychiatry, University of Michigan Medical Center, 1500 E. Medical Center Drive, UH8D8806, Ann Arbor MI 48109-0116*

SUMMARY:

Clinical trials have found the newer generation of atypical antipsychotics to be at least as effective as the conventional agents, with a significantly lower propensity to cause EPS. In clinical trials, atypicals have been found to be superior to conventionals in the treatment of negative symptoms, perhaps primary "deficit" symptoms, with some possible neurocognitive advantages as well. Clozapine and perhaps other atypicals), has been found to be effective in about half the patients with schizophrenia refractory to conventional antipsychotics. Some studies suggest that rates of relapse may be lower in schizophrenic patients treated with atypical antipsychotics than with conventional agents. To what extent does clinical experience bear out these efficacy advantages of atypical over conventional agents

suggested by clinical trials? This issue will be reviewed with particular attention to the following questions: 1) Are atypical agents *always* at least as effective as conventional agents? 2) Which atypical agents work in patients refractory to conventional agents? 3) Are atypical agents superior to conventional agents in the treatment of negative symptoms? 4) If so, in what components? 5) Are atypicals superior to the conventionals in ameliorating the neurocognitive symptoms of schizophrenia? 6) Are the benefits in better negative-symptom efficacy, lesser dysphoria, and less impaired cognition explained by the lesser EPS? 7) Are atypicals superior in treating aggression and violence? 8) Do some patients respond to conventionals, but not atypicals? 9) How do atypicals compare with the conventionals in the treatment of other psychotic disorders? 10) How do the various atypical agents compare with regards to their overall efficacy, spectrum of activity, and efficacy in specific populations? "Real" clinical practice implications of these differences in efficacy will be discussed.

No. 21C
NEWER ANTIPSYCHOTICS: SIDE-EFFECT PROFILES

Stephen R. Marder, M.D., *Department of Psychiatry, West Los Angeles Veterans Affairs Medical Center, 11301 Wilshire Boulevard (116A), Los Angeles CA 90073*

SUMMARY:

The most characteristic feature of the newer antipsychotics is their association with relatively few extrapyramidal side effects (EPS). However, these agents are associated with other side effects that can interfere with their acceptance by patients. For clozapine, common side effects include sedation, hypersalivation, seizures, and hypotension. For other new antipsychotics—including risperidone, olanzapine, ziprasadone, sertindole, and quetiapine—side effects may include hypotension, tachycardia, weight gain, and erectile and ejaculatory disturbances. This talk will compare the side-effect profiles of each of these agents. Data from randomized, controlled trials will be contrasted with the experiences of clinicians as demonstrated by case reports. These case reports will focus on patients with EPS, weight gain, and ejaculatory disturbances. Management strategies for each of these side effects will be reviewed.

No. 21D
SERVICES RESEARCH AND USE OF ATYPICAL ANTIPSYCHOTICS

Lisa B. Dixon, M.D., *Department of Psychiatry, University of Maryland, 645 W. Redwood Street, MSTF Room 300, Baltimore MD 21201*

SUMMARY:

How effective and cost-effective are the new atypical antipsychotic agents when typical physicians prescribe them in typical clinical settings for typical patients? Although more research on this question is clearly necessary, several themes emerge. Clozapine has a high probability of being cost-effective for patients who are high hospital utilizers or state hospital patients in large part because responders are more likely to stay out of the hospital. However, more outpatient services will be used and must be available. Also, payers must make an up-front investment to realize downstream benefits. The reduced side effects of all atypical agents lead to increased compliance and improved effectiveness. Ease of dosing and patient acceptability render some atypical agents attractive even to the most difficult, noncompliant patients. Many outpatient clinical programs serving patients who require assertive community treatment and other intensive programs have eagerly integrated the new atypical agents into their care plans. Effectiveness also focuses on nonclinical outcomes such as functional status and quality of life. The atypical antipsychotic agents with reduced extrapyramidal symptoms have clear advantages over typical agents in these domains with far-reaching effects that might be underestimated by efficacy studies. More data are necessary to understand the patient and family impact of the new atypicals "beyond research." However, in the same way that the impact of interventions to reduce noncompliance may be underestimated by clinical trials because many noncompliers will not participate or will drop out, the true impact of the atypical drugs in real clinical life may be greater than what is reflected in the controlled efficacy research.

No. 21E
COMBINING ATYPICALS WITH PSYCHOSOCIAL INTERVENTIONS

Ira D. Glick, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Suite 2122, Stanford CA 94305-5490*

SUMMARY:

Compared with conventional antipsychotics, the new atypicals are more effective for the treatment of negative symptoms and produce fewer EPS. This means, that in theory, patients are more compliant and may be more amenable to psychosocial intervention aimed at an improved quality of life. This presentation compares data from the random-assignment controlled studies with experience from clinicians both in acute and long-term settings. It focuses on studies combining new psychosocial and rehabilitation strategies with medication strategies. It will cover the rationale and theoretical basis for combining therapies, as well as guidelines for combining treatments, including a review of how the atypicals have changed medication strategies and how to combine them with individual therapy, family therapy, and different rehabilitation treatments. Indications and contraindications will be discussed and a "quality treatment equation" presented. Issues of sequencing, structuring of a treatment visit, and laying out treatment objectives for each modality will be described in detail.

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INDUSTRY-SUPPORTED SYMPOSIUM 22—OPTIMIZING PATIENT OUTCOMES WITH NOVEL ANTIPSYCHOTICS: CHANGING EXPECTATIONS Supported by Novartis Pharmaceuticals Corporation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand where the field is moving in the treatment of psychotic disorders given the efficacy of the novel antipsychotic agents. There will be a discussion of the pharmacology of these agents as well as a presentation of clinical strategies for their use, which may improve the overall outcome of patients with psychotic disorders.

No. 22A
ANTIPSYCHOTIC DRUGS: TRANSLATING PHARMACOLOGY INTO CLINICAL EFFECTS

David Pickar, M.D., *ETB/DIRP, National Institute of Mental Health, 10 Center Drive, Building 10, 4N-212, Bethesda MD 20812*

SUMMARY:

The introduction of numerous new antipsychotic drugs, broadly referred to as atypical antipsychotics, has opened new treatment options for the clinician and patients. Most of these compounds are based on overlapping psychopharmacological principles, including affinities for selected dopaminergic and serotonergic receptors. Nevertheless, the new compounds are not the same, each having differing side effects and potential therapeutic profiles. This talk will review the relative pharmacological properties of the new antipsychotics, highlighting how these effects may have clinical relevance for dosing, clinical response, and patient selection. The opportunity to improve the overall treatment of schizophrenia is at hand. Each clinician will have a unique opportunity to utilize the new drugs in the treatment of the most serious mental disorders.

No. 22B
EARLY INTERVENTION: CAN WE CHANGE THE COURSE OF ILLNESS?

Jeffrey A. Lieberman, M.D., *Department of Psychiatry, University of North Carolina School of Medicine, 7025 Neurosciences Hospital, CB716, Chapel Hill NC 27599*

SUMMARY:

New atypical antipsychotic agents are likely to alter the strategy of schizophrenia treatment by shifting the focus of management to disease control at the earliest onset. Administering the new agents early may control the course of the illness, preventing patients from spiraling downward toward functional incapacity.

While it would be ideal to have a treatment to alleviate the morbidity caused by schizophrenia and return people to their premorbid state, it is not yet within our clinical capacity. While conventional antipsychotic agents are effective, they are not necessarily the optimal treatment choice for patients first becoming ill. The efficacy of conventionals is limited and, at moderate to high doses, they introduce the potential for cumulative drug effects that may alter brain structure and function possibly on a sustained basis.

Beyond holding considerable promise for curtailing the descending pathology of schizophrenia, atypical antipsychotic agents are showing superior efficacy compared with conventional antipsychotic drugs in treating psychosis in resistant patients; they have also demonstrated benefits in alleviating some of the hard-to-treat negative symptoms of schizophrenia.

Atypical agents also appear to be more benign than conventionals and usually do not produce the extrapyramidal symptoms or tardive dyskinesia associated with traditional antipsychotic medication. If they prove to be unlike the atypical forerunner clozapine, which can cause agranulocytosis, newer agents such as olanzapine, risperidone, sertindole, and quetiapine could be broadly administered at the first sign of the disease.

As a group, first-episode patients tend to exhibit greater therapeutic responses to treatment than their chronic, multiepisode counterparts. They show increased pharmacologic sensitivity to medication, with a higher portion of patients ultimately responding to treatment and rebounding to former levels of functioning. It appears that effective therapeutic interventions made at this stage of the illness can alter its long-term course and outcome.

Findings also suggest that the number of psychotic episodes after initial onset has a cumulative effect—the greater the number of episodes, the poorer the patient results. It appears that during the psychotic phase of the illness, critical neurobiologic damage may occur that ultimately interferes with the patient's capacity to respond to treatment. Such findings lend support to the idea of initiating therapy with atypical antipsychotic agents as early as possible.

No. 22C
AGGRESSION, VIOLENCE AND SUICIDE IN SCHIZOPHRENIA

Peter F. Buckley, M.D., *Case Western Reserve University, 2040 Abington Road, Cleveland OH 44106*

SUMMARY:

Patients with schizophrenia frequently have problems resulting from the use of alcohol and other substances. The lifetime prevalence of substance use disorder is nearly 50% in patients with schizophrenia. The rate of alcohol use disorder is three times higher in patients with schizophrenia, and cocaine use disorder is over 10 times higher than in the general population. Comorbid alcohol/substance use disorders contribute to the morbidity of schizophrenia through increased relapse, noncompliance with treatment, more hospitalizations, and violence.

Typical antipsychotic agents, long the mainstay of treatment for patients with schizophrenia, are of limited value in controlling alcohol/substance use in dual-diagnosis patients and may actually increase its rate. However, case reports and preliminary data from our group and others suggest that the atypical antipsychotic clozapine may limit alcohol use (and other substance use) in dual-diagnosis patients with schizophrenia.

This presentation will review the important problems resulting from alcohol and substance use in patients with schizophrenia. Preliminary data regarding the effects of clozapine in this population will be presented. Potential mechanisms involved in the apparent effect of clozapine will be discussed.

No. 22D
COMORBID SUBSTANCE ABUSE: DO ANTIPSYCHOTIC DRUGS HAVE A ROLE?

Alan I. Green, M.D., *Department of Psychiatry, Harvard Medical School, 74 Fenwood Road, Boston MA 02115-6106*

SUMMARY:

Although patients who exhibit aggressive behavior are very much in the minority among those diagnosed with schizophrenia, this patient subgroup is notoriously difficult to treat and tends to reside

long term in state facilities. Conventional antipsychotics, particularly when given to excess, can exacerbate aggression. Benzodiazepines, beta blockers, and mood stabilizers have been tried as adjunctive agents; results thus far are equivocal. The use of novel antipsychotics in state facilities has now produced clinical and research evidence of efficacy in treating aggression, with recent studies suggesting that these agents may possess a selective effect on aggression. This has important clinical and pharmacoeconomic implication, particularly since effective management of inpatient aggression may result in substantial cost efficiencies.

No. 22E
BEYOND SYMPTOMS: OPTIMIZING REAL-WORLD OUTCOMES

Jean-Pierre Lindenmayer, M.D., *Department of Psychiatry, Manhattan Psychiatric Center, Ward's Island, Dunlop 14A, New York NY 10035*

SUMMARY:

This presentation will focus on three important areas of pharmacological intervention in the course of schizophrenic disorders: First, clinical strategies for choosing among antipsychotics during the acute phase in order to achieve optimal outcome will be reviewed. The respective clinical profiles and efficacy of the newer antipsychotics risperidone, olanzapine, quetiapine, and sertindole will be discussed and contrasted with conventional antipsychotics in the treatment of the acute patient. Then, treatment strategies for the relapsing patient will be addressed. Given that relapse rates during the first year of treatment can be as high as 75% for patients who discontinue their medication and 30% for patients with good compliance, available data on the longer-term efficacy for the newer antipsychotics, which generally present a better side effect profile, will be considered. In addition, issues related to the switching process from conventional to one of the newer antipsychotics will be reviewed as well. Finally, strategies for the treatment-refractory patient will be presented in the context of a multidimensional concept of treatment resistance. Thirty percent to 60% of patients experience partial or complete treatment resistance and need to be reassessed for appropriate treatment. The role of clozapine and its related management strategies will be compared with emerging data on risperidone and olanzapine in treatment-resistant schizophrenics.

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INDUSTRY-SUPPORTED SYMPOSIUM 23—THE ANXIETY LABYRINTH: FINDING A PATHWAY TO THE SOLUTIONS
Supported by Bristol-Myers Squibb

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to learn about (1) the impact of anxiety disorders on functioning, health, quality of life, with emphasis placed on generalized anxiety and PTSD; (2) frequency and patterns of comorbidity and its impact on prognosis and treatment; (3) better recognition of GAD and PTSD, their psychobiology and response to treatment.

No. 23A
COURSE AND PSYCHOSOCIAL IMPAIRMENT IN GAD

Jane L. Eisen, M.D., *Butler Hospital, Brown University, 345 Blackstone Boulevard, Providence RI 02906;* Martin B. Keller, M.D.

SUMMARY:

Generalized anxiety disorder (GAD) is a common and chronic psychiatric disorder with considerable morbidity and frequent comorbidity with other psychiatric disorders. Frequent comorbidity with other anxiety disorders as well as depressive disorders has raised questions regarding whether GAD is a specific disorder or is better understood as an underlying anxiety diathesis, which contributes to an increased risk of developing other anxiety disorders, such as panic disorder and social phobia. The Harvard Brown Anxiety Research Project (HARP), a large, prospective, naturalistic study of course of anxiety disorders, has addressed this issue by examining ongoing changes in comorbidity between GAD and other disorders, as well as the diagnostic stability of GAD over time. To date, 122 subjects with an intake diagnosis of GAD have been followed for seven to nine years. We will present data on the course of GAD as well as psychosocial functioning in subjects with this disorder. In addition, a number of subjects without GAD at intake (i.e., subjects who entered HARP because of other anxiety disorders, such as panic disorder or social phobia) developed GAD over the course of this study. We will describe whether there are differences between prospectively observed GAD and GAD present at intake.

No. 23B
GAD: UNLOVED AND MISUNDERSTOOD AND ITS RELEVANCE TO PSYCHIATRY

James G. Barbee IV, M.D., *Department of Psychiatry, Louisiana State University Medical Center, 1542 Tulane Avenue, Box T4–6, New Orleans LA 70112-2865*

SUMMARY:

The diagnostic validity of generalized anxiety disorder (GAD) has been ambivalently regarded by many psychiatrists, even though evidence suggests that such patients commonly present for treatment and suffer serious morbidity due to their symptoms. The DSM-IV definition of GAD will be reviewed in the context of accumulating evidence that much like panic patients, GAD patients often present for care with medical rather than psychological complaints. Data from studies such as the Epidemiologic Catchment Survey suggest that GAD may last years, if not decades, in many individuals. This

can lead to conceptual difficulties in distinguishing GAD from Axis II disorders. Data from clinical studies documenting the very high rates of comorbidity with other Axis I disorders, and a model for understanding GAD as "the mother of all anxiety and depressive disorders" will be presented.

Recent developments in the neurobiology of GAD will be discussed, and the implications of these data for treatment reviewed. GAD is a prototypic disorder for the biopsychosocial model, given the complexities of differentiating anxiety as an appropriate reaction to stress versus evidence of psychopathology.

A model for treatment of GAD will be reviewed, including elements of (1) education, (2) psychotherapy (both cognitive and insight-oriented), and (3) medication. The specific implications of long-term outcome data for GAD will be applied to this model.

No. 23C
COMORBIDITY: BAD NEWS AND GOOD NEWS

R. Bruce Lydiard, M.D., *Department of Psychiatry, Medical University of South Carolina, 171 Ashley Avenue, Charleston SC 29425*

SUMMARY:

Although anxiety disorders have been recognized as discrete disorders for some time, diagnostic hierarchies that existed until DSM-III-R prevented concurrent diagnosis of a mood and an anxiety disorder. It is becoming increasingly apparent that anxiety disorders often coexist with mood disorders and other anxiety disorders.

This presentation, which will emphasize generalized anxiety disorder (GAD), highlights the available literature regarding patterns of comorbidity associated with GAD and other anxiety disorders. The prognostic implications and treatment considerations for various patterns of comorbidity will be discussed.

No. 23D
PTSD: WHO RESPONDS TO WHAT TREATMENT?

Jonathan R.T. Davidson, M.D., *Department of Psychiatry, Duke University Medical Center, Box 3812, Durham NC 27710*

SUMMARY:

In the neurobiology of PTSD, there is strong evidence to implicate a role for serotonin, both from animal models as well as from direct study of subjects with PTSD. Other systems that almost certainly play a role include noradrenergic pathways and the HPA axis. Of the various pharmacological treatments that have been tried, the most successful to date have been drugs that either act selectively upon 5HT (e.g. SSRI, $5HT_2$ antagonists), or which have a conspicuously strong effect upon 5HT, while simultaneously affecting other neurotransmitters (MAOI, TCA). Some studies suggest benefit for anticonvulsants. Benzodiazepines appear to be ineffective as monotherapy and may interfere with resolution following acute PTSD. Catecholamine selective drugs (desipramine, α-adrenergic and β-adrenergic agents) are either of no benefit or of limited promise. Clinical trials of pharmacotherapy for PTSD will be reviewed, and discussion will be provided as to general clinical use of medication in PTSD.

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INDUSTRY-SUPPORTED SYMPOSIUM 24—DEPRESSIVE DISORDERS: ADVANCES IN CLINICAL MANAGEMENT
Supported by Organon Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to manage depressive disorders more effectively by (1) appreciating the value of diagnostic subtyping, (2) developing strategies to overcome treatment resistance, (3) utilizing computers for evaluation and treatment, and (4) improving compliance by minimizing side effects and avoiding adverse food and drug interactions.

No. 24A
DEPRESSION SUBTYPING: TREATMENT IMPLICATIONS

Paula J. Clayton, M.D., *Department of Psychiatry, University of Minnesota, 420 Delaware Street SE, Box 77, Minneapolis MN 55455-0374*

SUMMARY:

As DSM-IV directs us, patients presenting with depression should be classified as unipolar, bipolar I, or bipolar II depressives. They can also be classified as double, anxious, psychotic, seasonal, atypical, or post-partum depression. All these in the last group can be part of either a unipolar or a bipolar diagnosis, although psychotic, seasonal, atypical, and post-partum depression are more likely to be part of a bipolar rather than a unipolar disorder. This means the clinician should be suspicious of a past, or alert for a future, emerging bipolar disorder. The subtypes will be defined and treatments directed toward these disorders. Double depression is dysthymia plus major depression. Many dysthymics are actually chronic major depression. Anxious depression is anxiety symptoms, agitation, and irritability in a depressive disorder. Psychotic depression and atypical, seasonal, and post-partum depression are as defined in DSM-IV. Although the basic antidepressant treatments are probably similar in all conditions, the addition of other therapies vary by subtype. In some cases, the starting drug is different than the usual starting drug. Newer antidepressants, monoanoxidase inhibitors, the use of lights, and ECT will be considered.

No. 24B
STRATEGIES FOR OVERCOMING TREATMENT RESISTANCE

J. Craig Nelson, M.D., *Department of Psychiatry, Yale University, 20 York Street, New Haven CT 06504*

SUMMARY:

Antidepressant treatment failure is commonly encountered by psychiatrists, in part because these patients are more likely to be referred. Treatment failure has variously been described as treatment resistance or treatment-refractory depression. These distinctions will be

discussed and proposed criteria will be reviewed. When faced with a treatment-resistant patient, the clinician has the option of switching from one antidepressant to another or augmenting the first antidepressant. The relative advantages of each approach will be reviewed. Data regarding efficacy following a switch to a second antidepressant will be presented. In particular, the question of switching within a drug class will be addressed. Common augmentation strategies will be reviewed, as well as their method of administration. At the conclusion of this presentation, the participant should have a good understanding of how to approach the treatment-resistant patient.

No. 24C ASSESSMENT AND TREATMENT OF DEPRESSION BY COMPUTER

John H. Greist, M.D., *The Dean Foundation, 2711 Allen Boulevard, Middleton WI 53562*

SUMMARY:

Depression is underrecognized and undertreated in primary care and managed care is making it more difficult to provide psychotherapies for depression in all settings. Computer programs have been prepared that permit physicians to improve diagnosis, assessment, and psychotherapeutic treatment of depression. PRIME-MD, a structured diagnostic interview for psychiatric disorders seen in primary care, was little used because it took too much clinician time. Desktop and IVR-administered computer version permit patients to complete the PRIME-MD at no time cost for physicians who receive a printed report of PRIME-MD diagnoses.

Once diagnosed, assessing severity and monitoring change is an integral part of managing treatment. Desktop and IVR versions of the Hamilton Depression Rating Scale have been shown to provide scores equivalent to those obtained by trained interviewers. Again, clinician time is saved and IVR versions are constantly available.

Desktop and COPE™ IVR computer programs have been shown to be effective treatments for mild to moderate depression. COPE was at least as effective as cognitive behavior therapy, interpersonal therapy, and imipramine, and significantly more effective than placebo in the NIMH collaborative study of depression.

These clinical computer applications provide physicians with tools to extend and enhance their practices.

No. 24D DEALING WITH DANGEROUS AND DISTURBING SIDE EFFECTS

Edmund C. Settle, Jr., M.D., *415 Morris Street, Suite 306, Charleston WV 25301*

SUMMARY:

Antidepressant side effects causing significant morbidity or mortality are distinctly uncommon, but it is vital that clinicians be aware of them. The most effective preventative measure is to simply undertreat or not use antidepressants at all. This therapeutic nihilism ultimately fails, however.

Use of older tricyclic type medicines also will often fail our "first do no harm" test since hip fractures, cardiac events, and overdose lethality (just to mention a few) are major T.C.A.D. side effects.

The most worrisome concern with newer antidepressants is serotonin syndrome, which, although rare, can be initially insidious and deadly. Recent trends toward the use of medication combinations and augmentation, as well as increased use of fenfluramine for weight loss significantly increase the risk.

SIADH has been reported with most antidepressants, and seems more common with serotonergic agents and in the elderly.

Seizures are uncommon but can occur with certain antidepressants and these risks must be understood.

Sexual side effects and bleeding/bruising are seen with SSRI's. These can lead to noncompliance or treatment dropout.

Sleep disturbances are common with depression and newer data illustrate how crucial sleep regulation is to mood. Antidepressants vary in their sleep effects.

Lastly, we must be aware of infrequent events such as EPS and blood dyscracias.

No. 24E DRUG AND DIET INTERACTIONS: AVOIDING THERAPEUTIC PARALYSIS

James W. Jefferson, M.D., *The Dean Foundation, 2711 Allen Boulevard, Middleton WI 53562*

SUMMARY:

An explosion of information about drug and diet interactions has greatly complicated and confused the use of antidepressant drugs; yet if clearly understood, such information will actually enhance the safety and efficacy of these medications. The background against which antidepressants will be discussed includes an overview of the cytochrome P450 system, which now contains over 500 P450 genes; the concepts of enzyme specificity and chirality; the roles of genetics and non-pharmacologic environmental factors; and examples of beneficial and detrimental drug and diet interactions. For example, if a patient ate a diet heavy in charcoal-broiled beef for a few days, one would probably not expect blood levels of certain drugs to be reduced by well over 50%. In just such a study, however, phenacetin blood levels decreased by 78% because charbroiling potently induced the production of CYP1A2.

The comparative profiles of the various antidepressants will then be presented with consideration given to their roles as substrates, inhibitors, and inducers of P450 enzymes such as 1A2, 2B6, 2C, 2D6, and 3A4. Examples of clinically important antidepressant drug/drug and drug/diet interactions will be provided. For instance, inhibition of CYP1A2 by an antidepressant increased the half-life of caffeine by a factor of six.

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INDUSTRY-SUPPORTED SYMPOSIUM 25—TREATMENT OF DEPRESSION IN DIFFICULT SITUATIONS
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participants should be able to recognize and treat depression across a full spectrum of clinical presentations.

No. 25A
DEPRESSION ADVERSELY AFFECTS MENTAL AND PHYSICAL HEALTH

Dwight L. Evans, M.D., *Department of Psychiatry, University of Florida, P.O. Box 100256, Gainesville FL 32610*

SUMMARY:

Major depression is a life threatening medical disorder that affects millions of people throughout the world. In the United States, approximately 18 million adults are affected by depression each year. Recent epidemiologic data indicate a 12% lifetime prevalence of depression in men and a 25% lifetime prevalence in women. The majority of depressed patients are treated in the primary care setting and more than 50% of the patients who attempt suicide have seen a physician in the previous month. There is also evidence that patients with medical illness such as cancer, myocardial infraction, stroke, and HIV infection are at greater risk for and have a higher prevalence of major depression. Relatedly, there is growing evidence from recent studies suggesting that stress and depression are independent predictors of disease progression and mortality. For example, stress and depression have been associated with alterations in immunity and recent data indicate that stress and depression may influence the clinical course of immune-based diseases such as cancer and HIV infection. Thus, the recognition and treatment of depression is critical. Because of the high prevalence of adverse effects as well as lethal toxicity in overdose, the use of tricyclic antidepressants (TCA's) can be problematic in patients with depression. The selective serotonin reuptake inhibitors (SSRI's), as well as mixed reuptake inhibitors are both efficacious and well tolerated in patients with depression. Because these newer agents have fewer unwanted mechanisms of action, patients experience fewer adverse effects and compliance is improved. Compliance has become a special concern in the treatment of depression since the majority of patients require extended antidepressant treatment given the recurrent nature of the disorder; patients with depression and other medical illnesses are also generally more sensitive to adverse effects. Several recent studies have also underscored the importance of treating depression in patients with other associated medical illnesses. In fact, major depression is an independent risk factor for mortality in patients hospitalized following myocardial infraction, and in patients admitted to nursing homes. Thus, recognition and treatment of depression are essential in order to improve quality of life and prevent suicide in patients with depression, as well as improve morbidity and possibly mortality in depressed patients with comorbid medical illness.

No. 25B
TREATMENT OF SEVERE UNIPOLAR AND BIPOLAR DEPRESSION

Ned H. Kalin, M.D., *Department of Psychiatry, University of Wisconsin, 6001 Research Park Boulevard, Madison WI 53719*

SUMMARY:

With the advent of new antidepressants and mood stabilizing agents, the ability to effectively treat affective disorders has been enhanced. However, a significant number of patients suffer from severe and/or refractory symptoms that do not respond to the usual treatment approaches. Treatment approaches to the patient with severe unipolar and bipolar depression will be presented. In addition, data regarding the efficacy of SSRI's and some of the newer antidepressants in treating severe depression will be presented. Drug combination, and augmentation strategies will be reviewed in relation to the refractory patient. Special issues involving the treatment of bipolar depression will be presented. These include the role of MAOI's, the potential for antidepressant-induced mania and rapid cycling, and the use of mood stabilizers. Patients with severe unipolar and bipolar depressions remain a therapeutic challenge and require a treatment approach that is comprehensive and at times innovative.

No. 25C
TREATMENT OF DEPRESSION AND COMORBID ANXIETY

Dennis S. Charney, M.D., *Department of Psychiatry, Yale University, 25 Park Street, New Haven CT 06519*

SUMMARY:

There is clear evidence that patients with major depression comorbid with a range of anxiety disorders, including panic disorder, obsessive-compulsive disorder, and post-traumatic stress disorder, frequently do not respond adequately to standard antidepressant drug treatment approaches. This probably relates to the pathophysiology associated with these anxiety disorders. This presentation will review the available treatment studies related to depression comorbid with anxiety disorders. These findings will be discussed in the context of our knowledge of the mechanism of action of antidepressant drugs and the pathophysiology of anxiety and depression. Novel treatment approaches for these conditions will also be presented.

No. 25D
RECOGNIZING AND TREATING BODY DYSMORPHIC DISORDER IN DEPRESSED PATIENTS

Katharine A. Phillips, M.D., *Brown University, Butler Hospital, 345 Blackstone Boulevard, Providence RI 02906*

SUMMARY:

Body dysmorphic disorder (BDD), a preoccupation with an imagined or slight defect in appearance, is an underrecognized condition that is often comorbid with major depression and can complicate its treatment. BDD is characterized by prominent obsessional preoccupations and compulsive behaviors (e.g., mirror checking and excessive grooming), and it is associated with high rates of occupational and social impairment, psychiatric hospitalization, suicidal ideation, and suicide attempts. Major depression is the disorder that is most often comorbid with BDD. Conversely, available data indicate that nearly 10% of depressed patients have comorbid BDD, with the rate in atypical major depression (approximately 15%) significantly higher than in nonatypical major depression. Several studies have found that depressed patients with comorbid BDD have an unusually early age of onset of major depression and unusually chronic major depression. In addition, depressed patients with comorbid BDD are more impaired than those without BDD.

It is important to recognize BDD in depressed patients, because missing the diagnosis can result in refractory depression. Available data suggest that BDD and associated depression may not respond to all treatments for depression and may instead respond preferen-

tially to SRI's. In addition, lengthier treatment trials than those required for depression may be needed to successfully treat BDD.

It can be difficult and challenging to diagnose BDD in depressed patients because the symptoms are often kept secret due to embarrassment and shame. This presentation will discuss strategies for recognizing and treating this underrecognized disorder in patients with depression.

No. 25E
THE STUDY OF AFFECTS WITH NEUROIMAGING

Raquel E. Gur, M.D., *Department of Psychiatry, University of Pennsylvania, 3500 Spruce Street, 10th Gates Building, Philadelphia PA 19104*

SUMMARY:

Structural and functional neuroimaging methods have been applied in the study of affect regulation and affective disorders. This presentation will highlight research methods and findings in this area. Neuroanatomic studies with MRI have examined regional changes associated with affective disorders and the association of white matter lesions with depression. Functional studies, measuring cerebral metabolism and blood flow, have evaluated the pattern of brain function at resting states and in response to affective states elicited by the application of neurobehavioral or neuropharmacologic probes. Clinical studies have related neuroimaging findings to disease variables: symptom severity and treatment response. These studies suggest some neural substrates for depression with implications for future research and treatment directions.

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3. Phillips KA, Nierenberg AA, Brendel G, Fava M: Prevalence and clinical features of body dysmorphic disorder in atypical major depression. J Nerv Ment Dis 1996;184:125–129

INDUSTRY-SUPPORTED SYMPOSIUM 26—EXPANDING THE SPECTRUM OF PSYCHOSES: THE INTERFACE OF AFFECT
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the neuropharmacological and biological basis of affective symptoms in psychosis, recognize the risk-benefit ratio of atypical and typical antipsychotic agents, consider treatment strategies for these conditions.

No. 26A
A BIOLOGICAL BASIS FOR OVERLAP OF MOOD IN PSYCHOTIC DISORDERS

Paul E. Keck, Jr., M.D., *Biological Psychiatry, University of Cincinnati, 231 Bethesda Avenue, Cincinnati OH 45267*

SUMMARY:

Over a century ago the European school of psychiatry viewed major depression, manic depressive illness, schizoaffective disorder, and schizophrenia as a continuum of disorders, which they termed the "endogenous psychoses." Since then numerous lines of evidence have been developed that link psychotic disorders and major mood disorders. Phenomenologic studies indicate that psychotic signs are present in unipolar psychotic depression and manic depressive illness, and that symptoms of depression and mania are frequently present within the clinical profile of schizophrenia. Epidemiologic genetic studies have shown an increased morbid risk of schizophrenia in families of mood disorder probands, and an increased risk of mood disorders in the families of schizophrenia probands. Neuroimaging studies have demonstrated that pathomorphologic abnormalities of the ventricular system, mesiotemporal lobe, and basal ganglia are not specific to schizophrenia but occur in major mood disorders patients as well (albeit in lower frequency). Post-mortem and invivo neurochemical studies have found similar abnormalities in both patient populations, particularly in the 5HT receptor subtypes.

The advent of compounds with selective properties for the 5HT system including selective serotonin reuptake inhibitors (SRI's) and atypical antipsychotic drugs, which have efficacy in both mood and psychotic disorders, has provided an important pharmacologic association between the mood and psychotic disorders. This presentation will discuss the common neurobiological substrates of mood and psychotic disorders and the therapeutic implication for the use of existing agents and for future drug development.

No. 26B
THE PSYCHOPHARMACOLOGIC TREATMENT OF SCHIZOAFFECTIVE DISORDER

Susan L. McElroy, M.D., *Department of Psychiatry, University of Cincinnati College of Medicine, 231 Bethesda Avenue, ML 559, Cincinnati OH 45267-0559*

SUMMARY:

In this presentation, we review the available literature regarding the acute and prophylactic pharmacologic treatment of schizoaffective disorder. Acute treatment studies of the manic phase of schizoaffective disorder, bipolar type, found that typical antipsychotics and lithium were comparable in efficacy except in agitated patients for whom antipsychotics were superior. In agitated patients the combination of lithium and antipsychotics appeared to be superior to antipsychotics alone. In the only controlled study of the acute treatment of schizoaffective disorder, depressive type, combined treatment with antipsychotics and antidepressants was not superior to treatment with antipsychotics alone. Controlled data also show that olanzapine is an effective treatment for schizoaffective disorder. Preliminary data from open trials suggest that the mood stabilizers valproate and carbamazepine and the novel antipsychotics clozapine and risperidone may be promising new treatments for schizoaffective disorder. Although combination treatment with antipsychotics and thymoleptics is common practice in the prophylactic management of schizoaffective disorder, the efficacy of this strategy has not been studied in controlled trials.

No. 26C
PSYCHOTIC MAJOR DEPRESSION

Alan F. Schatzberg, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 300, Stanford CA 94305-5548*; Joel A. Posener, M.D., Charles DeBattista, M.D.

SUMMARY:

In recent years, increasing attention has been paid to major depression with psychotic features being a distinct depressive subtype. This presentation will review distinguishing features, emphasizing hypothalamic-pituitary-adrenal (HPA) axis dysfunction, as well as differential treatment response. Recent data from our group are presented and these point to markedly elevated ACTH levels in these patients, suggesting increased central drive of the axis. Controlled and open-label trials on optimal treatment strategies are then reviewed. Historically, these patients have been reported to respond best to the combination of tricyclic antidepressants in combination with antipsychotics or to electroconvulsive therapy (ECT). Of particular interest are recent reports that SSRI's by themselves may be helpful in these patients as may be the atypical antipsychotic olanzapine. Clinical implications are discussed.

No. 26D
EXPERIENCE USING OLANZAPINE IN THE TREATMENT OF ACUTE BIPOLAR MANIA

Mauricio Tohen, M.D., *Department of Research, Eli Lilly and Company, Lilly Corporate Center, Indianapolis IN 46285*; Todd Sanger, Ph.D., Gary D. Tollefson, M.D., Susan L. McElroy, M.D., Michael G. Greaney, M.S., Verna Toma

SUMMARY:

Background: There has recently been an interest in using atypical antipsychotic drugs to treat acute mania. *Methods:* To assess the efficacy of olanzapine in the treatment of an acute mania, a double-blind, placebo-controlled study was conducted. Patients were randomized to either olanzapine (5–20 mg/day) or placebo during a three-week period. Patients had a mean age of 39.49 years, 72.7% were Caucasian, 51.8% were male, 82.7% were bipolar manic, 17.3% were bipolar mixed, and 53.2% were currently psychotic. *Results:* The Olz treatment group had a significantly greater reduction with the Y-MRS total score (Olz-10.26, placebo –4.88, p = .019), PANSS total score, (Olz-11.06, placebo –3.09, p = .019) and PANSS positive score (Olz-4.67, placebo –2.00, p = .040) than the placebo treatment group. The analysis of mean change from baseline to endpoint in HAMD-21 total and CGI-BP severity of depression scores showed no statistically significant treatment differences in depressive symptoms. In the analysis of the Simpson-Angus total score, the Barnes Akathisia global score, and the AIMS total score, there was no statistically significant mean change from baseline to endpoint or baseline to maximum score on any scale. In addition, in the categorical analysis of Simpson-Angus total scores and Barnes Akathisia global scores, there were no statistically significant treatment differences. Very few extrapyramidal symptoms emerged and anticholinergic medication use was negligible for both treatment groups. No olanzapine-treated patient was discontinued because of an adverse event, or experienced a serious adverse event. Finally, there were no clinically significant changes in vital signs, weight, laboratory analyses, or ECG's.

No. 26E
AFFECTIVE DISORDERS, TARDIVE DYSKINESIA AND ATYPICAL ANTIPSYCHOTICS

William M. Glazer, M.D., *Massachusetts General Hospital, Harvard Medical School, 100 Beach Plum Lane, Menemsha MA 02552*

SUMMARY:

There are studies that support the notion that mood disorders constitute a risk factor for TD. It is less clear from these data whether mood disorders contribute to the *new science* of TD or to its *severity once it has emerged*, but it is relatively clear that TD in patients with an affective component to their psychotic condition is worse than in patients without an affective component. Prevalence and incidence data will be reviewed to support this view.

Emerging data are pointing to a reduced risk of TD from atypical antipsychotic medications as compared with typicals. What mechanisms might explain such a relationship? Do the atypical antipsychotics reduce/alleviate the problem? A recent study comparing the atypical antipsychotic agent olanzapine with the typical agent haloperidol found a marked reduction in risk with the former medication. This presentation will consider further analysis of these data to determine the impact of olanzapine in patients manifesting affective symptoms with their psychotic condition. Videotaped material will be used to demonstrate how TD cases can be more severe when there is an affective component involved.

If atypical antipsychotic medications lower the incidence and severity of TD in general, they may be particularly important for patients with an affective component to their psychotic condition.

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INDUSTRY-SUPPORTED SYMPOSIUM 27—SEXUAL DYSFUNCTION, DEPRESSION AND ANTIDEPRESSANTS Supported by Glaxo Wellcome Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to better evaluate sexual dysfunction that originates from organic causes from that which may be an untoward effect of psychotropic medication (with emphasis on antidepressants) with or without psychogenic causes. The participant will have a better understanding of the role that antidepressants and other psychotropic medications may play in causing sexual dysfunction and will understand alternative medications and approaches. They will be able to provide the patient with information on current therapies and interventions in treating sexual dysfunction.

No. 27A
AVOIDING AND MANAGING SEXUAL SIDE EFFECTS OF ANTIDEPRESSANTS

Troy L. Thompson II, M.D., *Department of Psychiatry, Jefferson Medical College, 1025 Walnut Street, Suite 320, Philadelphia PA 19107-5005*

SUMMARY:

Sexual dysfunction of various types occurs in 10% to 27% of the nondepressed general population, so a careful baseline history is essential to determination of whether depression or antidepressants initiated a dysfunction or exacerbated or had no effect on an existing condition. Many depressed patients have decreased libido and other sexual dysfunctions as a symptom of that illness, and some antidepressants frequently produce sexual dysfunctions as a side effect, often creating a vicious cycle, which may result in noncompliance and relapse. Anxiety, independently or frequently as a symptom of depression, may also produce sexual dysfunction. A thorough biopsychosocial evaluation and careful interviewing about such symptoms at each follow-up appointment are the keys to diagnosis and effective treatment of sexual dysfunction associated with depression and antidepressants.

Serotonin re-uptake inhibiting medications frequently inhibit sexual functioning. The SSRI's may cause 30% to 40% of patients to develop some degree of sexual dysfunction, and this may occur in libido, excitement, orgasm, and resolution stages. The related "good news" is that SSRI's often effectively treat premature ejaculation; the "bad news" is that they may prevent or greatly interfere with libido and orgasm or ejaculation in patients who otherwise might be responding with an improvement in depression symptoms. Spontaneous resolution of such dysfunctions rarely occurs after a few weeks. Dose reduction should be the initial approach to determine if the side effect might subside while the therapeutic effect is maintained. Drug holiday strategies increase the risk of depression relapse. Augmenting with an antidepressant that is an "antidote" for sexual dysfunction (e.g., bupropion) is a wise next step.

No. 27B
THE SEXUAL SIDE EFFECTS OF COMMONLY PRESCRIBED DRUGS

Theresa L. Crenshaw, M.D., *3750 Riviera Drive, Apt. #1, San Diego CA 92109-6658*

SUMMARY:

Sexually toxic drugs are primarily a noncompliance issue that can result in serious consequences—morbidity, mortality, and liability. Sexually sophisticated prescribing can avoid these casualties, and in many cases improve a patient's sexual function. The adverse effects of antidepressant drugs on sex are extensive. Since reduced libido and sexual responsiveness are common complications in the medical management of depression, new drugs are being used singly and in combination to treat depression without undesirable sexual consequences. While many of the medicines commonly in use affect sex in a negative way, a number of drugs have been identified for their favorable sexual properties. This presentation will summarize the most up-to-date information about the sexual side effects of antidepressant drugs, sorting fact from fantasy. It will interpret current research in a clinically useful way, and recommend methods of increasing a physician's awareness of drug-related sexual complications. The interrelationship between sex and depression will be discussed with a specific focus on antidepressant drugs that are contraindicated when certain sexual symptoms preexist, with special emphasis on the distinctions between the sexes in regard to pharmacological response.

No. 27C
A COMPREHENSIVE APPROACH TO SEXUALITY AND DEPRESSION

Domeena C. Renshaw, M.D., *Department of Psychiatry, Loyola University, 2160 South First Avenue, Maywood IL 60153*

SUMMARY:

When a woman seeks help for a clinical depression, it is rare that she will volunteer the symptom of sexual apathy. She is more likely to present symptoms of insomnia, crying, concentration problems, or appetite loss. Depressed men, however, are more likely to visit a urologist for loss of desire or erection problems before they speak of divorce, job, or money problems, and are referred to a psychiatrist.

Sexual symptoms that accompany a clinical depression may show either absence or excess of anticipated norms of sexual expression. Atypical promiscuity may be reported because some depressed women seek multiple sexual contacts to be held and comforted as an antidote to dejected feelings. A depressed man may seek casual sex to boost his self-esteem or test his erections with a different partner. Always a baseline sexual history of desire, coital frequency, and morning erections must be recorded because several effective antidepressants have negative sexual side effects; however, some may pre-date the use of medication.

Does a depression cause a specific sex dysfunction or does a sexual dysfunction cause the depression? This is often an academic question when the patient is evaluated since both sexual and depressive symptoms may co-exist and must be addressed in treatment.

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INDUSTRY-SUPPORTED SYMPOSIUM 28—TREATMENT STRATEGIES FOR SUCCESSFUL OUTCOMES IN PATIENTS WITH PANIC DISORDER
Supported by U.S. Pharmaceuticals, Pfizer Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will be able to understand the methodology required to assess efficacy in panic disorder, determine whether reduction in panic attacks is the only measure required to evaluate patient progress, understand the usefulness of pharmacotherapy and therapeutic selection in these patients, appreciate the ability of cognitive-behavioral therapy as a therapeutic strategy in panic disorder

No. 28A
REDUCTION OF PANIC ATTACKS, AS A SINGLE MEASURE, IS INSUFFICIENT FOR ASSESSING TREATMENT EFFICACY IN PANIC DISORDER

David A. Spiegel, M.D., *Center for Anxiety and Related Disorders, Boston University, 648 Beacon Street, 6th Floor, Boston MA 02115-2015*

SUMMARY:

As initially specified in DSM-III, the necessary and sufficient condition for the diagnosis of panic disorder was the occurrence of

three sometimes unexpected panic attacks within a three-week period. Based on that definition, the goal of therapy was seen to be the elimination of attacks, and accordingly, the ability of a treatment to reduce attacks was the principal measure of its efficacy. Agoraphobia was a separate disorder with its own treatment efficacy criteria. As the conceptualization of panic disorder evolved to its present form in DSM-IV, the importance of other symptoms was recognized, and their presence became a requirement for diagnosis. The reduction of those symptoms thus became an important aspect of the assessment of treatment outcome (Shear & Maser, 1994) Proponents of the centrality of panic attacks contend that decreases in panic attack frequency and severity invariably lead to reductions in the other essential features of the disorder and therefore, if not sufficient criteria in themselves, at least *predict* treatment efficacy. This presentation will examine that hypothesis in the light of data from recent clinical trials and will conclude that it is incorrect.

No. 28B CLINICAL TREATMENT STRATEGIES FOR SUCCESSFUL OUTCOMES IN PANIC

Donald F. Klein, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 722 West 168th Street, Unit 22, New York NY 10032-2603*

SUMMARY:

The three-layer cake theory of agoraphobia by now is generally accepted. Initially, spontaneous panic attacks are extremely frightening experiences that often lead to the belief that one is in mortal danger. With recurrent attacks, chronic anticipatory anxiety becomes pervasive. At that point, the patient develops avoidances centering around the theme of being unable to get to help or have help get to them if they were to have a panic attack. This latter stage is referred to as agoraphobia. However, patients may not evolve past any point on this trajectory. Some only have recurrent panic attacks, some have recurrent panic attacks and develop only chronic anticipatory anxiety, some develop a limited range of phobic avoidance that can easily be extended by a trusted companion, and some are housebound (which does not prevent recurrent spontaneous panics but does lessen feelings of helplessness). It is of great interest that patients who only have panic attacks with no phobic manifestations also have a very high spontaneous remission rate. During placebo treatment, this could be considered a placebo response, although this interpretation is not definitive. In such pure panic, it has not been shown as yet that patients show the superiority of any antipanic treatment over placebo. In patients who develop at least moderate agoraphobia, recurrent spontaneous panic attacks often lead to a reinstatement of phobic avoidances. Therefore, although in the agoraphobic patient it is the avoidant behavior that is the major impairing issue, without cessation of spontaneous panics it is difficult to maintain the overcoming of phobic avoidance. This whole situation is complicated by poor definitions of panic, inadequate patient education, the confusion of waves of anticipatory anxiety with panic, and reliance on measures of so-called frequency of panic, rather than severity of panic, as target symptoms. Because of its easy confounding, measures of frequency of panic are highly unreliable and therefore should be minor measures for treatment efficacy studies. Measures of severity of panic that emphasize spontaneous onset, abruptness, and swift crescendo marked by dyspnea, are sensitive measures of anti-panic drug potency.

No. 28C PHARMACOTHERAPY OF PANIC DISORDER

Jack M. Gorman, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York NY 10032;* Laszlo A. Papp, M.D., Jeremy D. Coplan, M.D., Justine M. Kent, M.D., Gregory M. Sullivan, M.D.

SUMMARY:

It has been known for almost 40 years that medication works for panic disorder. Beyond question, studies have shown the tricyclics and benzodiazepines eliminate panic attacks in most patients. Among the tricyclics, imipramine is the best studied but chlomipramine is probably even more effective. Among the benzodiazepines, two have been approved for the treatment of panic disorder by the FDA—alprazolam and clonazepam. There are considerable drawbacks to both classes, however. Tricyclics produce a number of adverse side effects that appear particularly troublesome for panic patients, including dizziness secondary to orthostatic hypotension and tachycardia secondary to anticholinergic effects. The possibility that the vagolytic activity of tricyclics may increase the risk of cardiac disease has also diminished enthusiasm for their long-term administration. Benzodiazepines have few of these side effects, but are sedating, contraindicated in patients with alcohol abuse problems, and entail a high risk for physical dependency and subsequent withdrawal problems. Since 1996 two drugs in the SSRI class have been approved for the treatment of panic disorder: paroxetine and sertraline. On the basis of well-designed multicenter studies. SSRI's have been shown to be at least as—and probably more—effective than tricyclics and benzodiazepines with virtually no cardiovascular side effects and no risk of physical dependency. They are regarded by most experts as the drugs of choice for the initial treatment of panic disorder. Long-term studies have shown that SSRI's are well tolerated and continue to block panic. Furthermore, studies with sertraline indicate that the medication effect extends beyond panic blockade and includes a reduction in phobic avoidance and a general improvement in quality of life. The most important question that needs to be addressed with respect to medication treatment of panic disorder remains whether there is a length of treatment after which there is a reasonable chance of remaining well off drug. Preliminary data suggest that this may be somewhere between one and two years of drug exposure.

No. 28D COGNITIVE-BEHAVIORAL THERAPY OF PANIC DISORDER

M. Katherine Shear, M.D., *Department of Medical Anxiety, University of Pittsburgh Medical Center/WPIC, 3811 O'Hara Street, Pittsburgh PA 15213-2593*

SUMMARY:

The NIH Consensus Development Conference for the Treatment of Panic Disorder endorsed cognitive-behavioral treatment as a standard approach for panic disorder. Studies have documented the efficacy of this approach in comparison with waitlist controls. Cognitive-behavioral panic control treatment has now been shown to have effects equal to medication. This treatment targets very specifically a putative pathogenic mechanism of panic generation, fear of bodily sensations. Techniques used address physiological, cognitive, and behavioral components of this fear. Specifically, breathing retraining reduces physiological arousal, cognitive restructuring corrects misinterpretation of bodily sensations, and interoceptive exposure desensitizes the conditioned sensation fears. This treatment has excellent short-term results. Long-term outcome without further intervention is less impressive. In addition, cognitive-behavioral panic control treatment is very specific and does not target common comorbidity or personality characteristics typical of panic disorder patients. This presentation will review the principles of PCT strategy and specific techniques, highlighting results that may differentiate effects of this treatment from medication effects. A brief description of other psychotherapy strategies will also be presented.

REFERENCES:

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2. Klein DF: Discussion of methodological controversies in the treatment of panic disorder. Behav Res Ther 1996;34(11–12):849–853
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INDUSTRY-SUPPORTED SYMPOSIUM 29—CLINICAL ASPECTS OF VIOLENCE Supported by Novartis Pharmaceuticals Corporation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to more effectively assess and treat potentially violent patients.

No. 29A
RISK ASSESSMENT FOR VIOLENCE

Phillip J. Resnick, M.D., *Department of Psychiatry, University Hospital, 11100 Euclid Avenue, Cleveland OH 44106*

SUMMARY:

This presentation will review recent research on the validity of psychiatric predictions of violence. The demographics of violence and the specific incidence of violence in different psychiatric diagnoses will be covered. Dangerousness will be discussed in persons with schizophrenia, mania, and depression. Special attention will be given to persons with specific delusions, erotomania, command hallucinations, and premenstrual tension. Personality traits associated with violence will be discussed. Advice will be given on taking a history from potentially dangerous patients. Instructions will be given in the elucidation of violent threats and "perceived intentionality." Finally, strategies will be given to reduce the likelihood of malpractice liability from patient violence toward others.

No. 29B
ASSESSMENT OF VIOLENT THREATS

Park E. Dietz, M.D., *Department of Psychiatry, University of California Los Angeles School of Medicine, 537 Newport Center Drive, #300, Newport Beach CA 92660-6937*

SUMMARY:

Within a psychiatrist-patient relationship, risk assessment for threats differs from other violence risk assessment in two ways. First, issuing required warnings to foreseeable victims can jeopardize the patient's relationships and employment status. Second, when the threat is reported by a third party, such as an employer, the clinician may inadvertently endanger others by revealing to the patient that the threat has been reported.

The context of a threat is often more informative than the verbal content. By determining what provoked or precipitated a threat, the clinician may learn that the patient becomes threatening upon feeling threatened or humiliated. By exploring the feelings associated with a threat, the clinician may learn that the patient experienced fleeting shame, frustration, or powerlessness, which were expressed angrily. By exploring thoughts associated with a threat, the clinician may learn that the patient uses threats to intimidate others into giving him his way or to establish interpersonal boundaries by scaring people away. Factors that should raise the level of assessed risk include threats directed toward delusional persecutors, threats intended to cause suffering, identification with others who have carried out similar threats, and threats accompanied by planning and preparation for an attack.

No. 29C
CHILD AND ADOLESCENT VIOLENCE

Robert T.M. Phillips, M.D., *1726 Deacon Way, Annapolis MD 21401-5872*

SUMMARY:

Violence is pandemic in the United States and its effects are measured not only in its human carnage but also in its devastation to our communities and destruction of the lives of our citizens. It is not just an "inner city" problem or unique to racial or ethnic minorities. Children have increasingly become the victims of violence and also its fastest growing segment of perpetrators. Violence is manifested not only by the act of murder, but overtly and covertly by acts committed against others, as well as against self, such as physical and sexual assault, rape, arson, child abuse, spouse abuse, elder abuse, and suicide. Efforts to bolster law enforcement's response to violence are both laudable and essential, but in the absence of informed public policy that addresses the root causes of violence, they are destined to fail.

The politics of violence, its occurrence, and its prevention, are uniquely human, and, therefore, lend themselves to social and behavioral analysis. This presentation will explore the sociology of violence and the related economics and public policy issues that are the key to understanding causality and cure.

No. 29D
VIOLENCE AGAINST PSYCHIATRISTS

John R. Lion, M.D., *Department of Psychiatry, University of Maryland, 328 East Quad/5100 Falls Road, Baltimore MD 21210*

SUMMARY:

Recent findings show that a significant proportion of practicing clinicians have, in the course of their careers, received threats or sustained assaults in the workplace. This risk of harm is acknowledged by new federal OSHA guidelines on mental health safety, and by JCAHO as well. Yet denial remains a strong force in dealing with the problem of danger. This paper reviews the incidence of assaults and describes typical threats incurred by psychiatrists who work on inpatient settings or within clinics. Case examples illustrating the dynamics of assault and stalking behavior are also presented. Recurring issues are improper monitoring of the transference in the

therapy of more regressed patients, and failure to set limits with patients who become menacing.

No. 29E
PHARMACOLOGIC APPROACHES TO VIOLENCE

Renee L. Binder, M.D., *Department of Psychiatry, University of California San Francisco, 401 Parnassus Avenue, Box F, San Francisco CA 94143*

SUMMARY:

This presentation will review the literature and give clinical examples of the use of pharmacologic agents in managing and treating aggressive behavior. Pharmacologic agents are used for acute management of violent behavior, the treatment of violence occurring in the context of underlying psychiatric conditions, and long-term treatment of aggressive behavior.

The presenter will first discuss the differential diagnosis of acute violent behavior often seen in the psychiatric emergency room or acute inpatient unit, e.g., drugs, alcohol, psychosis, personality factors. She will illustrate how understanding the factors underlying the violence helps determine if pharmacologic agents are indicated and, if so, which ones should be chosen. The most common agents currently used in the acute pharmacologic management of violent behavior are benzodiazepines and neuroleptics, either alone or in combination.

The presenter will then discuss the variety of psychiatric conditions that can have violence as a symptom. These range from schizophrenia, bipolar illness, and personality disorders, to autism, brain injury, dementia, and intermittent explosive disorder. Different pharmacologic agents are recommended for the violence of each disorder, e.g., neuroleptics, lithium, anticonvulsants, β-blockers, and antianxiety agents.

Finally, the presenter will describe studies suggesting special benefits of the atypical neuroleptics for aggressive behavior, especially risperidone, clozapine, and olanzapine. She will also review the use of SSRI's to treat aggressive behavior and certain paraphilias.

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INDUSTRY-SUPPORTED SYMPOSIUM 30—PRACTICAL APPROACHES TO THE TREATMENT OF PSYCHOSES IN THE ELDERLY
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to review new clinical studies and treatment options for psychoses in the elderly.

No. 30A
CHRONIC AND LATE-ONSET PSYCHOTIC DISORDERS

Ira R. Katz, M.D., *Department of Psychiatry, University of Pennsylvania, 3600 Market Street, Room 759, Philadelphia PA 19104*

SUMMARY:

The psychotic disorders of the elderly include both those with early and late initial onset. Early-onset patients are primarily those with chronic schizophrenia who have grown older. Many of these patients have been maintained in the community with varying degrees of support for most of their adult lives. Others have been able to adjust to life in the community only because they have responded to treatment with clozapine. Managing these patients when they experience the expectable medical and neurological disorders of late life requires the integration of psychiatric and other medical care. Their psychopharmacological treatments must be designed to minimize drug-disease and drug-drug interactions.

Although they include late-onset schizophrenia and delusional disorders, the psychotic disorders of late onset are primarily those associated with delirium, Alzheimer's disease, diffuse Lewy body disease, and the treatment of Parkinsonism. For patients with these conditions, psychopharmacological treatment must be designed to minimize the cardiac, autonomic, central anticholinergic, and extrapyramidal effects of medications.

Thus, the newer atypical neuroleptic agents show promise for the treatment of patients with late-life psychosis, including both those with early and late initial onset.

No. 30B
ORGANIC DISORDERS WITH PSYCHOTIC FEATURES IN THE ELDERLY

Jeffrey L. Cummings, M.D., *Department of Neurology, University of California Los Angeles School of Medicine, 710 Westwood Plaza, Los Angeles CA 90095*

SUMMARY:

Psychosis is a common feature of neurological illness. It occurs in Alzheimer's disease, vascular dementias, Huntington's disease, epilepsy, frontotemporal degenerations, and dementia with Lewy bodies. It is common among patients with Parkinson's disease who are cognitively compromised and treated with dopaminergic substances. Anatomical studies suggest a common neurobiological substrate for psychotic and delusional beliefs that involves the frontal lobes, the anterior temporal regions, and subcortical structures, particularly the ventral striatum. From a biochemical point of view, both enhancement of dopaminergic function and reduction in cholinergic function are associated with the occurrence of psychosis. Psychosis is only weakly correlated with cognitive disturbances and in patients with epilepsy may be entirely divorced from any intellectual alterations. Visual hallucinations are common in neurological disorders

with psychosis, and hallucinations in the auditory domain and other modalities may also occur. Formal thought disorders of the type seen in schizophrenia are unusual. A variety of pharmacologic agents are available for treatment of psychosis in neurological disorders. Conventional neuroleptics may be used with caution but may exacerbate any associated extrapyramidal disturbances. Novel antipsychotics are efficacious with fewer side effects and cholinergic agents may be useful in disease such as Alzheimer's disease with cholinergic deficiencies.

No. 30C
TREATMENT OPTIONS AND PRACTICAL ISSUES FOR ELDERLY PATIENTS WITH PSYCHOSES

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

SUMMARY:

The differential diagnosis of psychosis in the elderly includes early onset of schizophrenia carried into old age, late-onset schizophrenia, schizophreniform and schizoaffective psychoses, affective disorders with psychosis, and organic mental syndromes including the dementias. Relevant information in the comparison of early- and late-onset schizophrenia will be presented, with the remainder of the focus being on late-onset schizophrenia and psychosis associated with dementia. The management of psychotic features includes careful medical and standard psychiatric evaluation and employment of a variety of nonpharmacologic interventions. Current "expert consensus" treatment approaches will be summarized, followed by information about the newer, atypical agents, which afford the hope of greater efficacy and considerably reduced safety and tolerability problems. Specific agents to be discussed include clozapine, risperidone, olanzapine, quetriapine, and sertindole.

No. 30D
PSYCHOTIC DISORDERS AMONG PATIENTS IN LONG-TERM-CARE FACILITIES

Barry W. Rovner, M.D., *Geriatric Psychiatry, Wills Eye Hospital, 900 Walnut Street, 8th Floor, Philadelphia PA 19107*

SUMMARY:

Late-life-onset psychoses in nursing homes have diverse etiologies including Alzheimer's disease (9.5%), multiinfarct dementia (3.1%), and schizophrenia (2.4%). Although psychosis predicts physically aggressive behavior, psychotic patients often fail to receive appropriate treatment. Instead, many are prescribed psychotropic medications uncritically or are physically restrained. Structured activities, appropriate medication use, and education reduce behavior disorders and unnecessary antipsychotic drug and physical restraint use. Activities provide predictable schedules removed from the random activity of busy nursing units or the isolation of one's room. Psychotropic medications treat delusions or hallucinations that are unresponsive to psychosocial treatment. Newer antipsychotic medications are less likely to induce extrapyramidal side effects. Long-term-care facilities are mental institutions for elderly persons with psychosis. Care programs based upon modern psychiatric principles can reduce the disruptive effect of psychosis and improve patients' lives.

No. 30E
NONPHARMACOLOGIC APPROACHES IN MANAGING ELDERLY PATIENTS WITH PSYCHOSES

Soo Borson, M.D., *Department of Psychiatry, University of Washington School of Medicine, 1259 NE Pacific Street, Seattle WA 98195*

SUMMARY:

The success of treatment in late-life psychosis depends on the creation of an individualized "safety net," designed for each patient on the basis of the specific strengths and weaknesses of the patient, family members, health care and social service providers, and the broader social network. Heterogeneity—in personality attributes, cognitive competencies, awareness of illness, willingness to accept treatment, underlying etiologic factors, medical comorbidities, and capacity for relationship—characterizes late-life psychoses as a group, and each must be considered in developing a broad-based care plan. Assumptions that older psychotic patients are incompetent, socially isolated, immutably ill, and treatment-avoidant, while true of some patients, are not characteristic of most. The clinical tasks for psychiatrists, in addition to optimizing psychopharmacologic treatment, are: 1) to maintain a flexible, long-term, personalized psychotherapeutic orientation; 2) to establish a bridging alliance between patients, family members, case-managers, landlords or sheltered care staff, and primary care doctors, to reduce fear, therapeutic nihilism, and adverse social and health outcomes, including avoidable involuntary commitment, disruptive confrontation, sub-nutrition, substance abuse, inappropriate polypharmacy, and noncompliance with necessary care; 3) to identify opportunities to promote positive social exchange and realistic, nonpsychotic appraisal of the patient's situation, through individual and group therapies when indicated; 4) to educate members of the patient's care network about the nature of psychotic illness and teach strategies for maintaining supportive interactions; and 5) to facilitate necessary medical treatment and health-promotion behaviors. This model implies proactive and ongoing advocacy for the patient's best interests, and outreach beyond the clinical setting. In this presentation, case examples will be provided to illustrate each of these elements in comprehensive care.

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INDUSTRY-SUPPORTED SYMPOSIUM 31—AGE-RELATED MEMORY LOSS: DETECTION AND TREATMENT
Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) differentiate various forms of age-related cognitive decline; (2) appreciate the pros and cons of treating age-related cognitive decline; and (3) recognize potential memory treatments and their risks and benefits.

No. 31A
FROM AGE-RELATED COGNITIVE DECLINE TO DEMENTIA

Steven H. Ferris, Ph.D., *Department of Psychiatry, New York University Medical Center, Aging Center, THN312B, 550 First Avenue, New York NY 10016;* Alan Kluger, Ph.D.

SUMMARY:

Cognitive decline over the human life span ranges from the very mild changes associated with normal aging to the profound loss of cognitive function in Alzheimer's disease (AD). Relative to cognitive performance as a young adult, most elderly individuals experience varying amounts of decline in certain cognitive functions, most notably in recent memory but also in attention and speed of processing, executive function, problem solving, and other complex mental activities. Terms such as age-associated memory impairment (AAMI), and in DSM-IV, age-related cognitive decline (ARCD), have been used to describe this well-documented, behavioral consequence of normal brain aging. While the longitudinal outcome of these changes is typically benign, some individuals decline more rapidly and experience clinically significant, but mild cognitive impairment (MCI). The longitudinal outcome of MCI is heterogeneous, with a majority of individuals progressing to a clinical diagnosis of Alzheimer's disease within several years. Much has been learned in recent years regarding risk factors for ARCD, MCI, and transition to AD. Potential treatments are also emerging that may slow the rate of decline in ARCD and MCI, and that may delay the transition to AD. Recent findings on early detection and treatment will be reviewed.

No. 31B
DOES DEPRESSION PREDICT COGNITIVE DECLINE IN THE ELDERLY?

Davangere P. Devanand, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 722 West 168th Street, Box 72, New York NY 10032-2603;* Mary Sano, Ph.D., Ming-X Tang, Ph.D., Karen Marder, M.D., Karen Bell, M.D., Yaakov Stern, Ph.D., Richard P. Mayeux, M.D.

SUMMARY:

A total of 1,070 elderly individuals, aged 60 years or older, were identified as part of a registry for dementia in the Washington Heights community of North Manhattan, New York. In a prospective, longitudinal design with follow-up for 1 to 5 years, annual physician evaluation and neuropsychological testing were used to assess levels of cognitive impairment and to make the diagnosis of dementia. The 17-item Hamilton Rating Scale for Depression (HRSD) was used to assess depression.

Of the 1,070 subjects, 218 met criteria for dementia at baseline evaluation. In the 852 subjects without dementia, depressed mood was more common in individuals with greater cognitive impairment. In a follow-up study of 478 of these subjects without dementia (mean 2.54, SD 1.12 years of follow-up), the effect of baseline depressed mood on the end-point diagnosis of dementia (93.4% had possible or probable Alzheimer's disease) was evaluated in a Cox proportional hazards model. Depressed mood at baseline was associated with an increased risk for incident dementia (RR = 2.94; 95% confidence interval [CI]. 1.76 to 4.91, $p < .001$). This effect remained after adjusting for age, gender, education, language of assessment, Blessed Memory Information and Concentration test scores, and Blessed Functional Activity Scale scores (RR = 2.05; 95% CI, 1.16 to 3.62, $p < .02$). Similar results were obtained when the total HRSD score was used as the "depression" variable, using the same covariates (RR = 1.07 per point interval, 95% CI, 1.02-1.11, $p < .01$).

Depressed mood moderately increased the risk of developing dementia, primarily Alzheimer's disease. These data are consistent with those previously obtained from inpatient settings. Whether depressed mood is a very early manifestation of Alzheimer's disease, or increases susceptibility through another mechanism, remains to be determined.

No. 31C
METHODS FOR EARLY DETECTION OF MEMORY LOSS

Gary W. Small, M.D., *Department of Psychiatry, University of California Los Angeles, Neuropsychiatric Institute, 760 Westwood Plaza, Los Angeles CA 90024-8300*

SUMMARY:

A key to effective treatment of age-related memory loss is the ability to differentiate stable forms of memory complaints from those that will progress to Alzheimer's disease (AD) and related conditions. Such early detection methods are most efficiently demonstrated in populations with a high probability of incipient dementia based on current knowledge of disease risk and biological markers (e.g., persons > 75 years with a family history of AD). A major AD genetic risk factor, apolipoprotein E-4 (APOE-4), has its greatest effect in the onset ages ranging from 60 to 75 years, while another recently reported genetic marker, human leukocyte antigen A2 (HLA-A2), appears to have its greatest effects on patients with younger and older dementia onset ages. Such genetic, familial, and age risk factors must be considered in conjunction with promising biological markers, particularly brain imaging. Positron emission tomography (PET) scanning shows a consistent and early pattern of parietal and temporal cortical deficits. Development of small molecule probes that label amyloid plaques may eventually become a disease-specific PET imaging method. Preliminary data on a "cognitive stress test," wherein subjects perform memory tasks during functional magnetic resonance imaging (fMRI), suggest that persons with age-related memory loss demonstrate different brain activation patterns during learning and recall: those with the APOE-4 allele show increased brain activity in the left intraparietal region and in frontal regions bilaterally compared with those without the genetic risk. This presentation will provide an update on these promising methods for early detection of AD.

No. 31D
FROM NEUROBIOLOGY TO NOVEL TREATMENTS

Murray A. Raskind, M.D., *Department of Psychiatry, Veterans Affairs Puget Sound Medical Center, 1660 S. Columbian Way, 116A, Seattle WA 98108*

SUMMARY:

The pathogenetic processes underlying Alzheimer's disease (AD) likely are operative for years prior to the clinical expression of dementia. Although data from prospective clinical trials are not yet available to support specific interventions for delaying the onset of clinical AD, epidemiologic and neurobiologic studies suggest promising areas for investigation. A leading hypothesis is that the beta amyloid peptide (Aβ) of AD brain plaques contributes to neuronal degeneration and loss. Aβ neurotoxicity appears greater for the 42 amino acid rather than the 40 amino acid form, and also appears more toxic after beta pleated sheet aggregation. Several of the point mutations on chromosomes 21, 14, and 1, identified in early onset familial AD, either increase the ratio of Aβ-42 to Aβ-40 or increase total Aβ concentrations. The mechanism by which the E4 isoform of apolipoprotein E (ApoE) increases AD risk may involve differential effects of the ApoE isoforms on Aβ aggregation. Development of drugs to reduce production of Aβ from its precursor protein and/or its aggregation is a high priority. Interestingly, drugs

that enhance brain cholinergic activity may decrease Aβ production. Epidemiologic studies suggest that estrogen and nonsteroidal anti-inflammatory drugs (NSAIDs) may reduce AD risk. Estrogen also may delay AD onset, perhaps through neurotrophic effects. NSAIDs may protect against AD by modifying the CNS inflammatory response associated with AD plaques. Finally, if neuronal oxidative damage contributes to AD, antioxidant drugs such as vitamin E and selegiline may prove effective. These and other approaches to arresting the progress of preclinical AD should receive attention in clinical trials.

No. 31E
CURRENT MEMORY TREATMENTS: CHALLENGES AND PROSPECTS

Lon S. Schneider, M.D., *Department of Psychiatry, University of Southern California, 1975 Zonal Avenue, KAM-400, Los Angeles CA 90033*

SUMMARY:

There is now a broad range of available treatments for cognitive decline in the elderly, ranging from FDA-regulated cholinesterase inhibitors and hormones to over-the-counter vitamins and nutritional supplements. Several cholinesterase inhibitors have been approved in the United States and elsewhere for the symptomatic treatment of mildly to moderately severe Alzheimer's disease. Yet, because people with mild aged-related cognitive decline as well as preclinical AD have functional and neurotransmitter impairments similar to AD, it is possible to consider the use of these medications in these groups. Unfortunately, results of clinical trials are lacking, leaving only observational evidence for possible efficacy in conditions other than AD. The differential pharmacology of the several cholinesterase inhibitors, however, suggest potential advantages and disadvantages among them for various indications. The use of antioxidants, selegiline, estrogen hormones, and plant-derived substances will also be discussed with respect to treatment approaches to preventing further cognitive decline in people with mild cognitive impairment. Available evidence for several compounds will be presented and the methodological requirements for clinical trials to clearly demonstrate the effectiveness of interventions in mild cognitive decline or in preventing the onset of dementia will be discussed. Current treatment options will be considered.

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INDUSTRY-SUPPORTED SYMPOSIUM 32—CONTEMPORARY ISSUES IN TREATMENT-RESISTANT DEPRESSION
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize, understand, and treat treatment-resistant depression. Treatment algorithms will be discussed as well as potential promising modalities.

No. 32A
OVERVIEW OF TREATMENT-RESISTANT DEPRESSION

Andrew A. Nierenberg, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 812, Boston MA 02114-3117*

SUMMARY:

Up to 40% of depressed patients fail to respond fully to antidepressants and up to 15% become refractory to treatment. Those who fail to respond fully have persistent residual symptoms and those who are refractory continue to meet full criteria for major depressive disorder. Causes of treatment-resistant and refractory depression (TRD) include noncompliance, difficulties with absorption, medical and psychiatric misdiagnoses, medication-induced depression, severe comorbid conditions, substance abuse, and persistent psychosocial adversity and stress. Clinicians have minimal data to compare competing options for psychopharmacological approaches to TRD at key decision points. After optimizing an antidepressant trial, clinicians must decide either to use polypharmacy or to switch patients to alternative antidepressants. Evidence-based polypharmacy options range from augmentation (e.g. with either lithium, thyroid, buspirone, pindolol, and stimulants) to combinations (e.g., SSRI's with tricyclics, bupropion, and trazodone). Options to switch antidepressants include changing drugs within a class or changing classes to take advantage of putative alternative mechanisms of action. Electroconvulsive therapy is always an option for appropriate patients. The challenge for clinicians is to tailor the evaluation and treatment algorithm for patients with TRD and to make decisions under conditions of uncertainty.

No. 32B
ALGORITHMS IN TREATMENT-REFRACTORY DEPRESSION

Jan A. Fawcett, M.D., *Department of Psychiatry, Rush-Presbyterian Medical Center, 1725 West Harrison, Suite 955, Chicago IL 60612*

SUMMARY:

The advantages of following an established algorithm in approaching a patient with treatment-resistant or refractory depression include a process for checking whether prior failed treatment has been delivered adequately and stepwise recommendations based on available data. The algorithm may bring up the indication for procedures that one is not easily motivated to think about, such as the indication for a course of MAO inhibitors or a course of ECT. Limitations of algorithms in clinical situations include the possibly of "routine" or superficial compliance, which "misses the mark"

in the refractory patient where everything must be questioned and checked. The knowledge base for decisions on sequencing augmentations and combinations may be lacking, or may vary with the clinical situation in ways not taken into account by an algorithm. The algorithm confronts us with the choices we have available, the knowledge with which to make these choices (if available), and the conditions under which these choices should be carried out. It also points out areas where adequate knowledge is not available to choose one approach over another. If we routinely and exhaustively upgrade algorithms as new information becomes available and honestly accept confrontation by the algorithm, it could function as a best current practice consultation that would improve treatment and practice in general.

No. 32C
ESTROGEN: WHAT IS THE MAGNITUDE OF THE EFFECT?

Barbara B. Sherwin, Ph.D., *Department of Psychology, McGill University, 1205 Dr. Penfield Avenue, Montreal, PQ, H3A 1B1, Canada*

SUMMARY:

The demonstration that estrogen enhances serotonergic metabolism and availability provides an explanation for its potential to enhance mood. Indeed, there is some evidence from menstrual cycle studies and from studies of post-menopausal women that healthy women have lower depression scores when estrogen levels are higher but still within the normal menstrual cycle range. However, in depressed post-menopausal women, even pharmacologic doses of estrogen are ineffective as a sole antidepressive agent. Whether or not estrogen potentiates the effect of an antidepressant in the treatment of post-menopausal women with a MDD is still unclear. One older controlled study found that adjunctive estrogen shortened the latency of response to a tricyclic antidepressant but, by six weeks post-treatment, no differences in the response rate were evident between the adjunct estrogen and adjunct placebo groups. In a recent SSRI study, a greater proportion of elderly post-menopausal women with an MDD who were, coincidentally, estrogen users, had a greater fluoxetine response and a lesser placebo response than that in nonusers. However, estrogen treatment was not randomized. Although estrogen clearly has effects on mood in women, currently available evidence does not permit a conclusion regarding the possible therapeutic efficacy of this steroid hormone in refractory depression.

No. 32D
COMBINATION TREATMENT IN RESISTANT DEPRESSION

David Bakish, M.D., *Department of Psychiatry, Royal Ottawa Hospital, 1145 Carling Avenue, Ottawa, ON, K1Z 7K4, Canada;* Cynthia L. Hooper, M.A.

SUMMARY:

The development of specific second generation antidepressants, including specific serotonin reuptake inhibitors (SSRI's) and reversible inhibitors of monoamine oxidase A (RIMA's), improved tolerability and patient compliance, and ultimately the treatment of unipolar depression. For resistant depression, however, the new antidepressants in most cases were only able to provide a partial response. Broad spectrum antidepressants, such as mirtazapine and venlafaxine, have improved not only the treatment of simple depressions but the outcome for patients with resistant depressions as well. There remain however, a significant proportion of patients for whom monopsychopharmacology does not work. These patients require multiple agents to control their depression symptoms. Several combination and potentiation strategies are available to the patient with resistant depression. Antidepressants that can be used successfully in combination include venlafaxine, nefazodone, moclobemide, fluoxetine, paroxetine, sertraline, and fluvoxamine. Potentiation strategies include the addition of trazodone, lithium, valproate, carbamazepine, or antipsychotics. Recently, several studies have suggested that the addition of pindolol may provide an earlier onset of action as well as efficacy in resistant depression. Treatment-resistant depression can be clinically frustrating, but the various potentiation and combination strategies, along with broad spectrum antidepressants offer several options for patients with treatment-resistant depression.

No. 32E
TREATMENT-RESISTANT DEPRESSION: PUSHING OUT THE EDGES OF THE ENVELOPE

Jay D. Amsterdam, M.D., *Department of Psychiatry, University of Pennsylvania, 3600 Market Street, Room 850, Philadelphia PA 19104*

SUMMARY:

Research efforts have been directed toward the development of novel diagnostic and treatment strategies for treatment-resistant depression (TRD). This presentation will provide a brief historical perspective on treatment approaches to TRD, and a survey of recent, cutting-edge strategies for refractory depression. It will further focus on the identification of the possible causes of TRD, including neurotransmitter, neuroreceptor, and neuroendocrine mechanisms, as well as iatrogenic contributions. New treatment strategies including high-dose monotherapy, drug combination/augmentation therapy, steroid suppression therapy, rapid receptor desensitization therapy, and other treatments will be briefly described.

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4. Zohar J, Belmaker RH: Treating Resistant Depression. New York: PMA Publishing Corp, 1987

INDUSTRY-SUPPORTED SYMPOSIUM 33—PRACTICAL CLINICAL STRATEGIES FOR MANAGING REFRACTORY DEPRESSION, AGITATION AND ANTIDEPRESSANT SIDE EFFECTS: PRACTICAL CLINICAL PSYCHOPHARMACOLOGY FOR THE PHYSICIAN
Supported by Bristol-Myers Squibb

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM

At the conclusion of this symposium, the participant should be able to (1) understand mechanisms of action, metabolism, and management of side effects of newer antidepressants; (2) recognize and treat sleep disturbances and sexual dysfunction in depressed patients; (3) provide pharmacologic augmentation strategies and management of agitation in the elderly.

No. 33A
COMBINED TREATMENT: A RATIONAL APPROACH FOR PHYSICIANS

Stephen M. Stahl, M.D., *Department of Psychiatry, University of California San Diego, 8899 University Center Lane #130, San Diego CA 92122*

SUMMARY:

There are two types of psychopharmacologists: those who can count, and those who can't. The best may be those who cannot count, because they find clever drug combinations where synergy yields therapeutic effects that are greater in combination than they are by themselves, or where 1 + 1 = 10. These same psychopharmacologists may also prescribe two drugs whose side effects are cancelled by the other's mechanism of action, or where 1 + 1 = 0. As psychiatrists see increasing numbers of patients who are nonresponders or nontolerators of antidepressants, combining medications is an increasingly important strategy for managing such patients. Although drug combinations are ideally derived from controlled clinical studies, there are far too few studies to address the needs of all treatment-resistant and treatment-intolerant patients. In the absence of such data, the clinician nevertheless has a rational approach to developing augmentation strategies, namely, by combinating multiple pharmacologic mechanisms. This strategy emphasizes combinations of mechanisms, not just combinations of drugs, many of which may themselves exhibit multiple pharmacologic mechanisms. This presentation will outline rational drug combination strategies, including practical tips on how to use more than a half dozen specific therapeutic cocktails for the difficult to treat patient.

No. 33B
PRACTICAL TIPS IN MANAGING COMMON SIDE EFFECTS OF ANTIDEPRESSANTS

Norman Sussman, M.D., *Department of Psychiatry, New York University School of Medicine, 20 East 68th St., Suite 204, New York NY 10021-5836*

SUMMARY:

The quality, severity, and probability of medication side effects are often determinants of drug selection. Knowledge of potential side effects and the management of side effects once they emerge represent an essential aspect of clinical skill, especially for psychiatrists. Side effects can be classified in three categories based on temporal features. Acute side effects emerge at the outset of treatment, but abate or disappear with time. Late side effects do not emerge until weeks or months have passed. Persistent side effects occur at the start and continue largely unchanged over time. Acute side effects can often be managed by using lower doses and using slow upward dose titration. The other types of adverse events more typically require the addition of a second drug to offset the side effect. Sexual dysfunction and sleep disturbances associated with SSRI's, for example, are often managed with add-on therapy. Each of the newer antidepressants has a characteristic side effect profile, so that it is possible to select a drug based on the absence of a particular side effect. For example, several drugs do not produce sexual dysfunction. These are nefazodone, mirtazapine, and bupropion. Nefazodone and mirtazapine do not produce significant sleep disturbance or activation, such as agitation or anxiety. SSRI's, which are known for their ability to reduce appetite, actually cause weight gain in many patients during long-term treatment. Weight gain associated with mirtazapine tends to be an acute effect that diminishes with time. Somnolence is associated with all of the newer agents except bupropion. Contrary to their image as activating agents, SSRI's produce considerable sedation and lethargy in a substantial minority of patients. Stimulants are often used to mitigate these effects. Mirtazapine is the most sedating of the antidepressants, but this effect tends to diminish in both severity and prevalence over time. Nefazodone is mildly sedating early in treatment, and this side effect can be managed by giving the total daily dose at night.

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INDUSTRY-SUPPORTED SYMPOSIUM 34—PRACTICAL CLINICAL STRATEGIES FOR MANAGING REFRACTORY DEPRESSION, AGITATION AND ANTIDEPRESSANT SIDE EFFECTS: PRACTICAL STRATEGIES FOR MANAGING SLEEP DISTURBANCES AND SEXUAL DYSFUNCTION WHEN TREATING DEPRESSED PATIENTS
Supported by Bristol-Myers Squibb

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) understand mechanisms of action, metabolism, and management of side effects of newer antidepressants, (2) recognize and treat sleep disturbances and sexual dysfunction in depressed patients, (3) provide pharmacologic augmentation on strategies and management of agitation in the elderly.

No. 34A
MANAGING SLEEP DISTURBANCES WHEN TREATING DEPRESSED PATIENTS

Michael E. Thase, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh PA 15213*

SUMMARY:

A large majority of depressed people suffer from disturbed sleep. These complaints range from marked hypersomnolence to severe insomnia. This presentation will review the prevalence of different types of sleep disturbance in depression, the incidence of treatment-emergent sleep difficulties, the clinical and polysomnographic correlates of hypersomnia and insomnia, and common therapeutic strategies employed to deal with these problems. One benefit of the introduction of a number of new classes of antidepressants is the capability to select between medications with bona fide differences in effects on sleep, which should lessen the need for cotherapy with sedative hypnotics. Important differences among SSRI's, nefazodone, bupropion, and mirtazapine are considered. Lastly, a number of cognitive-behavioral strategies will be described that may be employed as adjuncts to pharmacotherapy to improve management of depressive sleep disturbances.

No. 34B
MANAGEMENT OF ANTIDEPRESSANT-INDUCED SEXUAL DYSFUNCTION

Anthony J. Rothschild, M.D., *Department of Psychiatry, University of Massachusetts Medical Center, 55 Lake Avenue N., Room S7-802, Worcester MA 01655*

SUMMARY:

Patients with depressive disorders frequently have concurrent sexual problems. The sexual dysfunction is often masked by the mood disorder and many patients have difficulty discussing these problems openly. Thus, sexual dysfunction is often only detectable by very careful inquiry. The relationship between sexual dysfunction and depressive disorders is further complicated by antidepressant therapy which itself may cause sexual dysfunction, increasing the risk of noncompliance and relapse. Studies will be presented that indicate that antidepressants may cause 30% to 40% of patients to develop some degree of sexual dysfunction. Management strategies for alleviating sexual dysfunction as a complication of antidepressant treatment will be discussed in terms of supporting research studies as well as practicality. Spontaneous resolution of antidepressant-induced sexual dysfunctions rarely occurs. Dose reductions risk losing the antidepressant effect. Antidotes, drug holidays, and timing sexual relations with respect to antidepressant dose are effective for some patients, but have not been studied with double-blind paradigms. Switching to antidepressants, which cause sexual dysfunction at lower rates, and data comparing rates of sexual dysfunction amongst antidepressants will be discussed. The important role that psychiatrists have in the assessment and treatment of antidepressant-induced sexual dysfunction will be emphasized.

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1. Feiger A, Kiev A, Shrivastava RK: Nefazodone versus sertraline in outpatients with major depression: focus on efficacy, tolerability, and effects on sexual function and satisfaction. J Clin Psychiatry 1996;57(suppl 2):53–62
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INDUSTRY-SUPPORTED SYMPOSIUM 35—PHARMACOTHERAPY COMBINATION STRATEGIES IN CLINICAL PRACTICE Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the principles of rational copharmacy and use drug combinations with confidence in their practice.

No. 35A SKILLFUL POLYPHARMACY IS THE CURRENT PRACTICE

Devdutt V. Nayak, M.D., *New York Methodist, 506 Sixth Street, Brooklyn NY 11215*

SUMMARY:

Traditional practice of psychiatry has always advocated the use of single-drug therapy, the rationale being that polypharmacy leads to a higher incidence of adverse effects and poorer patient compliance. In general, use of multiple similar drugs is to be avoided. However, "copharmacy," the simultaneous use of several different classes of drugs may be very helpful. Well tolerated monotherapy is effective only in 50% to 60% of patients with OCD, depression, and bipolar disorders. Adding other drugs can be beneficial from the pharmacokinetics as well as pharmacodymanic interactions. Combined treatments are growing with the introduction of newer "specific agents" and discovery of new uses for old agents, e.g., anticonvulsants, B blockers, and Ca channel blockers. It is not uncommon for patients to have two or more diverse psychiatric disorders simultaneously or in succession, and comorbidity with drug and alcohol abuse is on the rise. With passage of time and recurrences some disorders will become chronic and refractory to single drug and only combination pharmacotherapy will bring some relief, lessen the mortality risk, and improve the quality of life for our patients.

No. 35B CLINICAL STRATEGIES IN INTRACTABLE DEPRESSION

Jan A. Fawcett, M.D., *Department of Psychiatry, Rush-Presbyterian Medical Center, 1725 West Harrison, Suite 955, Chicago IL 60612*

SUMMARY:

This presentation will focus on the use of stimulant potentiation of various antidepressant medications including monoamine oxidase inhibitors in patients suffering from treatment-resistant (partial response only with prior treatment) and treatment-refractory depression (no improvement with prior treatments). Data will be presented reviewing clinical results and adverse effects encountered with the use of stimulant potentiation of MAOI medication as well as conventional antidepressants. Specific clinical issues involved will be addressed by the presentation of illustrative cases. Important considerations to be addressed in the selection of patients, obtaining informed consent, and procedures and precautions to be taken in the administration of stimulant potentiation, will be discussed.

No. 35C RATIONAL COPHARMACY FOR BIPOLAR DISORDER

Philip G. Janicak, M.D., *Department of Research, Psychiatric Institute, 1601 West Taylor Street, Chicago IL 60612*

SUMMARY:

Optimal treatment of bipolar disorder often requires complicated multiple drug therapies during at least some phases of the illness. Unfortunately, there are few data from well-controlled studies to guide rational copharmacy for this disorder. In this context, we outline treatment approaches for various phases and subtypes of bipolar disorder based on the best available data. We discuss the role of low-dose conventional neuroleptics, as well as the use of novel antipsychotics (e.g., clozapine; risperidone) in combination with mood-stabilizing agents; benzodiazepines, particularly for acute manic exacerbations, to minimize antipsychotic use or as substitutes; the role of thyroid supplementation; and finally, ECT for either phase of the illness, especially when used in combination or sequentially with medication. We next consider anticonvulsant mood stabilizers, whether combined with other psychotropics or with each other, emphasizing their role for specific subtypes (e.g., rapid cyclers, mixed rates, organic mood disorders). The management of the depressive phase is also addressed, particularly regarding the potential for switching into mania or precipitation of a more virulent course. Finally, all these drug combinations will be considered for their acute and maintenance value, their clinically relevant pharmacokinetics, and their potential for serious interactions.

No. 35D COPHARMACY IN TREATMENT-RESISTANT ANXIETY STATES

Michael R. Liebowitz, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 722 West 168th Street, MB #120, New York NY 10032-2603*

SUMMARY:

Anxiety disorders, like other psychiatric conditions, are sometimes resistant to monotherapy. Depression and substance abuse are especially likely to complicate anxiety disorders, leading to treatment failure and chronicity. For example, monotherapy is ineffective in up to 40% of comorbid panic disorder and up to 60% of OCD. The circumstances where copharmacy is appropriate for anxiety disorders will be reviewed, and promising strategies for several disorders discussed. These include: for panic disorder, antidepressant plus benzodiazepine, multiple antidepressant plus beta blocker, or antidepressant plus benzodiazepine plus beta blocker strategies; for OCD, combined serotonin reuptake inhibitor (SRI) and selective serotonin reuptake inhibitor (SSRI) (sometimes with an anticonvulsant), SRI or SSRI plus fenfluramine, or SRI or SSRI plus neuroleptic regimens. The kinds of evidence available for efficacy of these regimens will also be discussed. A limitation of the copharmacy literature is that, with a few notable exceptions, the positive evidence comes from clinical experience or uncontrolled trials. Recently, several copharmacy regimens that showed promise in open clinical trials in anxiety disorder patients did not prove effective in placebo-controlled trials.

No. 35E
TREATMENT OF DRUG-REFRACTORY SCHIZOPHRENIA

Sidney Fein, M.D., *Department of Psychiatry, New York Methodist, Sixth Street, Brooklyn NY 11215*

SUMMARY:

Schizophrenia, a devastating and heterogeneous disease that consists of various subgroups, is often resistant to monotherapy. Approximately 10% to 30% of patients with schizophrenia show a poor response to neuroleptics alone. Even with treatment, 50% of schizophrenics lead severely debilitated lives. This paper reviews the literature on adjunctive treatments to augment neuroleptic effects. Successful adjunctive medications have been lithium, antidepressants, benzodiazepines, carbamazepine, reserpine, and electroconvulsive therapy (ECT). Also ECT in combination with clozapine has been successful. Some patients have responded to propranolol, clonidine, valproic acid, and L-dopa. Also, the combined use of risperidone with haloperidol and thioridazine will be reviewed. Thus, if a schizophrenic patient remains treatment resistant to an adequate trial of neuroleptics, a change to an atypical antipsychotic such as risperidone or clozapine, or augmentation treatment should follow.

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INDUSTRY-SUPPORTED SYMPOSIUM 36—HOT TOPICS IN ALZHEIMER'S DISEASE
Supported by Bayer Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should have a greater knowledge of new developments in clinical uses of genetics, diagnosis, new treatment strategies, and experts' opinion.

No. 36A
APOLIPOPROTEIN E-E4 AND ALZHEIMER'S DISEASE: SEARCH FOR TRUTH

Kathleen Welsh-Bohmer, Ph.D., *Department of Psychiatry, Duke University, 2200 W. Main St., Suite A230, Durham NC 27713;* Bonita W. Wyse, Ph.D., David C. Steffens, M.D., Joann Ischanz, Ph.D., Maria C. Norton, Michael J. Helms, M.A., John C.S. Breitner, M.D.

SUMMARY:

The role of the apolipoprotein E-ϵ4 (APOE) gene in the onset of Alzheimer's disease (AD) after age 80 has been a subject of controversy. Population studies of the "old-old" permit an opportunity to explore this issue while mitigating the influence of confounding factors such as volunteer and ascertainment biases. We will present the results of our large population study of AD and vascular dementia (VaD) in Cache County, Utah. In this study we obtained genotypes on 4,896 elderly residents (86% response rate) in the county. The subjects were screened (97% + sensitivity) for prevalent cases of AD and VaD. In the 267 cases of dementia identified (crude prevalence 5.5%), 216 subjects had AD and 74 had forms of VaD. When occurrence of these disorders was examined by age and APOE genotype, the ϵ4 genotype was shown to be a strong risk factor for dementia (both AD and, to a lesser extend, VaD) but that almost all of this risk was apparent by age 80 in a large majority of subjects. These data suggest that APOE is a strong risk factor for AD before the age of 80, but that other genes or environmental factors may play more important roles in the late onset forms of the illness.

No. 36B
DIAGNOSTIC TESTING: BENEFITS OR JUST COSTS?

Gary W. Small, M.D., *Department of Psychiatry, University of California Los Angeles Neuropsychiatric Institute, 760 Westwood Plaza, Los Angeles CA 90024-8300*

SUMMARY:

With increased awareness of the "epidemic" of dementia, numerous diagnostic tests have been marketed that purportedly "rule in" Alzheimer's disease (AD) with high sensitivity and specificity. Although such tests incur additional costs to the dementia evaluation, advocates argue that such costs are offset by savings from avoiding other more conventional assessments. Today's managed care environment emphasizes the need to minimize costs, yet systematic data on cost-effective diagnostic testing are unavailable. The various consensus statements recommend diagnostic assessments that include a complete history, physical and neurological examinations, and a careful mental status examination. The routinely recommended laboratory tests for dementia basically attempt to search for potentially treatable medical conditions. Cerebrospinal fluid examination is not routinely recommended but may be useful in rare cases. New diagnostic markers derived from cerebrospinal fluid examinations (e.g.,

increased tau and decreased beta-amyloid) have not been tested in large clinical populations, and thus many experts question their clinical utility. Although the consensus groups do not recommend routine use of either structural or functional imaging scans, in practice clinicians often obtain these examinations for their patients with dementia. Genetic risks have been identified in recent years, but rarely is genetic testing recommended. In fact, overreliance on and over interpretation of laboratory findings should be avoided. This presentation will describe available diagnostic tests for dementia along with an approach to assess their costs and benefits.

No. 36C
PREVENTION OF ALZHEIMER'S DISEASE: NON-STEROIDAL ANTI-INFLAMMATORY AGENTS, ESTROGENS AND H2 BLOCKERS

John C.S. Breitner, M.D., *Department of Mental Hygiene, Johns Hopkins University, 624 North Broadway, Baltimore MD 21218*

SUMMARY:

It is now clear that Alzheimer's dementia (AD) is the late consequence of a neurodegenerative process that evolves over decades. The extended *latent stage* of this process offers a target for interventions that can delay or prevent onset of dementia symptoms. In fact, a dramatic flow of epidemiologic evidence suggests that several common medicines may be neuroprotective, and may thereby prevent AD. Over 20 scientific reports, including prospective designs, show that anti-inflammatory drugs (especially non-steroidal agents) may delay or prevent onset of AD symptoms. The evidence is almost as compelling that post-menopausal estrogen replacement therapy may act similarly in women. A smaller but intriguing group of experiments suggest that histamine H2 blocking drugs may also delay AD onset. These empirical findings suggest a strong probability of success for randomized controlled prevention trials that will be needed to prove the drugs' efficacy. A prevention trial with estrogen replacement is underway, and trials of anti-inflammatory agents should start soon. If these are successful, and especially if new evidence supports a protective effect of H2 blockers (among the safest and best tolerated of all prescription drugs), the public health consequences will be incalculable.

No. 36D
ANTIOXIDANTS IN SELEGILINE: ARE THEY READY FOR THE CLINIC?

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

SUMMARY:

Several possible mechanisms will be reviewed by which selegiline, a monoamine oxidase inhibitor, and α-tocopherol, might have an effect on Alzheimer's disease (AD). Fourteen clinical studies have been published that suggest that there is significant short-term benefit of selegiline. These will be reviewed, along with unpublished data from an eight-week trial at the University of Rochester. Only four long-term studies of selegiline administration have been conducted. The largest was that of Sano, et al., a two-year study of 341 patients with AD of moderate severity in which patients received selegiline 10 mg qd or α-tocopherol 2000 IU qd. The primary outcome of the study was timed to reach death, institutionalization, loss of basic activities of daily living, or severe dementia. There is a significant reduction in the risk of reaching the primary outcome for selegiline and α-tocopherol, and a trend toward reduction and risk for combination therapy with both. Two published studies and one unpublished two-year study in patients with mild AD, conducted at the University of Rochester, will also be reviewed, suggesting benefit of selegiline. The only positive clinical evidence so far for the use of α-tocopherol is the study of Sano, et al. At this point, the cost-benefit analysis would suggest that clinicians may use α-tocopherol in patients with AD in hopes of delaying progression. Toxicity with selegiline is higher, so that the threshold for use should also be higher. Evidence is mounting, however, that it may have an important role: a multicenter trial of transdermal selegiline, completed in 1997, may definitively address this issue.

No. 36E
CHOLINESTERASE INHIBITORS: GREATER THERAPEUTIC POSSIBILITIES?

Martin R. Farlow, M.D., *Department of Neurology, Indiana University, 541 N. Clinical Drive, Suite 583, Indianapolis IN 46202;* Debomoy K. Lahiri, Ph.D., Anne M. Hake, M.D.

SUMMARY:

The losses of memory and other cognitive functions in Alzheimer's disease (AD) are associated with deficits in brain cholinergic function, AD patients in several investigational trials have shown beneficial effects during treatment with centrally active acetylcholinesterase inhibitors (ChE-I's). Though short-term symptomatic improvements were seen for time intervals ranging from 24 to 30 weeks, none of these trials demonstrated that a ChE-I can delay disease progression. However, these drugs have a range of other non-neurotransmitter effects that might slow disease progression by interfering with the pathological cascade of events that underlies decline in functional abilities.

First, accumulation of free radicals with oxidative stress may contribute to neuronal loss in AD. Monoamine oxidase (MAO) inhibition is hypothesized to be neuronally protective. At therapeutic dosages, tacrine has modest MAO-A and -B inhibitory effects that might contribute to its therapeutic efficacy. Second, high levels of butyrylcholinesterase are found in the plaques of patients with AD but not in the protein depositions associated with normal aging. ChE-I's may delay or prevent conversion of these deposits to neuritic plaques. Third, the amyloid plaques, which characterize AD, are composed of amyloid-β protein, which is derived from the β-amyloid precursor protein (APP). Cell line studies have recently shown that tacrine and other ChE-I's can modulate processing of APP reducing secretion of both amyloid-β protein and its precursors. These studies suggest that ChE-I's may decrease β-protein deposition in plaques and by this mechanism delay clinical progression of AD.

Further studies are needed to determine the range and magnitude of these effects in ChE-I's currently in use or under development and to demonstrate whether these mechanisms actually contribute to symptoms improvement or delay progression of disease.

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INDUSTRY-SUPPORTED SYMPOSIUM 37—UPDATE ON DIAGNOSIS: PATHOPHYSIOLOGY AND TREATMENT OF PRIMARY HEADACHE DISORDERS FOR THE PRACTICING PSYCHIATRIST Supported by Merck U.S. Human Health

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participants should be able to: (1) properly diagnose primary headache disorders. (migraine, tension-type, and cluster), (2) differentiate primary headache for organic causes, (3) understand the prevalence and impact of primary headache on the population in the United States, (4) learn recent advances in the pathophysiology of primary headache and their application to new advances in pharmacotherapy, (5) understand psychiatric aspects from etiologic, psychophysiologic, and comorbid perspectives (e.g. depression), (6) learn about issues related to women and headache, (7) implement pharmacotherapy for acute as well as chronic daily headache, (8) be able to implement pharmacotherapy for acute episodes and prophylaxis, and (9) learn modern behavioral and nonpharmacologic techniques.

No. 37A
EPIDEMIOLOGY AND COMORBIDITY OF PRIMARY HEADACHE DISORDERS

Richard B. Lipton, M.D., *Headache Unit, Albert Einstein College, 111 East 210th Street, Bronx, NY 10467*

SUMMARY:

Primary headache disorders are common and quite often disabling. Tension-type headache, the most common of the primary headache disorders, affects up to 70% of the population. Though it rarely causes work absenteeism, it is associated with decrements in performance in a variety of spheres. Migraine affects about 12% of the population and is a major cause of work absenteeism as well as disability at work. Both disorders are most common in mid-life and more common in women. Migraine prevalence is inversely related to socioeconomic status. Primary headache disorders have an influence that extends well beyond the acute attack. These disorders are associated with substantial direct and indirect costs as well as measurable enduring decrements in quality of life. The enormous ictal and interictal impact of headache disorders provides an appropriate target for acute and preventive treatment.

No. 37B
THE DIAGNOSIS AND CLASSIFICATION OF PRIMARY HEADACHE DISORDERS

Alan M. Rapoport, M.D., *New England Center for Headache Disorders, 778 Long Ridge Road, Stamford CT 06902*

SUMMARY:

Accurate headache diagnosis requires a detailed history of the various types of headaches, plus relevant medical history, a careful physical and detailed neurological examination, and a working knowledge of different headache types. The currently recognized headache classification was derived by headache specialists from many countries who were part of the Classification Committee of the International Headache Society, and was published in the journal Cephalagia in 1988. There are 13 major headache classifications, including three primary headache disorders. The most common type is tension-type headache, affecting a large segment of the population and presenting as a mild to moderate, bilateral, steady, and non-throbbing pain anywhere in the head. It is usually brief in duration, easy to treat, and not very frequent. Migraine is a more severe, long lasting, throbbing, often unilateral headache occurring one to four times a month and more prevalent in women. It is sometimes associated with visual aura and is often triggered by hormonal events in women. The most painful type is cluster headache, which is much more prevalent in men. It is usually episodic, occurring for four to six weeks in the year and coming back on a daily basis during that period of time. The pain is excruciating with a periorbital or eye pain, is boring in nature, and associated with certain autonomic findings such as red and tearing eye, and stuffed and running nostril, all on the side of the pain. These primary headache disorders can be differentiated from psychiatric and secondary organic headache disorders by careful history, examination, and occasionally appropriate laboratory testing.

No. 37C
PATHOPHYSIOLOGY OF PRIMARY HEADACHE DISORDERS

Ninan T. Mathew, M.D., *Houston Headache Clinic, 1213 Herman Drive, Suite 350, Houston TX 77004*

SUMMARY:

The old concepts, that cranial vascular dilatation and pericranial muscle contraction are the basic mechanisms of migraine and tension-type headache, respectively, are not substantiated. Data accumulated recently indicate that there is a generator of migraine in the upper brain stem periaqueductal dorsal rhaphe area. Activation of ascending pathways from the brain stem, particularly to the occipital cortex, may result in spreading oligemia (most probably secondary to spreading cortical depression) and may account for the aura of migraine. Clinical and neurophysiological observations suggest central neuronal hyperexcitabiliby in migraineurs. Low cerebral magnesium levels and increased glutamate activity have been postulated as mechanisms underlying the central neuronal hyperexcitability. Prophylactic anti-migraine agents act centrally, altering this process.

Pain of migraine originates at the perivascular nerve endings of intracranial extra-cerebral blood vessels (trigeminal vascular system). Experimental and clinical evidence suggest vasodilatation and neurogenic inflammation as the processes that transduce pain. Specific anti-migraine agents, particularly 5-HT_1 agonists, cause vasoconstriction and reduce neurogenic inflammation.

Central and peripheral (trigeminal vascular system) serotonin systems are important in migraine pathophysiology. Disturbances of central neurotransmitor systems, including serotonin, may explain frequent comorbidity of migraine with other disorders such as depression, bipolar illness, and anxiety. Evidence for possible central origin of tension-type headache will also be presented.

No. 37D
PHARMACOLOGIC TREATMENT OF PRIMARY HEADACHE DISORDERS

Joel Saper, M.D., *Neuro Institute, Michigan Head Pain, 3120 Professional Drive, Ann Arbor MI 48104-5199*

SUMMARY:

Modern techniques for the pharmacological treatment of headaches are now focused on using medications that directly influence neurotransmission and receptor/neurotransmitter function. More than

ever before, this pharmacological approach blends the neuroscience experience of both neurology and psychiatry. With the recognition that many, if not most, patients with difficult headache disorders suffer from neuropsychiatric comorbidities, treatment strategies have employed neuropsychiatric phenomena.

The symptomatic treatment of headache revolves around the use of medications, such as the ergot derivatives, sumatriptan, analgesics, nonsteroidal medications, and a variety of peripheral drugs. Also, a more enlighted attitude regarding the use of opiods in selected cases of intractable pain deserves mention.

The preventive treatment of headache, while still employing the use of beta blockers and other vasoactive medications, is now reflecting the increased interest in centrally acting drugs, which affect upper brainstem neurotransmission. In addition to the tricyclic antidepressants, which have become one of the pillars of headache prophylaxis, agents being used with increasing frequency and success include SSRI's, anticonvulsants (valproic acid, gabapentin, etc.), MAO inhibitors, and others.

As part of this presentation a review of guidelines for the use of opiod medications in the treatment of headache will be provided, as well as a brief review of protocols for intractable and persistent headache. A review of why patients do not improve will also be offered.

No. 37E
MENSTRUAL AND MENOPAUSAL MIGRAINE

Ivy Fettes, M.D., *Department of Medicine, University of Toronto, 2075 Bayview Avenue, Toronto, ON., M4N 3M5, Canada*

SUMMARY:

Migraine is more than twice as common in adult women as men. The peak incidence is at menarche. Migraines occur *exclusively* with menses in about 14% of migraineurs. Menstrual migraine typically occurs between days –2 and +3 of the menstrual cycle, where day 1 is the day menstrual bleeding begins. Migraines that occur from days –7 to –3 of the cycle may be associated with premenstrual syndrome. The causes of menstrual migraine are thought to be different from those of the premenstrual syndrome. Estrogen levels fall before menstruation and this is thought to be the trigger for menstrual migraine. Prostaglandin secretion increases as estrogen levels decrease. Prostaglandins may be involved in the mechanism of migraine as well as a cause of dysmenorrhea. *Short term prophylaxis* with an estrogen patch and/or a nonsteroidal anti-inflammatory drug may be helpful in the prevention of menstrual migraine.

As estrogen levels fluctuate and fall during the perimenopausal years, there may be an exacerbation of migraine. There may also be an exacerbation of migraine in post-menopausal women who are placed on cyclic hormonal replacement therapy. In both situations, stabilization of the hormonal mileau with *continuous* hormonal replacement therapy will relieve the migraine in the majority of patients.

No. 37F
BEHAVIORAL AND PSYCHOPHYSIOLOGICAL APPROACHES TO PRIMARY HEADACHE DISORDERS

Steven M. Baskin, Ph.D., *New England Center for Headache Disorders, 7781 Long Ridge Road, Stamford CT 06902*

SUMMARY:

The present review describes a biobehavioral approach that has emerged from psychobiologic models of primary headache disorders. The first phase of this model is a thorough assessment with multiple types of data collected including clinical interview and psychophysiologic evaluation. Treatment strategies are based upon the detailed behavioral assessment. Psychological and pharmacological interventions are often combined in a comprehensive multifaceted program. A detailed educational program is undertaken. Patients learn a group of coping skills that foster self-regulation incorporating sensory and reactive components. The sensory component involves perception of pain sensations. It can be altered through biofeedback and relaxation techniques. The reactive component consists of thoughts and feelings that accompany head pain and may lead to problematic behaviors. Headache-specific cognitive and behavioral psychotherapies are effective change agents. Behavioral strategies to enhance compliance with drug regimens have been shown to maximize outcome. Recent research has shown a comorbidity of migraine, tension-type headache and mood and anxiety disorders. Treating these comorbid psychiatric factors is important to successful treatment, especially in the refractory patient. These behavioral therapies help the headache sufferer incorporate a variety of coping skills, encouraging personal involvement and responsibility. They expand the scope of treatment to include emotional, cognitive, behavioral, and social factors that often have a bearing on outcome.

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INDUSTRY-SUPPORTED SYMPOSIUM 38—EXPLORING THE COURSE OF SCHIZOPHRENIA
Supported by U.S. Pharmaceuticals, Pfizer Inc

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the factors that are critical to successfully manage schizophrenia. Topics include acute psychotic episodes, relapse prevention, managing depression, long-term quality of life issues, and adverse effects.

No. 38A
RAPIDLY CONTROLLING ACUTE PSYCHOTIC SYMPTOMS WITH ANTIPSYCHOTIC DRUGS

William C. Wirshing, M.D., *Department of Psychiatry, West Los Angeles Veterans Affairs Medical Center, 11301 Wilshire Blvd. (B-151H), Los Angeles CA 90073*

SUMMARY:

Although antipsychotic medications have been remarkably effective pharmacologic tools in the management of a whole range of psychotic symptoms, they have a crucial limitation in the treatment of the acutely psychotic patient: they have a delayed onset of action. The controlled clinical data compellingly confirm that antipsychotic medications, irrespective of molecular subclass, begin to exert their effect after one to two weeks of chronic therapy. Raising the dose rapidly as was done during the heyday of "rapid neuroleptization" fails to shorten the time to onset of antipsychotic action. High doses of conventional antipsychotic medication do have a clinically "exploitable" side effect: they are densely sedating. The sedative properties of these molecules are probably determined by their particular binding to both histaminic and noradrenergic receptors in the central nervous system. The elaboration of what has come to be called novel or atypical compounds has not altered the speed at which antipsychotic activity is achieved. Indeed, the slow titration to therapeutic range mandated by the toxicity of clozapine sometimes delays rather than shortens this time. In general, the newer medications differ from their older counterparts in the treatment of acute psychosis in several ways. They cannot be used acutely at doses above the range necessary to control symptoms chronically. They have somewhat more alpha I affinity and therefore should not be used parenterally because of the risk of orthostatic hypertension. At prudent starting doses they are less sedating. This presentation will review the data on time course to antipsychotic activity for older and newer antipsychotic medications, and discuss the rational use of adjunctive strategies to maximize behavioral control and minimize short- and long-term toxicities.

No. 38B RELAPSE PREVENTION

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

SUMMARY:

Relapse prevention is a critical goal in the long-term management of schizophrenia. Maintenance medication is associated with a substantial reduction in the risk of psychotic relapse and rehospitalization. Despite the proven value of continued drug treatment, many patients discontinue medication. Reasons for this include inadequate psychoeducation, denial, adverse effects, and in some cases, lack of strong recommendations or oversight by mental health professionals. Risk-benefit concerns, particularly surrounding a 5% per year incidence of tardive dyskinesia with conventional antipsychotics, have stimulated a large body of research on dosage reduction strategies. Low dose continuous treatment appears to have advantages over targeted or intermittent treatment, and psychosocial treatment for patients and families can help to augment the effects of medication.

With a new generation of antipsychotic drugs becoming available, the risk-benefit equation for maintenance treatment may improve and a reduction in side effects might help to enhance compliance.

It is probable that with repetitive relapses, quality of life, level of psychosocial functioning, and community adjustment will suffer. In addition, risk of suicide and self-injurious behavior is higher in patients with frequent symptom exacerbations.

Efforts to prevent relapse have enormous public health implications.

No. 38C LONG-TERM STUDIES IN SCHIZOPHRENIA: IMPROVING FUNCTIONAL OUTCOMES

Mihaly Arato, M.D., *Psychiatry, Hiete-Opni, Nyeki Ut 10-12, Budapest 27 1281, Hungary*

SUMMARY:

Although the course of schizophrenia is variable, it is all too frequently synonymous with a pattern of repeated hospitalizations and a pernicious decline in social, occupational, and personal functioning. Rehospitalization is generally related to exacerbation of positive symptoms and functional decline related to severe and persistent negative symptoms. Despite the advent of new treatments, strategies that target the key drivers underlying the progressive decline that occurs in many persons with schizophrenia remain among the most elusive goals in psychiatric care.

A patient who's illness has progressed to the point of repeated hospitalizations and decline in functioning may reach a state of "stability" but still be in need of assistance in daily living and may even remain hospitalized. Short-term studies are insufficient to address the long-term outcome of new treatments in such patients. In addition to demonstrating efficacy in the treatment of positive and negative symptoms, the prevention of relapse—a primary goal of treatment—can only be evaluated in long-term studies. Long-term studies (i.e., those of at least one year) can be useful in addressing other aspects of schizophrenia such as global functional impairment for which short-term studies are inadequate.

Data from chronic symptomatic patients first treated with older antipsychotics and then with a novel antipsychotic will be presented. Long-term data regarding improvement in functional outcome and negative symptoms will be presented.

No. 38D ASSESSMENT AND TREATMENT OF DEPRESSION IN SCHIZOPHRENIA

Donald E. Addington, M.D., *Department of Psychiatry, Foothills Hospital, 1403 29th Street, NW, Calgary, AB, T2N 2T9, Canada*

SUMMARY:

This presentation is designed to enhance the attendees' ability to recognize, assess, and treat depressive symptoms and syndromes in schizophrenia. Recognition of depression depends on eliciting key cognitive symptoms of depression. Level of depression can be assessed by the Calgary Depression Scale for Schizophrenia (CDSS). The CDSS is a semi-structured interview and scale specifically designed for the assessment of level of depression in schizophrenia. It is highly reliable and measures depression separate from negative and positive symptoms. Treatment recommendations are based on a limited number of randomized studies. The first step is optimal treatment of the schizophrenia. This involves minimizing positive symptoms and extrapyramidal side effects. The next step varies according to the severity of the depression and the presence of a major depressive episode. Cognitive therapy may be useful for moderate levels of depression. Antidepressants are indicated for a major depressive episode in the stabilized patient. It has been suggested that newer antipsychotics may be useful for schizophrenia patients with high levels of depression. The suggestion needs verification by randomized prospective studies of patients with schizophrenia and depression using depression measures validated in this population.

No. 38E ADVERSE EFFECTS PROFILE OF NEW ANTIPSYCHOTIC AGENTS

Daniel E. Casey, M.D., *Department of Psychiatry, Veterans Affairs Medical Center, 3710 SW US Veterans Hosp Road, Portland OR 97201*

SUMMARY:

Antipsychotic drugs are the mainstay for treating both the acute and chronic phases of the lifetime course of schizophrenia. However,

these compounds have many side effects that have imposed an additional burden on patients who are already impaired by their psychosis. All the conventional, or typical neuroleptic drugs have the particularly troublesome neurological adverse effects of acute extrapyramidal syndromes (akathisia, dystonia, and parkinsonism) as well as the late onset tardive dyskinesia. These syndromes are often cited by patients as reasons for noncompliance with drug therapy because the neurological symptoms of both motor (objective) and mental (subjective) symptoms are intolerable. Other side effects involve the autonomic nervous system, sexual dysfunction, and health problems with weight gain. The new novel, atypical antipsychotic agents have substantially improved the side effect profile by decreasing or not causing extrapyramidal symptoms and tardive dyskinesia, but some of these new agents still have a range of side effects that patients may still find unacceptable and negatively impact compliance. Some of the newest antipsychotic agents have further improved the adverse effect profile so that even the difficult and common side effect of weight gain may not occur with some of these new agents. This presentation will compare and contrast the wide range of adverse effects for the conventional neuroleptics with the new novel agents. Further, a comparison will be made between the new and novel agents to characterize the unique adverse effect profiles for each of these new medicines for managing the lifelong course of psychosis.

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INDUSTRY-SUPPORTED SYMPOSIUM 39—CLINICAL CHALLENGES IN THE TREATMENT OF DEPRESSION SUBTYPES Supported by Solvay Pharmaceuticals, Inc. and Pharmacia & Upjohn Company, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize and diagnose subsyndromal forms of depression, identify common clinical correlates of the presence of psychosis or comorbid psychiatric disorders in depression, and appreciate the specific therapeutic approaches with established efficacy in certain subtypes of unipolar depression.

No. 39A MINOR AND SUBSYNDROMAL DEPRESSION AND THEIR TREATMENT

Mark H. Rapaport, M.D., *Department of Psychiatry, University of California San Diego School of Medicine, 8950 Villa Jolla Drive, #2243, La Jolla CA 92037;* Lewis L. Judd, M.D.

SUMMARY:

This presentation reviews the overwhelming epidemiology suggesting that both minor depression and subsyndromal depressive symptoms adversely impact functioning and quality of life. New data will be presented investigating the disability associated with minor depression and subsyndromal depressive symptoms from a clinical sample. Data demonstrating the stability of these constructs over time will be discussed. Treatment data from both psychotherapy and pharmacotherapy trials of minor and subsyndromal depression will be presented. These findings suggest that patients who have minor and subsyndromal depression and demonstrated functional impairment benefit from either pharmacotherapy or psychotherapy. At the end of this presentation participants will be able to better conceptualize minor depressive disorder and subsyndromal depressive disorder within the spectrum of unipolar disorder. They will possess state of the art knowledge about the genetics, phenomenology, and treatment of minor depression and subsyndromal symptoms of depression.

No. 39B DYSTHYMIC DISORDER

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

SUMMARY:

Dysthymic disorder is a form of chronic depression that research increasingly shows has similarities with chronic major depressive disorder. In this presentation we will discuss the current diagnostic criteria and proposals for alterations of diagnostic criteria for dysthymic disorder and review the treatment approaches for this condition. The current literature provides increasing evidence for the efficacy of antidepressant medication and psychotherapy for the treatment of patients with dysthymic disorder. The SSRI's may be preferable to the tricyclic antidepressants because of the mild nature of dysthymic disorder and the emerging data noting decreased tolerability of tricyclic antidepressants in comparison with SSRI's for the treatment of patients with mild depressive states such as dysthymic disorder. Combined treatment studies (psychotherapy and pharmacotherapy) have to date not been reported but logically are the optimal treatment for a chronic depression condition.

No. 39C ANXIOUS DEPRESSION: TREATMENT APPROACHES

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

SUMMARY:

Major depression is frequently accompanied by comorbid anxiety disorders such as social phobia, panic disorder, and generalized anxiety disorder. When depression and anxiety co-exist, the term anxious depression is often used in the literature. In some cases, significant anxiety symptoms may occur in depressed patients who present with only subsyndromal forms of anxiety disorders. Although many patients with anxious depression have participated and participate in clinical trials in major depression, very few studies have examined the efficacy of drug treatment specifically in this population. In general, the presence of comorbid anxiety disorders in depressed patients has been found to predict poorer response to antidepressant treatment. However, it is unclear whether this is true for all antidepressants, as there may be some variability across different agents in their anxiolytic effect. Anxious depression is also often regarded as a common indication for the use of the combination of

antidepressant and antianxiety agents, in spite of the lack of clear evidence for the superiority of this combination over antidepressants alone. The co-occurrence of anxiety disorders in patients with major depression appears to predict relatively greater psychosocial impairment and psychological distress. A review and critique of the relevant literature on anxious depression will be presented.

No. 39D
DEPRESSION WITH ALCOHOL AND/OR DRUG ABUSE

Patrick J. McGrath, M.D., *171 Deerfield Lane North, New York NY 10570-1429;* Edward V. Nunes, M.D., Frederic M. Quitkin, M.D.

SUMMARY:

Depressive disorders occur commonly in the course of substance abuse and dependence and affect clinical outcomes. While much depression results from the toxic effects of alcohol and drugs, some represents independent mood disorder. Studies to be reviewed in this presentation have shown that antidepressant medication is efficacious in treating depression in alcoholics with primary depression, and in alcoholics with secondary depression that persists in abstinence. Antidepressants are not effective in reducing drinking in nondepressed patients. Studies to be reviewed among drug abusing and drug dependent subjects have shown similar results.

Among depressed alcoholics, antidepressants appear to decrease drinking among those whose depression responds. In the case of selective serotonin reuptake inhibitors (SSRI's), one study suggests that they may possibly also decrease drinking by a direct mechanism. Currently, SSRI's appear to be the treatment of choice for alcoholics with comorbid depression.

Effective management of substance abuse with depression requires accurate syndromal diagnosis of depressive and other comorbid disorders. Ideally this is done during a period of abstinence. Even when this is not possible, antidepressant treatment can be administered safely and effectively. Further studies are needed to delineate the role of antidepressants and other pharmacotherapy in the management of depressed substance abusers.

No. 39E
PSYCHOTIC DEPRESSION

Barbara Hochstrasser, M.D., *Department of Psychiatry, Privatklinik, PO Box 612, Meiringen, BE 3860, Switzerland*

SUMMARY:

Psychotic depression is considered as a distinct subtype of unipolar depression, albeit the clinical syndrome may present in the course of unipolar and bipolar disorder. This subtype has also been associated with both early and late onset of unipolar depression.

The treatment of psychotic depression remains a challenge for the clinician. Studies with tricyclic antidepressants have shown a small minority of patients responds to antidepressant therapy alone, with most psychotically depressed patients requiring a combination of both antipsychotic and antidepressant medication. Some of the newer antidepressants and antipsychotic agents may prove useful in the treatment of this form of depression. However, the use is still minimally documented. ECT appears to be the most effective and efficient treatment. This review will focus on the use of antidepressants and antipsychotics in psychotic depression.

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INDUSTRY-SUPPORTED SYMPOSIUM 40—RECENT ADVANCES IN PSYCHOPHARMACOLOGY
Joint Session with the American Society of Clinical Psychopharmacology, Inc., and Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to use new treatments for schizophrenia and bipolar disorder, should be able to treat depression and eating disorders, and should be able to employ new advances in geriatric psychiatry.

No. 40A
NEW TREATMENTS FOR SCHIZOPHRENIA

Carol A. Tamminga, M.D., *Department of Psychiatry, University of Maryland, P.O. Box 21247, Baltimore MD 20854*

SUMMARY:

Drug treatments for schizophrenia have greatly improved over the last decade and hold even greater promise for the future. The first wave of antipsychotic drugs introduced in the 1960's imparted significant antipsychotic action and great clinical benefit. These drugs we now call traditional antipsychotics emptied out state mental hospitals and allowed many persons suffering with schizophrenia a measure of symptom relief. In the four subsequent decades, however, the limitations of these treatment agents have become apparent: (1) they fail to treat symptoms at all in perhaps 20% of patients (treatment-refractory schizophrenia); (2) they have prominent motor side effects, which are uncomfortable, unsightly, and compromise compliance;

(3) other side effects like hypotension, cardiac arrhythmias, seizures, blood dyscrasias, and the like can be serious; and (4) they leave significant areas of mental dysfunction in schizophrenia largely untouched, e.g., primary negative symptoms and cognitive dysfunction. Clozapine led the wave of "new" antipsychotic drugs, even though the drug is not itself new. But it was shown to have a therapeutic advantage in treatment-refractory patients and a very low motor side-effect profile. Several new drugs have followed: first risperidone, then olanzapine, sertindole, quetiapine, and soon ziprasidone. These new neuroleptics all have a potent action on positive symptoms of psychosis, some action on negative symptoms, and a very low motor side-effect profile. Each of these new compounds has distinctive metabolic and pharmacokinetic profiles. *In vivo* human brain imaging has contributed to our knowledge of the action of these drugs. The primary actions of these new drugs may be similar; clinicians are looking for these drugs to distinguish themselves on secondary actions and/or on side effects.

No. 40B
ANTICONVULSANTS IN BIPOLAR DISORDER

Joseph R. Calabrese, M.D., *Department of Psychiatry, Case Western Reserve University, 11400 Euclid Avenue, Suite 200, Cleveland OH 44106-3986*

SUMMARY:

Over the last quarter of a century, there have been no published placebo-controlled maintenance treatment trials in bipolar disorder. Based on the older literature, lithium has been viewed as an extremely effective form of treatment for bipolar disorder. Recent naturalistic data, however, suggest lithium's response rate has deteriorated substantially over the past two decades, with reported nonresponse rates varying between 40% and 54% over 1.7- to four-year follow-up periods. These relapse rates are due not only to pharmacotherapeutic treatment nonresponse, but also poor compliance and the less than optimal use of psychotherapy. In addition, recent studies have employed nomenclatures that have allowed for the inclusion of more lithium refractory variants of illness such as mixed states, rapid cycling patterns of presentation, and the presence of mood incongruent psychotic symptoms. The inclusion of these treatment-refractory variants appears to have contributed substantially to the apparent deterioration in lithium's response rate. This presentation with review the evolving role of anticonvulsants in the treatment of bipolar disorder including the presentation of new data regarding the spectrum of prophylactic efficacy of divalproex sodium versus lithium and placebo in the maintenance treatment of bipolar disorder.

No. 40C
TREATMENT OF CHRONIC DEPRESSION

James H. Kocsis, M.D., *Department of Psychiatry, New York Hospital, 525 East 68th Street, Box 147, New York NY 10021-4873*

SUMMARY:

Many chronic depressions continue to go undetected or to get misdiagnosed as personality disorders or medical illness. Since the inclusion of dysthymia in the affective disorders section of DSM-III in 1980, much progress has been made on classification, epidemiology, and treatment of chronic depression. Randomized clinical trials using various antidepressant medications have now been completed in patients having dysthymia with or without concurrent major depression, i.e., double-depression, pure dysthymia. These studies have established the effectiveness of tricyclic antidepressions and selective serotonin reuptake inhibitors for the treatment of at least a subset of chronic depressions. Two maintenance treatment trials have recently been completed showing the efficacy of antidepressants for long-term treatment of chronic depression.

Patients with chronic depression who respond to treatment with medication have also been found to have remarkable improvement in social, interpersonal, and vocational functioning, which suggests that many of these disabilities may represent chronic symptoms of affective illness.

This paper will review and discuss these findings.

No. 40D
CURRENT TREATMENTS FOR EATING DISORDERS

B. Timothy Walsh, M.D., *Clinical Psychopharmacology, New York State Psychiatric Institute, 722 West 168th Street, Unit 98, New York NY 10032-2603*

SUMMARY:

There has been substantial progress in the last 10 years in the development of psychopharmacological treatments for eating disorders.

Progress in the treatment of bulimia nervosa has been most dramatic. Approximately 15 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 interventions.

Progress has also been made in the treatment of binge eating disorder, which was first described in DSM-IV. Several studies suggest that antidepressant medication and the serotonergic agent fenfluranine may be useful in the treatment of this illness.

Anorexia nervosa remains relatively refractory to pharmacological intervention. However, a recent study suggests that patients with this illness who have regained to a near-normal body weight may relapse less frequently when treated with fluoxetine.

No. 40E
ADVANCES IN GERIATRIC PSYCHIATRY

J. Craig Nelson, M.D., *Department of Psychiatry, Yale University, 20 York Street, New Haven CT 06504*

SUMMARY:

Geriatric psychiatry is a rapidly expanding area, in part related to the growth of the elderly population and in part related to an increased interest in treatment of the elderly by investigators in the field. Three specific advances in treatment, selected from a review of geriatric psychopharmacology topics, will be highlighted. Alzheimer's disease, once thought to be an untreatable illness, is now an active area of investigation. Two drugs have been marketed for symptomatic treatment of memory disturbance in dementia. Their characteristics and indications will be reviewed. Clinical questions such as when to treat memory disturbance, how to assess response, and how long to continue treatment, will be addressed. A related topic involves treatment of behavioral disturbance in dementia. The evolving status of treatments for behavior disturbance will be discussed and a simple algorithm presented. The third issue is the treatment of psychosis in Parkinson's disease. This presents a particular challenge for the psychopharmacologist because the conventional neuroleptics, used to treat psychosis, can cause parkinsonism or exacerbate symptoms of Parkinson's disease. Alternatively, dopaminergic agents used to treat Parkinson's disease, can cause psychosis. Clozapine appears

to be a particularly effective treatment for psychosis in Parkinson's disease and represents a significant advance in the treatment of this problem. The use of clozapine and other atypical neuroleptics in this condition will be reviewed.

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INDUSTRY-SUPPORTED SYMPOSIUM 41—TREATING THE DIFFICULT-TO-TREAT DEPRESSED PATIENT

Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize patients who aren't responding to their first antidepressant, diagnose depression in patients with personality disorders, understand the impact of hormones on depression, differentiate antidepressant based on cardiac safety profile, understand the diagnosis and treatment issues specific to the elderly, and choose the appropriate antidepressant for difficult to treat patients.

No. 41A
WHEN THE DEPRESSED PATIENT IS NOT RESPONDING

Steven P. Roose, M.D., *Clinical Psychopharmacology, New York State Psychiatric Institute, 722 West 168th Street, PI 98, New York NY 10032*

SUMMARY:

Although depression is considered a treatable illness, as many as 40% of patients do not respond to their first treatment. When faced with the depressed patient who is not getting better as expected, clinicians ask themselves, How long do I wait? and What do I do next? Intrinsic in the latter question is the confidence that what I have done so far is adequate. There is some consensus on what constitutes an "adequate" trial of a tricyclic (TCA) with respect to dose and duration. However, the selective serotonin reuptake inhibitors (SSRI's) have replaced the TCA's as the first treatment for depression in most patient populations, and so a compelling question is, What dose and duration of SSRI treatment is optimal? This information is necessary for the clinician to decide when to change treatments. To make this critical decision, the clinician needs to know the conditional probabilities of future response given nonresponse at an earlier time point, that is, If my patient is not better now, what is the chance the patient will be better after one, two, or three more weeks of the same treatment? Unfortunately, once a decision has been made to change treatments, the methodological problems inherent in studying second treatments for depression have limited the available data. This talk will review the extant information on several treatment options, including changing from one class of antidepressant medication to another, switching from one SSRI to another, and augmenting SSRI therapy with concomitant administration of lithium or a TCA.

No. 41B
ANTIDEPRESSANT USE IN PATIENTS WITH HEART DISEASE

Alexander H. Glassman, M.D., *Clinical Psychopharmacology, New York State Psychiatric Institute, 722 West 168th Street, New York NY 10032-2603;* Peter A. Shapiro, M.D., Steven P. Roose, M.D.

SUMMARY:

Patients who overdose with tricyclic antidepressants (TCA's) commonly die from cardiovascular causes associated with high doses of these drugs. At usual therapeutic doses in patients free of heart disease, orthostatic hypotension is the only cardiovascular complication that occurs frequently with the TCA's. In patients with preexisting cardiovascular disease, the problems are multiplied. Orthostatic hypotension is much more common and patients with preexisting conduction disease are at risk for heart block. Finally, patients with ischemic heart disease may have a greater risk of mortality. These problems, combined with the evidence that depression adversely affects the course of heart disease, raised interest in the safety of the SSRI's as alternative antidepressants. In depressed patients free of cardiac disease, there is almost no evidence of serious complications. However, the current data on SSRI use in patients with heart disease have been limited. There are only three unpublished studies involving 96 patients with known heart disease. Results of these studies showed no evidence of cardiac complications, which is consistent with safety data on SSRI's in overdose; however, further testing in patients with heart disease is needed. Although it has been suggested that there are differences among SSRI's in the complications associated with overdose, death very rarely occurs and only in the presence of massive dose ingestion. This makes comparisons difficult, but the clinician should remember that massive doses of any antidepressant can be dangerous.

No. 41C
TREATMENT OF DEPRESSION WITH COMORBID PERSONALITY DISORDERS

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

SUMMARY:

The presence of one or more personality disorders complicates the diagnosis and treatment of depression. In the NIMH Treatment of Depression Collaborative Research Project, the investigators found that patients with personality disorders who were also depressed had poorer outcomes in social functioning and a much greater likelihood of residual depressive symptoms compared with depressed patients who did not have personality disorders. This presentation will review the common types of personality disorders associated with depression, review data on the prevalence of comorbidities, and discuss the difficulties of diagnosing a personality disorder when a patient is also depressed. Treatment strategies for depressed patients with comorbid personality disorders will also be discussed. Both pharmacotherapy and psychotherapy may be useful, and there are preliminary data suggesting that some antidepressants may have a positive impact on symptoms that are not considered part of the depressive illness. The implications for understanding of state versus trait and Axis I versus Axis II conditions will be discussed.

No. 41D
ESTROGENS AND PROGESTINS: DO THEY CAUSE OR TREAT MOOD DISORDERS?

Kimberly A. Yonkers, M.D., *Department of Psychiatry, University of Texas Southwestern Medical Center, 5959 Harry Hines Boulevard, #520, Dallas TX 75235-9070;* Karen Bradshaw, M.D.

SUMMARY:

Clinical lore suggests that estrogens have mood-elevating properties, while progestins have been implicated in the genesis of dysphoric symptoms. Recent biological data from patch clamp and rodent studies lend evidence to support the activating effects of estradiol and the sedating effects of progesterone. For example, beta-estradiol has been shown to augment the activity of excitatory neurotransmitters such as glutamate. Conversely, selected metabolites of progesterone have been shown to augment the inhibitory transmitter, GABA, and to have anesthetic properties. In animal models, progesterone metabolites have shown anxiolytic properties. It remains unclear whether basic and animal data for estrogen and progesterone are relevant for humans. Data regarding antidepressant effects of estrogen are mixed and neither dysphoric-inducing nor anxiolytic properties have been convincingly shown in women administered progestin or natural progesterone. However, a recent, double-blind study has demonstrated that elderly depressed women on estrogen replacement therapy (ERT) who received a selective serotonin reuptake inhibitor (SSRI) had a substantially greater mean HAM-D percentage improvement than women on ERT who received placebo. The investigators concluded that ERT may augment the response of the SSRI. This presentation will review available human data apropos to the mood modifying effects of exogenous estrogens (with or without concomitant SSRI therapy), progestin, and oral contraceptives.

No. 41E
TREATMENT OF DEPRESSED PATIENTS WITH COGNITIVE IMPAIRMENT

Carl G. Gottfries, Ph.D., *Department of Neuroscience, Goteborg University, Molndal Hospital, S-43180 Molndal, Sweden*

SUMMARY:

Depression in the elderly is a common condition that often presents with a predominance of somatic symptoms, including cognitive impairment. Neurodegenerative conditions, such as Alzheimer's disease or Parkinson's disease, are associated with increased rates of depression. Although the diagnosis of depression in patients with dementia is problematic, it has been repeatedly documented that most patients with dementia have affective symptoms. Tricyclic antidepressants (TCA's) are effective in the treatment of late-life depression; however, their side-effect profile limits their use in the elderly. This is particularly so in patients with cognitive impairment because of the anticholinergic effects of the TCA's. The selective serotonin reuptake inhibitors (SSRI's) have a different side-effect profile than that of the TCA's and, in particular, do not have anticholinergic effects. Clinical trials of SSRI's in elderly depressed patients with cognitive impairment and in patients with dementia suggest that SSRI treatment improves some dimensions of cognitive functioning, including specific performance tasks and recent and distant memory. SSRI treatment may be especially advantageous for the patient with affective symptoms and cognitive impairment.

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INDUSTRY-SUPPORTED SYMPOSIUM 42—PRACTICAL CLINICAL STRATEGIES FOR MANAGING REFRACTORY DEPRESSION, AGITATION, AND ANTIDEPRESSANT SIDE EFFECTS: NEW ADVANCES IN AUGMENTATION AND AGITATION TREATMENT STRATEGIES Supported by Bristol-Myers Squibb

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) understand mechanisms of action, metabolism, and management of side effects of newer antidepressants, (2) recognize and treat sleep disturbances and sexual dysfunction in depressed patients, (3) provide pharmacologic augmentation strategies and management of agitation in the elderly.

No. 42A
AUGMENTATION STRATEGIES FOR THE NEWER ANTIDEPRESSANTS

Lauren B. Marangell, M.D., *Department of Psychiatry, Baylor College of Medicine, One Baylor Plaza #110D, Houston TX 77030*

SUMMARY:

Although antidepressant medications are highly effective, 30% to 40% of patients do not respond to an initial course of treatment, and many more have only partial responses. Augmentation strategies are vital tools for achieving a more clinically meaningful treatment response. The goal of augmenting an antidepressant medication is to produce pharmacologic synergy in order to increase the magnitude of antidepressant response. This strategy has the advantage of often being more rapidly effective than switching to another monotherapy. This presentation will review the indications and conceptual framework for augmenting the newer antidepressants, and then present clinically useful guidelines for both common and novel augmentation strategies.

No. 42B
CLINICAL PEARLS IN MANAGING AGITATION IN THE ELDERLY

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

SUMMARY:

Agitation, ranging from mild irritability to overtly aggressive behavior, affects up to 80% of patients with dementia sometime during the course of the illness. A variety of triggers for agitation have been identified. These include delirium, psychosis, and the presence

of a mood disorder or anxiety disorder. Concomitant medical disorders and painful states may also be implicated. Use of a behavioral diary to guide interventions and environmental modifications may be helpful. Targeted pharmacotherapy includes the use of neuroleptics, mood stabilizers, serotonergic agents, as well as estrogen.

REFERENCES:

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2. Zayas EM, Grossberg GT: Treating the agitated Alzheimer's patient, J Clin Psychiatry, pp. 1–6, 1996

INDUSTRY-SUPPORTED SYMPOSIUM 43—NEUROCOGNITION IN SCHIZOPHRENIA
Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize neuropsychological tools used to demonstrate deficits and describe a model for categorizing the deficits into clinically pertinent subgroups and compare differences in measured deficits between first break patients and densely refractory elderly schizophrenic subjects.

No. 43A
NEUROCOGNITIVE DEFICITS IN SCHIZOPHRENIA: TRAITS OR STATES?

Keith Nuechterlein, Ph.D., *University of California Los Angeles, Neuropsychiatric Institute, 760 Westwood Plaza, Los Angeles CA 90024*

SUMMARY:

Research has indicated that certain subtle abnormalities in perceptual and memory functions are often present even during clinically remitted periods in many individuals with schizophrenia and among some of their first-degree relatives. Some of these anomalies are likely to be components of the neurocognitive predisposition to schizophrenia and convey an enduring, stable proneness to development of schizophrenic symptoms. Other neurocognitive abnormalities are more closely related to the current clinical state of the individual with schizophrenia. Some of these are probably secondary to symptoms, while others are likely to be direct contributors to the onset of certain types of schizophrenic symptoms. This presentation will describe several prominent types of neurocognitive deficits in schizophrenia and their trait vs. state characteristics. Anomalies in early perceptual processing and vigilance are found to persist at a stable level into clinical remission. Abnormalities involving activated or working memory show significant change with clinical state and may be mediating vulnerability factors for development of negative symptoms. Recent evidence showing the importance of neurocognitive deficits for predicting and influencing work and social functioning in schizophrenia will be described. Increased recognition of substantial individual differences among schizophrenia patients in the extent of various neurocognitive deficits would strengthen treatment decision-making.

No. 43B
FUNCTIONAL OUTCOME CORRELATES OF NEUROCOGNITIVE DEFICITS IN SCHIZOPHRENIA

Michael F. Green, Ph.D., *Department of Psychiatry, University of California, P.O. Box 6022, Camarillo CA 93011*

SUMMARY:

Many of the neurocognitive deficits in schizophrenia appear to be central features of the illness that are independent of the symptoms, medications, and the effects of institutionalization. While these deficits have been well-established, it is not known how they influence the daily life of patients. A growing literature has sought to determine which, if any, neurocognitive deficits are linked to the daily functioning of schizophrenic patients. Outcome areas have included: (1) prospective studies of community functioning, (2) cross-sectional studies of social problem solving, and (3) studies of the neurocognitive correlates and predicators of psychosocial skill acquisition.

Despite wide variation in the selection of neurocognitive measures across studies, some consistencies can be noted. Verbal memory was associated with all types of functional outcome; vigilance was related to social problem solving and skill acquisition; and executive functioning predicted community functioning. In terms of symptoms, negative symptoms were associated with social problem solving. Notably, psychotic symptoms were not significantly associated with outcome measures in any of the studies reviewed. It appears that capacities such as verbal memory and vigilance are necessary for adequate functional outcome. Because of their relationship to outcome, these deficits present likely targets for behavioral and/or pharmacological interventions.

No. 43C
SPATIAL WORKING MEMORY IN SCHIZOPHRENIA

Susan R. McGurk, Ph.D., *Department of Psychiatry, Vanderbilt University, 1601 23rd Avenue South, #306, Nashville TN 37212*

SUMMARY:

As suggested by Baddeley, working memory refers to a mental system for the temporary holding and manipulation of information that is no longer physically present. Spatial working memory is measured by delayed response tasks where accurate responding depends on the formation of an internal representation of the location of a stimulus across the delay period. Extensive studies in nonhuman primates using delayed response tasks have demonstrated that the dorsolateral prefrontal cortex is involved in the cross-temporal maintenance of spatial locations. Neurochemical studies have demonstrated that dopamine 1 receptor antagonists and antimuscarinic agents impair performance on this task. Schizophrenia patients have demonstrated impaired performance on spatial working memory tasks (Park and Holzman, 1992). Deficits in spatial working memory in schizophrenia are consistent, and correlated with impaired performance on other putative measures of the dorsolateral prefrontal cortex, such as the Wisconsin Card Sort (McGurk et al., 1996), and with negative symptoms. Thus far, spatial working memory has been shown to be improved by risperidone and impaired by antimuscarinic agents in schizophrenia patients (McGurk et al., 1996). The effects of other atypical antipsychotic medications on spatial working memory and the impact of risperidone on additional neurocognitive domains will be discussed.

No. 43D
COGNITIVE DEFICITS IN FIRST-EPISODE SCHIZOPHRENIA

Kimberly P. Good, Ph.D., *Department of Psychiatry, Dalhousie University, 5909 Jubilee Road, Suite 3136, Halifax, NS, Canada B3H 2E2;* Lilli C. Kopala, M.D.

SUMMARY:

Prior studies documenting cognitive deficits in patients with schizophrenia examined predominantly chronically ill, hospitalized individuals. Recently, there has been more interest in evaluating patients in the early phases of illness. Data suggest that the early detection and treatment of psychotic illness will result in superior functional outcomes. With the development of novel antipsychotic medications, the effective treatment of positive and negative symptoms without troublesome extrapyramidal side effects has allowed us to focus on cognitive function. Superior outcomes are related to consistent compliance with antipsychotics—a challenge for individuals who perceive their functioning to be worsened by medication.

Some, but not all, first-episode patients have interference with executive function memory or attention. Typical antipsychotic medications and the anticholinergics or benzodiazepines, which are generally co-administered, doubtless further compromise impairment. The possibility of preventing worsening of cognitive embarrassment or curtailing decline over time is of great interest. During this presentation, clinical and cognitive data from a first-episode sample will be discussed.

No. 43E
COGNITIVE CHANGES WITH AGING IN SCHIZOPHRENIA

Philip D. Harvey, Ph.D., *Department of Psychiatry, Mt. Sinai Medical Center, One Gustave L. Levy Place, New York NY 10029*

SUMMARY:

Cognitive impairment is a common feature of schizophrenia and has been linked to several other features of the illness, including negative symptoms and impaired functional outcome. In late-life patients with schizophrenia, there appears to be considerable variability in the severity of impairment. Patients with good lifetime adaptive outcome and patients with a late-life onset of illness have cognitive impairments that are no more severe than those seen in younger patients. Poor outcome patients, especially those with a lifetime chronic course illness, have a very different presentation. As many as two-thirds of geriatric poor outcome patients meet clinical criteria for dementia, although neuropathological stigmata associated with degenerative conditions such as Alzheimer's disease (AD) are not found at postmortem. The profile of impairment in performance appears different from AD, in that there is sparing of recall memory and preservation of recognition memory in schizophrenia. Although the course of cognitive decline is not rapidly progressive as in AD, some geriatric patients with chronic schizophrenia manifest a distributed pattern of stepwise cognitive decline that may be correlated with episodes of symptomatic exacerbation. Finally, overall functional status appears more strongly correlated with cognitive functioning than with any other symptom of schizophrenia, across age and outcome status of the patients.

No. 43F
IMPACT OF ANTIPSYCHOTIC PHARMACOTHERAPY ON NEUROCOGNITION

William C. Wirshing, M.D., *Department of Psychiatry, West Los Angeles Veterans Affairs Medical Center, 11301 Wilshire Boulevard (B-151H), Los Angeles CA 90073*

SUMMARY:

Although the acute use of atypical antipsychotic medication appears to impair certain attentional measures in normal controls, their chronic use in schizophrenic subjects seems to improve measures of continuous performance. Their impact on new learning (e.g., secondary verbal memory) and executive system measures (e.g., Wisconsin Card Sort, Trails B, Stroop Test, etc.) is highly variable, but in general ranges from a null to slightly deleterious in effect. Atypical antipsychotic molecules of which clozapine is the prototype, like their conventional counterparts, have been demonstrated to have a variable impact across a reasonably wide range of neurocognitive domains. Such variability is to be expected given the fact that these drugs as a group vary considerably in their sedative potential, their inherent antimuscarinic characteristics, and the putative mechanisms whereby they exert their antipsychotic and toxic effects. In general, however, they seem to be somewhat superior to the older medications in impacting neurocognitive domains. This presentation will focus on the methodology used to demonstrate the pharmacotherapeutic impact on neurocognition, the apparent differences between typical and atypical molecules on various measures of neurocognitive performance, and the theoretical neuromolecular basis for the mediation of these observed differences.

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INDUSTRY-SUPPORTED SYMPOSIUM 44—MANAGEMENT OF MENTAL DISORDERS IN BABY BOOMERS AND BEYOND
Supported by U.S. Pharmaceuticals, Pfizer Inc

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to develop effective strategies to manage depression, anxiety, dementia, and psychosis both independently and collectively.

No. 44A
AGING AND ADAPTATION TO LIFE: A PSYCHIATRIC PERSPECTIVE

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

SUMMARY:

Recent research suggests that affective disorder is associated with increased mortality and physical morbidity, but the reasons for this association remain uncertain. This report describes a 50-year prospective study of 240 men evaluated from the time they were university students in 1940–1942. A family history of mental illness was obtained and the men's habits, psychological adjustment, and marital and occupational satisfaction were followed every two years and their objective physical health was tracked every five years until age 70. Twenty-five men were identified as having affective spectrum disorder prior to age 53. Of the variables studied, the presence of affective spectrum disorder was the most powerful predictor of poor psychosocial outcome at age 65 and one of the most powerful predictors of poor physical health. Alcohol abuse and cigarette abuse accounted for the observed increased rates of heart disease and cancer. When alcohol abuse, smoking, and suicide were controlled for, affective disorder made a significant contribution to physical morbidity by age 70, but not to mortality from natural causes. Affective spectrum disorder, even in an educated population without antisocial trends, carries a profound negative risk to late-life physical and social adjustment.

No. 44B
LATE-LIFE DEPRESSION

Donald P. Hay, M.D., *Department of Psychiatry, St. Louis University, 1221 S. Grand Boulevard, St. Louis, MO 63104*

SUMMARY:

Individuals over the age of 65 constitute 13% of our population and those over 85 are the fastest growing cohort in our society. By the year 2020 it is anticipated that there will be more persons over the age of 65 than under 18, and by the year 2080, that there will be more than one million over the age of 100. The prevalence of major depressive disorder in the elderly is estimated at 1% to 2%, and in the acute hospital or nursing home as much as 13%. Symptoms of depression or subsyndromal depression in the elderly may approach 20%. The comorbidities of depression and dementia may approach 30%, and the mortality rate of patients with dementia in the nursing home with comorbid depression may increase by greater than 20%. The elderly represent 13% of our population but account for 25% of all suicides. The treatment of depression with the six main groups of pharmacologic agents will be discussed along with the strategies of maintenance therapy, ECT, and transmagnetic stimulation.

No. 44C
ANXIETY AND DEPRESSION

Carl Salzman, M.D., *Department of Psychiatry, Harvard Medical School, 74 Fenwood Road, Boston MA 02115-6106*

SUMMARY:

Anxiety, agitation, and insomnia are common and often serious complaints in the elderly. There are multiple causes for each of these symptoms, but the causes often overlap so that one older person is likely to experience all three simultaneously. The first goal is a careful medical and clinical evaluation in order to eliminate any causes of these problems such as medication side effects. Treatment of the three symptoms may also overlap although there are distinct differences: *Anxiety:* Short half-life benzodiazepines are often helpful for the management of acute anxiety and stress circumstances. Doses need to be low and side effects that are common in the elderly include falls, discoordination, and reversible memory impairment. Benzodiazepines are less useful for the anxious demented person. *Agitation:* Neuroleptics remain the primary class of anti-agitation medication, especially for the demented or psychotic elderly patient: traditional neuroleptics such as haloperidol or newer atypical neuroleptics such as risperidone and olanzapine. Non-neuroleptic medication has increasingly been used for late-life agitation: trazodone, buspirone, valproate, SSRIs, beta blockers. Each class of drugs may have its own side-effect profile, necessitating low doses and cautious treatment. *Insomnia:* Many causes of late-life insomnia are treatable without medication. When medication is required, short half-life, low potency benzodiazepines such as temazepam or the benzodiazepine-like drug zolpidem may be useful. Non-benzodiazepine sedating medications are also commonly used, including trazodone and nefazodone. Low doses of the new antidepressant mirtazapine may also be helpful.

No. 44D
INTERFACE OF DEPRESSION AND MEDICAL ILLNESS

Richard C. Veith, M.D., *Director, Geriatric Research, Education and Clinical Center; 182B, Veterans Affairs Puget Sound Health Care System, 1660 S. Columbian Way, Seattle WA 98108-1532*

SUMMARY:

Depression frequently complicates the clinical course and management of patients suffering from acute and chronic medical illness. Growing evidence indicates that the presence of major or subsyndromal depression in this setting is an important predictor of increased mortality, functional impairment, and excess disability, and increased utilization of health care services. For example, depression occurring in the six-month period of recovery following myocardial infarction has been associated with a five-fold increase in mortality that is not attributable to differences in heart disease severity. This presentation will focus on these potential consequences of depression in the medical setting, with an emphasis on heart disease, diabetes, and cancer.

No. 44E
BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA

Sanford I. Finkel, M.D., *Department of Psychiatry, Northwestern University, 303 East Ohio, Suite 550, Chicago IL 60611*

SUMMARY:

The presence of the behavioral (e.g., hitting, wandering) and psychological (e.g., delusions, hallucinations, depression) signs and symptoms of dementia substantially increase the risk of institutionalization, as caregivers are unable to manage or tolerate them. BPSSD leads to diminished quality of life for both patient and caregivers, substantially increases financial costs, and contributes to caregiver burden and stress. Many of these signs and symptoms are frequent and intense, as patients become psychotic, depressed, agitated, and develop changes in their circadian rhythm pattern, changes in psychomotor activity, and aggressive behavior. BPSSD can be treated through a wide range of pharmacologic and nonpharmacologic interventions, including traditional and newer neuroleptic medications, anticonvulsants, background music, bright lights, electronic devices (e.g., alarms and bracelets), recreational and activity therapy, and a wide range of interpersonal interactions. Successful interventions and treatments decrease the potential for premature institutionalization. Caregiver education, therapeutic intervention, and environmental adjustments are often a critical component of the treatment plan. Finally, approaches to BPSSD in the nursing home and the community will be compared and contrasted.

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INDUSTRY-SUPPORTED SYMPOSIUM 45—PREDICTING OUTCOMES OF ANTIDEPRESSANT TREATMENT Supported by Pharmacia & Upjohn Company, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the biological and psychosocial predictors of outcome in antidepressant treatment, and understand their applications to patient care.

No. 45A CLINICAL PREDICTORS OF RESPONSE TO ANTIDEPRESSANTS

Andrew A. Nierenberg, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 812, Boston MA 02114-3117;* Jordan W. Smoller, M.D.

SUMMARY:

Researchers have been searching for clinical predictors to treatment outcome with antidepressants ever since the introduction of these medications into clinical practice. If a variable or set of variables could reliably predict outcome to treatment, then treatment could be tailored to individual patients by using a set of rational guidelines. Clinicians would know who needed medication and who did not. Of those who needed medication, predictors would determine which medication would work the best. Melancholia predicts nonresponse to placebo, atypical depression predicts nonresponse to TCA's, psychosis predicts nonresponse to antidepressants alone, and comorbid OCD predicts the need for serotonergic agents. Unfortunately, outside of these few exceptions, most clinical predictors are of academic interest with limited clinical usefulness. This presentation will critically evaluate those predictors of response that are helpful in clinical practice and those that are not. Conceptual, methodological, statistical, and clinical challenges in developing and interpreting data on predictors will be reviewed.

No. 45B NEUROPHYSIOLOGIC PREDICTORS OF TREATMENT RESPONSE

Ian A. Cook, M.D., *Department of Psychiatry, Neuropsychiatric Institute, 760 Westwood Plaza, NPI 37-443, Los Angeles CA 90024-1759;* Andrew F. Leuchter, M.D., Sebastian H.J. Uijtdehaage, Ph.D., Michelle Abrams, R.N., Catherine Anderson-Hanley, Ph.D., Susan Rosenberg-Thompson, M.N., Jennifer Dunkin, Ph.D.

SUMMARY:

Predicting individual response to any given antidepressant remains problematic. Neuroimaging studies suggest response is accompanied by shifts in cerebral energy utilization, but have not provided useful pretreatment markers. We employed quantitative EEG (QEEG) techniques to investigate neurophysiologic features that identify responders and nonresponders to fluoxetine, using pretreatment and early treatment EEG's.

In a double-blind, eight-week protocol, 20 adults with unipolar depression were studied while receiving fluoxetine (20 mg) or placebo. Neurophysiology was assessed before treatment and serially with cordance, a QEEG measure reflecting cerebral energy utilization.

Higher pretreatment cordance was associated with a more robust response to fluoxetine; higher cordance subjects showed lower final Hamilton Depression scores (7.8 ± 9.8 vs 18.0 ± 6.7 ($p < 0.05$)). Higher- and lower-cordance subjects did not differ on pretreatment clinical or historical features. Response to placebo was not related to pretreatment cordance, but when placebo subjects entered fluoxetine treatment after eight weeks, those with higher cordance had a more robust response. Cordance changes in the first two weeks further distinguished responders from nonresponders. Responders uniquely showed decreases in frontal cordance ($p<0.05$) as early as 48 hours, while nonresponders failed to exhibit decreased cordance.

No. 45C NEUROTRANSMITTER DEPLETION AND OUTCOME IN DEPRESSION

Pedro L. Delgado, M.D., *Department of Psychiatry, University of Arizona School of Medicine, 7402 AHSC, 1501 N. Campbell Avenue, Tucson AZ 85724;* Francisco A. Moreno, M.D., Rebecca L. Potter, M.D., Alan J. Gelenberg, M.D.

SUMMARY:

Purpose: Prediction of clinical outcome in patients with depressive disorders is an important goal given the chronic nature of these conditions and the high cost to the individual and society. Recently, safe methods have been developed to perform rapid but short-term depletion of serotonin or norepinephrine in humans. Some studies have suggested that the behavioral responses of patients to neurotransmitter depletion tests may predict clinical outcome. This presentation will review past and current research using neurotransmitter depletion paradigms to predict treatment outcome in patients with major depression. *Content*: Results will be presented from investigations using acute tryptophan (TRP) depletion or catecholamine depletion with alpha-methyl-para-tyrosine (AMPT) challenge testing in a variety of treated and untreated depressed patients and age-, gender-matched healthy subjects (no personal or family history of any mental illness). *Results*: Subjects who experience depressive symptoms during TRP or catecholamine depletion are more likely to develop future episodes of major depression. Antidepressant-treated depressed patients who experience depressive symptoms during TRP depletion are at higher risk for recurrence of depression during continuation treatment. *Implications*: Monoamine depletion challenge strategies may provide a clinical test that (in a manner analogous to a cardiac stress test) allows for clinical identification of individuals at higher risk for future illness or a more unstable course of illness. Ongoing studies continue to assess the positive and negative predictive value of neurotransmitter depletion paradigms for treatment outcome.

No. 45D NEUROIMAGING INDICATORS OF TREATMENT EFFECTIVENESS

Harold A. Sackeim, Ph.D., *Department of Psychiatry, Columbia University, 722 168th Street, Unit 72, New York NY 10032*

SUMMARY:

Neuroimaging indicators of the effectiveness of antidepressant treatments should be distinguished in terms of the structural or functional measures that predict antidepressant response prior to the

initiation of treatment and the changes in patterns of functional brain activity that accompany antidepressant response. Implicit in this distinction is the conceptual possibility that the changes in patterns of functional brain activity that accompany antidepressant response do not necessarily involve reversal of baseline deficits. Some of the most promising findings regarding prediction concern the presentation of encephalomalacia, MRI hyperintensities in deep white matter and subcortical gray matter structures. Such patients tend to have inferior response to ECT and antidepressant medications. There is also evidence that patients who fail to increase cerebral blood flow in response to hypercapnic challenge have inferior response to ECT. Both sets of findings suggest that severity of ischemic cerebral vascular disease may predict antidepressant response. Response to sleep deprivation and ECT appear to be linked to reduced functional activity in specific cortical and limbic regions, and sleep deprivation responders may have elevated levels at baseline. A consistent pattern of changes in functional activity with response to antidepressant medications has yet to be identified.

No. 45E
DIFFERENTIAL THERAPEUTIC RESPONSES IN DEPRESSION

Andrew F. Leuchter, M.D., *Department of Psychiatry, Neuropsychiatric Institute, 760 Westwood Plaza, NPI 37-452, Los Angeles CA 90024-8300;* Ian A. Cook, M.D., Michelle Abrams, R.N., Catherine Anderson-Hanley, Ph.D., Susan Rosenberg-Thompson, M.N., Sebastian H.J. Uijtdehaage, Ph.D., Jennifer Dunkin, Ph.D.

SUMMARY:

There is considerable heterogeneity in treatment response among depressed patients. Although most patients respond to the first antidepressant administered, up to 45% may require treatment with a second or third agent. In addition, 20% to 60% of depressed patients who receive placebo have a partial or complete remission of symptoms. Pretreatment clinical characteristics of patients are weak predictors of which patients will benefit from any specific medication. In studies of 35 subjects with major depression, we evaluated cordance as a predictor of differential responsiveness to antidepressant medication. Subjects were treated in double-blind, placebo-controlled trials with either a serotonergic or noradrenergic medication. Subjects with higher pretreatment cordance were most likely to benefit from treatment with a selective serotonergic antidepressant, while those with lower pretreatment cordance were most likely to benefit from an antidepressant with a mixed/noradrenergic neurochemical profile. After the start of treatment, all subjects who showed eventual clinical response had substantial reductions in frontal brain activity within 48 hours of starting medication. Conversely, the placebo responders showed significant increases in frontal brain activity within 48 hours. Changes in both groups persisted over several weeks of therapy. These results indicate that brain neurophysiology may identify subgroups of subjects with differential responses to antidepressant medication and placebo.

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INDUSTRY-SUPPORTED SYMPOSIUM 46—THERAPEUTIC CHALLENGES IN GERIATRIC PSYCHIATRY
Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the symptoms and functional effects of the major late-life mental disorders; determine the most likely underlying disease; and determine the most appropriate behavioral and pharmacological treatment.

No. 46A
DIAGNOSIS AND BIOLOGY OF LATE-LIFE DEPRESSION AND DEMENTIA

P. Murali Doraiswamy, M.D., *Department of Psychiatry, Duke University Hospital, P.O. Box 3018, Durham NC 27710*

SUMMARY:

The current approach to the differential diagnosis of depression and dementia in the elderly requires a thorough familiarity with diagnostic criteria, differences in typical clinical presentations, common reversible etiologies, and the emerging pathophysiologic links between these syndromes. For example, epidemiological studies have reported that depression in late life may be a strong risk factor for dementia and may confer an additive risk with apolipoprotein E status. Similarly, the presence of multiple cerebrovascular risk factors, cognitive impairment, or neurological signs in an elderly subject with depression usually signals an organic etiology. MRI studies have reported hippocampal volume loss and PET studies have reported widespread metabolic deficits in both late-life depression and Alzheimer's disease. In addition, silent ischemic changes in the frontal lobe or basal ganglia may be found in 15% to 40% of subjects with late-life depression. The presence of occult vascular changes or lacunes on MRI is usually associated with a later age of onset of mood symptoms, apathy, and a higher risk for both falls and cognitive impairment. These and other data will be reviewed in relation to their practical relevance in the evaluation and differential diagnosis of depression and cognitive impairment in late life.

No. 46B
THE MANAGEMENT OF ANXIETY IN LATE LIFE

Alastair J. Flint, M.B., *Psychiatry, Toronto Hospital, 200 Elizabeth Street, 8 Eaton North, Toronto, ON, M5G 2C4, Canada*

SUMMARY:

Most cases of primary anxiety disorder in late life are chronic, having persisted from patients' younger years. Generalized anxiety and agoraphobia account for most late-onset anxiety. Late-onset generalized anxiety is usually associated with a depressive illness. On the other hand, the majority of individuals with late-onset agoraphobia do not have comorbid depression and they rarely have a history of panic attacks; the agoraphobia often starts after a traumatic event. These epidemiologic findings have important implications for the management of anxiety in later life. For example, they suggest that the pharmacological treatment of choice for late-onset generalized anxiety is antidepressant medication rather than a benzodiazepine, and that behavior therapy rather than pharmacotherapy is the preferred intervention for most older persons with agoraphobia. In this presentation, epidemiologic data will serve as a framework for discussing the management of each of the anxiety disorders and anxiety associated with depression. The presentation will also examine the complex interplay between physical illness, anxiety, and the medications used to treat these conditions. There will be a discussion of the adverse effect of anxiety on the acute treatment of geriatric depression and the contribution of residual anxiety symptoms to depressive relapse.

No. 46C
TREATMENT-RESISTANT DEPRESSION IN LATE LIFE

Benoit H. Mulsant, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh PA 15213-2593*

SUMMARY:

Successful treatment is one of the most effective ways to reduce disability, prevent morbidity, and improve overall quality of life in an elderly person with depression. However, up to one-half of older depressed patients do not respond to their initial antidepressant treatment, and up to one-third remain continuously ill for at least one year. Existing data suggest that most cases of apparently refractory depression are due to variables involving the diagnostic or treatment process, and are, in fact, only relatively refractory.

Comorbid medical or psychiatric conditions, unrecognized secondary depression, and misdiagnosis contribute to treatment resistance. For instance, the presence of comorbid anxiety delays treatment response, suggesting the need for longer treatment trials. Similarly, even though the presence of psychotic features may require the use of ECT or a combination of an antidepressant with a neuroleptic, mood-congruent psychotic features often are unrecognized in older patients with severe depression. When these features are recognized, adequate pharmacotherapy rarely is used. Older patients with depression and physical illness are likely to complain not only about depressive symptoms but also about a variety of somatic symptoms. An important relationship exists between depression-associated somatization, pseudo side effects, and premature treatment discontinuation. Finally, adequacy of treatment may be measured in terms of selection of specific agents, dosages, and duration of treatment. A rational, stepped-care approach to the elderly patient with treatment-resistant depression is proposed.

No. 46D
COMORBID DEMENTIA AND DEPRESSION IN LATE LIFE

Barnett S. Meyers, M.D., *Department of Psychiatry, New York Hospital-Cornell, 21 Bloomingdale Road, White Plains NY 10605*

SUMMARY:

Data from clinical settings demonstrate that over 20% of Alzheimer's patients meet criteria for major depression and that a 22% incidence of new depression occurs in this population when patients are followed over six years. The association with depression is strongest early in the course of the dementia and in patients with previous affective episodes.

Many other patients with dementia suffer significant depressive symptoms without meeting full diagnostic criteria. Depression also is seen commonly in patients with vascular dementia. Dementia with concurrent depression has been associated with excess disability and increased rates of mortality, underscoring the need for effective treatment.

Preliminary findings suggest an association between effective treatment and both symptomatic improvement and increased functioning. For example, uncontrolled studies have reported the effectiveness of somatic treatment for depression that accompanies dementia, and some reports have demonstrated an association between decreases in depression and improved cognition. A placebo-controlled study with the SSRI citalopram demonstrated decreased depressive symptoms and improved cognitive functioning in patients randomized to active medication.

Recent research findings on the diagnosis, prognosis, and treatment of concurrent dementia and depression will be summarized.

No. 46E
BEHAVIORAL DISTURBANCES OF DEMENTIA

Bruce G. Pollock, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh PA 15213-2593*

SUMMARY:

Noncognitive, behavioral complications—such as restlessness, disruptive vocalizations, physical aggression, and psychosis—are the most distressing and costly manifestations of dementia. Moreover, the potential benefit of pharmacotherapeutic treatment of these symptoms presently is greater than that for the core symptoms of Alzheimer's disease and other dementias. There is, however, need for rigorous clinical studies, particularly that control for the immense inter-individual variability in drug concentrations observed in older patient populations.

The pathophysiologic rationale for the use of dopamine (D2) receptor antagonists for the treatment of behavioral problems remains uncertain, and the elderly (especially those who are poor metabolizers) are particularly prone to both acute and chronic adverse effects of neuroleptics. In contrast, evidence is accumulating from *in vivo* biochemical and neuroendocrine studies that serotonergic deficits in dementia contribute to its psychiatric symptoms.

In a small open-label study, we found that 9 of 16 patients treated with the highly selective serotonergic antidepressant citalopram experienced significant reduction in disruptive vocalizations, as measured by computer-assisted, real-time observation. We currently are conducting a double-blind, placebo-controlled study of the neuroleptic perphenazine and the SSRI citalopram in the treatment of behavioral disturbances of dementia, with prospective phenotyping for both cytochrome P450 isoenzymes 2D6 and 2C19. This application of clinical pharmacological methods may substantially improve pharmacotherapy of late-life mental disorders.

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INDUSTRY-SUPPORTED SYMPOSIUM 47—PRACTICAL ALZHEIMER'S DISEASE MANAGEMENT: A COMPARATIVE REVIEW OF NEW COMPOUNDS, DIAGNOSIS, TREATMENT AND OUTCOMES ASSESSMENT

Supported by Eisai, Inc. Pfizer, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the cascade of pathogenetic events occurring in Alzheimer's disease and leading to cell death and neurochemical deficits; know the comparative advantages/disadvantages of each available and emerging treatment for AD; and learn which psychotropic agents are most useful in treating behavioral disturbances in AD.

No. 47A
RECOGNITION OF ALZHEIMER'S DISEASE: THE IMPORTANCE OF EARLY DIAGNOSIS TO DESIRABLE PATIENT OUTCOMES

Rachelle Doody, M.D., *Department of Neurology, Baylor College of Medicine, 6550 Fannin, Suite 801, Houston TX 77030*

SUMMARY:

When standardized diagnostic criteria are applied, accuracy of an Alzheimer's disease (AD) diagnosis ranges from 88% to over 90%. Conditions most commonly found at autopsy in addition to AD include: Parkinson's disease, dementia with lewy bodies, and vascular dementia. Clinical criteria for these disorders rely upon early differences in symptoms and signs, and the temporal sequence of key symptoms. Early diagnosis in patients suspected of having AD helps to accurately differentiate it from other dementias.

Conditions other than dementia can mimic the clinical picture of AD: e.g., slowly growing neoplasms and depression. Benefits of diagnosing space-occupying lesions early are obvious. Major depression by DSM-IV criteria is rare in AD, but patients may have dysphoria or other depressive disorders. It is not uncommon to see AD patients who have spent two to five years taking antidepressants before they were diagnosed with dementia. Early diagnosis, targeted at distinguishing AD from depression, can save time and mental anguish for these patients and their families.

Although there is still no cure for AD, we have entered the therapeutic era. Pharmacological and nonpharmacological interventions can modify behavioral disturbances and improve cognition. Early intervention helps identify caregiving and safety issues before they result in a crisis, helps to alleviate suffering, and introduces hope for symptomatic relief of cognitive disturbances. Early intervention provides the critical window for creating a management framework that will support the patient and family through many years of living with Alzheimer's disease.

No. 47B
PATHOGENESIS OF ALZHEIMER'S DISEASE

Jeffrey L. Cummings, M.D., *Department of Neurology, University of California Los Angeles, School of Medicine, 710 Westwood Plaza, Los Angeles CA 90095*

SUMMARY:

Alzheimer's disease (AD) is a neurodegenerative disease manifested clinically by progressive impairment of memory, language, visuospatial skills, calculation, and judgment. Neuropsychiatric abnormalities including apathy, delusions, agitation, and depressive symptoms. The pathogenesis of AD is increasingly well understood. Mutations on chromosomes 21, 14, and 1 can cause AD. Each of these mutations has the effect of increasing the production of amyloid beta-protein in the brain. Mutations account for less that 10% of all cases of AD, usually those with early-onset disease. Most patients have the onset of symptoms late in life; risk factors for this late-occurring sporadic form of the illness are age, female gender, history of head trauma, low educational level, small head size, lack of estrogen replacement therapy (ERT), and ApoE-4 genotype. These factors increase amyloid production (head trauma) or aggregation (ApoE-4), increase neuronal vulnerability (age, trauma, lack of ERT) or decrease cognitive reserve (head size, education). Amyloid production and aggregation lead to neuritic plaque formation with death of local neurons. Nerve cell death is mediated by oxygen radicals, calcium influx, inflammation, or excitatory amino acid toxicity. Loss of neurons in forebrain and brainstem nuclei leads to deficiencies of acetylcholine, norepinephrine, or serotonin. Regional histopathology and neurotransmitter deficiencies produce the clinical dementia syndrome. The process likely exists in the brain for years or decades before becoming clinically apparent. The pathogenetic cascade of AD offers many opportunities for treatment. Cholinesterase inhibitors are available to compensate for the cholinergic deficiency; vitamin E and selegiline slow the progress of AD through antioxidant effects. Agents that decrease amyloid production, reduce amyloid aggregation, increase amyloid excretion, reduce inflammation, or provide neuroprotective effects, promise to significantly modify AD by delaying the onset, slowing the loss of function, improving cognitive deficits, or ameliorating behavioral disturbances.

No. 47C
COGNITIVE ENHANCEMENT IN ALZHEIMER'S DISEASE: A COMPARATIVE REVIEW OF NEW AND EMERGING THERAPIES

Trey Sunderland, M.D., *Department of Geriatric Psychiatry, National Institute of Mental Health, 10 Center Drive, MSC1264, 10-3D41, Bethesda MD 20892*

SUMMARY:

While there have been diverse lines of research investigating the underlying pathophysiology of Alzheimer's disease (AD) for many

years, cholinergic therapies have remained the mainstay of clinical treatment with AD patients. Cognitive enhancement has been the major focus of AD treatment research, and cholinergic therapy, specifically treatment with cholinesterase inhibitors, has remained at center stage. Currently, there are two clinically available cholinesterase inhibitor drugs in use by the practitioner and over a dozen cholinergic drugs under development by the pharmaceutical industry. In recent years, noncholinergic medications have also been demonstrated to provide clinical benefit to AD patients. These alternatives include such diverse treatment as alpha-tocopherol (Vitamin E), nonsteroidal antiinflammatory agents, and estrogen replacement therapy. Drugs targeting the underlying structural damage associated with AD (i.e., β-amyloid blocking agents) are also under development. More than just providing alternative or combination treatment suggestions, these drug studies have heralded a shift in the attention of AD clinical research from a narrow focus on "cognitive enhancement" to a broader view of AD outcomes, which includes cognitive, activities of daily living, quality of life, and even disease-relevant biologic measures. In this presentation, we will review the current treatments available for AD patients and look ahead to the emerging therapies, which address structural as well as functional deficits associated with the development and course of AD.

No. 47D
TREATING BEHAVIORAL MANIFESTATIONS IN PATIENTS WITH ALZHEIMER'S DISEASE: DIFFERENTIAL DIAGNOSIS AND THERAPIES

David L. Sultzer, M.D., *Department of Psychiatry, University of California Los Angeles, Neuropsychiatric Institute, 760 Westwood Place, Room 37-440, Los Angeles CA 90024-1759*

SUMMARY:

Although cognitive impairment is the hallmark of Alzheimer's disease, psychiatric and behavioral manifestations of the illness contribute prominently to patient morbidity and caregiver distress. Common symptoms include delusions, labile mood, apathy, disinhibition, and agitated behaviors. Neuroimaging and neuropathology studies indicate that psychiatric and behavioral disturbances in Alzheimer's disease may be fundamental expressions of the illness.

Behavioral symptoms in Alzheimer's disease warrant careful diagnostic evaluation. Specific characteristics of symptoms need to be identified and atypical clusters of symptoms may be present. Environmental changes, medications, pain, and other medical conditions may contribute to psychiatric or behavioral disturbances. Therapeutic intervention begins with identifying and correcting such problems.

Environmental adjustments, behavioral interventions with the patient, and caregiver education aid in successfully managing the behavioral manifestations of Alzheimer's disease. Pharmacologic treatment can also contribute to clinical improvement. Neuroleptics, trazodone, other serotonergic medications, and anticonvulsants are often effective in patients with select psychiatric symptoms. Recent evidence indicates that atypical antipsychotic medications and cholinergic agents may also be effective. Identifying specific symptoms that respond to specific interventions is a current research focus. Advances in understanding the pathophysiologic basis for symptoms and the efficacy of precise interventions will contribute to successful management.

No. 47E
ASSESSING ALZHEIMER'S DISEASE TREATMENT RESPONSE: OUTCOME STRATEGIES FOR THE OFFICE PRACTICE

Ira R. Katz, M.D., *Department of Psychiatry, University of Pennsylvania, 3600 Market Street, Room 759, Philadelphia PA 19104*

SUMMARY:

The availability of cholinergic treatments presents both new opportunities and challenges for psychiatrists working with patients with Alzheimer's disease. The most important of these may be about how to evaluate responses to an adequate trial of treatment and how to use this information in deciding whether patients should be continued on medications. Because the nature of the therapeutic responses may differ between patients, a flexible approach is necessary. One component of the information required for decision-making is a quantitative estimate of the probability that the patient's cognitive performance has improved as a result of drug treatment. This can be obtained by comparing a patient's pre- and post-treatment performance on standardized tests with the magnitude of change observed in patients treated with placebo in randomized clinical trials; this can be accomplished with reference to calculated prediction intervals or graphs of cumulative response frequencies. Other information needed includes evaluations of changes in behavioral symptoms, self-care, instrumental activities of daily living, discretionary activities, and social interactions. Although use of standardized instruments can facilitate evaluations, changes in these domains must be interpreted qualitatively. Results of these assessments should be discussed with the patient's family who should participate in decision-making. The results of this process should include both improvements in the cost-effective use of new treatments, in the family's sense of control, and in their ability to accept disability.

No. 47F
WHY TREAT? ECONOMIC IMPACT OF EARLY DIAGNOSIS AND EFFECTIVE TREATMENT OF ALZHEIMER'S DISEASE

Peter J. Neumann, Sc.D., *Health Policy/Management, Harvard School of Public Health, 718 Hungtington Avenue, Boston MA 02115*; Richard C. Hermann, M.D., Karen M. Kuntz, Sc.D., Joel Leon, Ph.D., Steven Duff, M.S., Sally Araki, M.S., Milton C. Weinstein, Ph.D.

SUMMARY:

New treatments for Alzheimer's disease (AD) offer a potent example of the clinical, financial, and quality-of-life issues at stake with new pharmacotherapies. The economic burden of AD is large, with estimates of the annual cost (direct and indirect) of caring for an Alzheimer's disease patient on the order of $45,000 to $65,000 per year. While physicians and patients have always weighed clinical benefits versus risks in evaluating potential treatments, in the new health care environment—characterized by an integration of delivery systems, and centralization of decision-making in the use of health care resources—cost has become part of the equation. Medications compete for positions in drug formularies and for shares of drug budgets; newer, more expensive products face greater scrutiny from drug utilization review organizations and other oversight bodies. This presentation will present results from an ongoing study of the economic impact of early diagnosis and treatment of Alzheimer's disease. Questions to be considered include: What are the cost and quality-of-life consideration attending these new treatments? Do the clinical benefits of the drugs justify their costs? To what degree do potential economic benefits related to decreased medical and supportive care for Alzheimer's disease patient's offset the costs of medications? Would dollars spent on AD medications produce greater effects if they were targeted to alternative interventions?

REFERENCES:

1. Cummings JL, Mega M: Alzheimer's disease: etiologies and pathogenesis. The Consultant Pharm 1996;11(suppl E):293–300.
2. Roger S, Friedhoff LT: The Donepezil Study Group: the efficacy and safety of donepezil in patients with Alzheimer's disease: results of a US multicentre, randomized, double-blind, placebo-controlled trial. Dementia 1996;7:293–303

3. Sano M., Ernesto C, Thomas RG, et al: A controlled trial of selegiline, alpha-tochoperol, or both as treatment for Alzheimer's disease. N Engl J Med 1997;33:1216–1222
4. Schneider LS, Farlow MF, Henderson VW, et al: Effects of estrogen replacement therapy on response to tacrine in patients with Alzheimer's disease. Neurol 1996;46:1580–1584
5. Sultzar DL, Gray KF, Gumay I, et al: A double-blind comparison of traxodone and haloperidol for treatment of agitation in patients with dementia. Am J Geriatric Psychiatry 1997;5:60–69
6. Zayas EM, Grossberg GT: Treating the agitated Alzheimer patient. J Clin Psychiatry 1996;57(suppl 7):46–51
7. Tariot PN, Schneider LS, Katz IR: Anticonvulsants and other non-neuroleptic treatment of agitation in dementia. J Geriatr Psychiatry Neurol 1995;8(suppl 1):S28–S39
8. Neumann PJ, Hermann R, Schaffler P, Weinstein MC: Methods of cost-effectiveness analysis in the assessment of new drugs for Alzheimer's disease. Psychiatric Services. (in press)

LECTURES

LECTURE 1
APA/APPL MANFRED S. GUTTMACHER AWARD "TWO HATS" REVISITED: CONTEXTS, COMPLICATIONS AND COMPROMISES BETWEEN CLINICAL AND FORENSIC ROLES

Larry H. Strasburger, M.D., *527 Concord Avenue, Belmont, MA 02178;* Thomas G. Gutheil, M.D., *Massachusetts Mental Health Center, 74 Fenwood Road, Boston, MA 02115;* Archie Brodsky, *11 Royce Road, #39, Allston, MA 02134*

SUMMARY:

When a treating psychiatrist is placed in the role of expert (forensic) witness, clinical, ethical and legal conflicts arise. These conflicts are reviewed and illustrated with a case example from the patient's perspective. The authors then examine the clinical pitfalls for the subsequent treater of a patient who has been involved in litigation - a common occurrence in our litigious society - as the evaluee/patient negotiates the transition from an "acted out" solution to an inner exploration. Finally, the authors discuss appropriate rules for situations where separation of clinical and forensic roles is impossible and the specific challenges posed by so-called "recovered memory" cases.

REFERENCE:

1. Strasburger LH, Gutheil TG, Brodsky A: On Wearing Two Hats: Role Conflict in Serving as Both Psychotherapist and Expert Witness. *Am J Psych* 154:448–456, 1997.

LECTURE 2
MAKING THINGS UP
Days of Creation Session

Mordecai Richler, *c/o Speakers Worldwide, 5301 Wisconsin Ave., N.W., Ste 330, Washington, DC 20015*

LECTURE 3
SERVICES EFFECTIVENESS RESEARCH: RELEVANCE, CHALLENGES AND OPPORTUNITIES

Barbara J. Burns, Ph.D., *Department of Psychiatry and Behavioral Sciences, Box 3454, Duke University Medical Center, Durham, NC 27710*

SUMMARY:

A major question facing the world of patients and clinicians is how to move into the 20th century with cost-effective treatment. Alternatively, what is the role of health services research in psychiatry? While significant clinical advances in medications and psychosocial treatments have occurred for the major mental disorders, the extent to which efficacious interventions could be disseminated into the real world of clinical practice is relatively unknown. The issue of generalization into practice is plagued by less homogenous patients, providers unlikely to adopt manualized treatments, and service settings in which limits imposed by managed care may arbitrarily restrict treatment regimens. Challenges to conducting effectiveness research are explored in the context of promising clinical interventions. Further, strategies for disseminating effective treatments into clinical practice in an era of practice guidelines/standards, monitoring the fidelity of interventions, and documenting outcomes are examined.

REFERENCE:

1. Santos AB, Henggeler SW, Burns BJ, Arana GW, Meisler N: Research on Field-Based Services: Models for Reform in the Delivery of Mental Health Care to Populations with Complex Clinical Problems. *Am J Psych* 152:1111–1123, 1995.

LECTURE 4
SUBSTANCE ABUSE AND REWARD SYSTEMS IN THE BRAIN
Collaborative Session With the National Institute on Drug Abuse

Floyd E. Bloom, M.D., *Department of Neuropharmacology, The Scripps Research Institute, 10666 N. Torrey Pines Road, La Jolla, CA 92037*

SUMMARY:

Convergent neuroscientific research over the past decade has successfully determined several important synaptic sites which underlie the initial rewarding sites at which drugs abused by humans act, and which in experimental animals lead to long-term repeated willingness to self-administer. Certain elements of the circuitry are generalizable to at least four classes of human abused drugs (opiates, psychostimulants, alcohol and nicotine): all these drugs act by various primary mechanisms to activate the ventrotegmental dopaminergic projections to the nucleus accumbens, and in particular the shell of this nucleus, known to maintain substantial interconnections to the amygdaloid complex. Current work is focused on defining the long-term changes which cause humans to become tolerant to their self-administered drugs, defining the basis of increased vulnerability due to inherited factors, and devising medications to reduce the health burden of chronic substance abuse.

REFERENCE:

1. Yang TT, Gallen C, Schwartz B. Bloom FE, Ramachandran VS, Cobb S: Sensory Maps in the Human Brain. *Nature* 368, April, 1994.

LECTURE 5
ARTISTS' INSPIRATION: SENTIMENT, SENTIMENTALITY OR NEITHER OF THE ABOVE
Days of Creation Session

Wolf Kahn, *217 West 21st Street, New York, NY 10011*

SUMMARY:

On this complex subject one can only claim to speak subjectively. One aims for sincerity rather than exact truth. One tries first of all to put aside the superficial, sentimental ideas which dominate conventional thinking about inspiration. Drawing upon a lifetime of practice as a working artist, this lecture will attempt to articulate the sources of my appetite for work, and speculate about the deeper motivations which might possibly be at the basis of an artist's work. I question the popular idea which equates inspiration with momentary excess of feeling, or bases it on the urge to spread a conscious message about "life." This leads me to deconstruct the deconstructivists, blaming the mistakes of this doctrine on a general inability of theoreticians to engage with the work of an art on its own formal terms. This leads to further questions: Is art of value to mental health? If so, how is it of value? What sort of art is of the greatest value? Is "beauty" an issue? How does contemporary art reflect the culture, or perhaps it doesn't. I will end the lecture in a blaze of metaphysics, since art, when practiced on a serious level invariably aims at transcendence of the everyday, and opens the mind to unconventional thinking and feeling.

LECTURE 6
INTEGRATING NEW KNOWLEDGE IN TREATING THE EATING DISORDERS

Paul E. Garfinkel, M.D., *Department of Psychiatry, University of Toronto, 250 College Street, Room 835, Toronto, ON L5J 4B2 Canada*

SUMMARY:

The past 30 years have seen dramatic changes in our approach to eating disorders. These include marked improvement in the recognition and understanding of the disorders and the reduction in morbidity and mortality of anorexia and bulimia nervosa. Bulimia nervosa, itself, now the focus of so much attention, was described less than 20 years ago. This talk will highlight empirical research that has improved our understanding of these eating disorders and has resulted in improved clinical care.

Some of the factors related to anorexia nervosa and bulimia nervosa have been well described. In both anorexia nervosa and bulimia nervosa, there is a depression avoidance of a normal body size related to fears of being able to control oneself independently. This problem in turn is rooted to other events in the individual, family and culture. These risk factors are multiple. Cultural factors include the idealization of the thin female form and pressures on women to achieve, often for others rather than for oneself. Factors in the family of importance include a likely genetic diathesis (there is a 5-fold increase in the monozygous versus dizygous twin concordance rates) and the over-representation of certain illnesses in these families; depression, alcoholism and eating disorders are all common. Controlled studies of families have revealed problems in the areas of performance expectations, role adaptability, style of communication and expression of feelings, although it is not known at present if these changes precede or follow the onset of illness. Within the individual, important factors include difficulties in emotional separation and functioning autonomously; difficulties in self-perception; obesity; personality characteristics; conceptual development and earlier sexual abuse.

A new level of understanding has helped us move towards a goal of step care treatment. That is, providing effective treatment based on evidence beginning with the least costly but least intrusive form and working up from there as the patient's need requires. Currently, treatments with proven efficacy relate to supportive care from the physician with group psychoeducation to intensive psychotherapy. Evidence for these will be provided as well as a statement of effects on patient outcome.

REFERENCE:

1. Garner DM, Garfinkel PE (eds): *Handbook of Treatment in Eating Disorders*, 2nd Edition. Guilford Press, New York, 1997.

LECTURE 7
APA'S ADMINISTRATIVE PSYCHIATRY AWARD
FOLLOW THE LEADER: FROM INSTITUTIONS TO SYSTEMS OF CARE

Michael J. Vergare, M.D., *8860 Germantown Avenue, Philadelphia, PA 19118-2725*

SUMMARY:

Psychiatric leaders of today are increasingly responsible for a complex array of clinical serviced, sites and institutions linked in new and sometimes confusing ways. The last 50 years have seen a shift from psychiatric care delivered in large state institutions to smaller, often private psychiatric hospitals, general hospitals and outpatient facilities. At the same time, the community mental health center movement has evolved from one that included psychiatric leadership to its present state where psychiatric involvement in management is rare. The focus has now shifted to what are called integrated networks for the delivery of behavioral health care.

The role of psychiatric leadership is evolving along with these changes. As the focus of care and education moves away from defined locations to more abstract networks, the tasks that leaders face day-to-day pose new challenges. Once again, we hear of responsibility for defined populations as well as individual patients. Although there are similarities to community-based services of the past, there are also significant differences in values and organizational structure. While the span of management's influence appears to have increased, the control of personnel and quality of care has become more delicate.

These new networks call for some re-examination of traditional thinking concerning psychiatric management and administration. This presentation will elaborate on these changes and discuss ways to face these challenges.

REFERENCES:

1. Bartlett CA, Ghoshal S: Changing the Role of Top Management: Beyond Strategy to Purpose. *Harvard Business Review* 72(6):79–88, 1994.
2. Rodenhauser P, Senior N: The Dynamically Informed Choice of a New Leader. *Administration and Policy in Mental Health* 23(1):3–15, 1995.

LECTURE 8
OLFACTION AS A WINDOW INTO BRAIN FUNCTION

Andrew Chess, M.D., *Associate Member, Whitehead Institute, 9 Cambridge Center, Cambridge, MA 02142*

SUMMARY:

One percent of the human genome, more than 1,000 genes, is devoted to a single task: making sure humans can distinguish among a vast number of odorant molecules. Although it is often overlooked in analyses of human behavior, the sense of smell developed very early in evolution and is vital to the function and survival of most animals. Understanding how we respond to the vast array of odors is not only interesting in its own right, it also provides information about how the human brain operates more generally.

The application of tools of molecular biology to the problem of olfaction has led to a number of insights into the functioning of this part of the nervous system. These finding will be presented and will serve as a starting point for a discussion of the interesting remaining questions about the functioning and establishment of the olfactory system and a discussion of the impact of these studies on our understanding of the rest of the nervous system.

REFERENCE:

1. Chess A, Simon I, Cedar H, Axel R: Allelic Inactivation Regulates Olfactory Receptor Gene Expression. *Cell* 78:823–834, 1994.

LECTURE 9
WILLIAM C. MENNINGER MEMORIAL CONVOCATION LECTURE

Justice Richard Goldstone, *Constitutional Court of South Africa, Braamfontein, 2017, South Africa*

LECTURE 10
APA'S PATIENT ADVOCACY AWARD
TITLE TO BE ANNOUNCED

Professor Arthur R. Miller, *Harvard Law School, Cambridge, MA 02138*

LECTURE 11
APA'S ADOLF MEYER AWARD
THE COURSE OF COMMON MENTAL DISORDERS: VULNERABILITY, DESTABILIZATION AND RESTITUTION

Professor Sir David Goldberg, *Institute of Psychiatry, de Crespigny Park, Denmark Hill, London SE5 8AF, England*

SUMMARY:

A dimensional model for common mental disorders is used to argue that symptoms of anxiety and depression lie along two correlated dimensions, and that most episodes of disorders that are common in the community will include admixtures of these two symptoms. Relatively few patients complain of symptoms in only one dimension: the current orthodoxy is to declare that patients with both sets of symptoms are "co-morbid" for two disorders, rather than being severe cases of a single disorder of mixed anxiety and depression.

Factors that determine individual vulnerability to life stress include both genetic factors and modifying events both in childhood and adolescence. Factors releasing episodes of common disorders, destabilization, are best understood, and these are mainly the presence of stressful life events, the current social setting including social support, self-esteem and coping behaviors. Finally, those factors that determine the course, restitution, will be described, and it will be argued that while severity of symptomatology and onset of the episode is of importance, that recovery is also determined by level of initial vulnerability, availability of social support, social stressors and the occurrence of various types of life events during the episode.

REFERENCE:

1. Goldberg DP et. al.: The Influence of Social Factors on Common Mental Disorders Destabilization and Restitution. *Brit J of Psych* 156:704–713, 1990.

LECTURE 12
THE DYSFUNCTIONAL FAMILY AS A MORAL EXEMPLAR: STUDYING GENESIS
Days of Creation Session

Rabbi Burton L. Visotzky, *The Jewish Theological Seminary of New York City, Midrash and Interreligious Studies, 3080 Broadway, New York, NY 10027*

SUMMARY:

The study of the biblical book of Genesis outside the realm of religious hermeneutics gives rise to the possibility that the first book of the Bible is an ugly little soap opera about a dysfunctional family. Why have religious communities and even secular writers in the Western tradition afforded such pride of place to the work? Applying Professor Lawrence Kohlberg's theories of moral development to the study of Genesis, Rabbi Visotzky concludes that the several stories in Genesis serve as moral dilemmas. Group study and discussion of these ancient tales spurs moral development. This interactive, non-judgmental study of Genesis not only strengthen moral reasoning, but also strengthens community bonds and the growth of listening skills.

REFERENCE:

1. Visotzky BL: *The Genesis of Ethics.* Three Rivers Press, 1997.

LECTURE 13
APA'S SOLOMON CARTER FULLER AWARD
VIOLENCE PREVENTION: A PUBLIC HEALTH MANDATE TO SAVE OUR CHILDREN

Deborah Prothrow-Stith, M.D., *Professor, Public Health Practice Harvard School of Public Health, 718 Huntington Avenue, Boston, MA 02155*

SUMMARY:

Violence takes a heavy toll on our nation's spirit, health, and economy. Violent injury, disability, and death consume enormous health care resources and diminish the quality of life of individuals, families, and communities. The U.S. has a problem with violence that is unlike any other country in the world. Our homicide rate, for young men is eight times that of Italy, the developed country with the next highest rate, and 100 times greater than the developed country with the lowest rate. The Federal Bureau of Investigation estimates that 1.8 million people in the U.S. are victims of violence each year.

U.S. public policy teaches us to view violence mainly as a criminal justice issue. People believe that building more prisons, lengthening prison sentences, trying children in adult courts, and preventing early parole are solutions. The criminal justice system intervenes only after someone has committed an act of violence. We need solutions that prevent violence from happening. Preventing violence demands a long-term commitment, a comprehensive set of strategies, and new partnerships. These combined efforts must focus on prevention and not solely on aggressive responses to violence.

The public health approach involves the application of its techniques of risk-factor analysis and prevention to the problem of violence. Public health's analytic approach to problems concentrates on identifying risk factors that become the focus of prevention efforts. There is an established record of accomplishment in reducing "accidental" (unintentional) injuries through both environmental and legal interventions (e.g., seat belt laws and childproof caps on medicine), and behavioral change (e.g., educational campaigns to reduce drunk driving and smoking). These public health techniques are valuable in the analysis and prevention of violence as well. As we learn more about violence and its causes, the application of public health strategies is logical.

REFERENCES:

1. Prothrow-Stith D, Weissman M: *Deadly Consequences.* Harper Collins, New York, 1991.
2. DeJong W: *Preventing Interpersonal Violence Among Youth: An Introduction to School, Community and Mass Media Strategies.* National Institutes of Justice, Washington, DC, 1994.

LECTURE 14
APA'S SEYMOUR D. VESTERMARK AWARD FOR PSYCHIATRIC EDUCATION
EDUCATIONAL IMPERATIVE: A UNIFIED PSYCHOTHERAPY CURRICULUM

James H. Shore, MD., *Department of Psychiatry, University of CO Health Science Center, 4200 E. 9th Avenue, Box C-249, Denver, CO 80220-3706*

SUMMARY:

It is an educational imperative for the field of psychiatry to address a core identity issue by developing a unified national approach for psychotherapy education and curricular design. The diversity of our current clinical practices and educational approaches has stimulated adversarial debate and tension. The pressures have been intensified by the health care revolution, managed care, interdisciplinary frictions, competing treatment methods, a lack of standardized treatments, and new research findings. Without an educational imperative for a unified psychotherapy approach, psychiatry's core identity is evolving to exclude a significant psychotherapy role for future practitioners.

This presentation proposed that a unified educational model for the psychotherapies is the only effective way to overcome the current diversity and dilution of psychotherapy training. This step is critical to succeed in retaining psychotherapy as a core identity for psychiatrists. Other critical issues include more specific educational stan-

dards in psychiatry for accreditation of residency training programs and for certification of individual psychiatrists. Curricular development must be based on empirical research and then advocacy for a patient care climate that supports a psychotherapy practice role for psychiatrists.

REFERENCE:

1. Special Theme: Teaching and Supervising Psychotherapy. *Academic Psychiatry* 21:3, Fall 1997.

LECTURE 15
WARD STORIES: WRITING ABOUT MEDICINE
Days of Creation Session

Sherwin B. Nuland, M.D., *Clinical Professor of Surgery, Yale University School of Medicine, PO Box 6356, Hamden, CT 06517*

SUMMARY:

These days, it's fashionable to remind our younger colleagues, usually as though we ourselves are blameless, about the humanities that seems to have been displaced by our headlong rush toward scientific credibility, and yet it is untaught that a major ingredient of our responsibility to our patients is that we take them along as knowledgeable partners on the journey of their illness. To fulfill such a responsibility requires their understanding of at least the rudiments of the disordered physiology we are treating. In the current atmosphere of shoddy teaching of science at the secondary school level, the burden on us becomes even greater. It is a burden that our profession has seemed reluctant to take up.

In such an atmosphere, the need for lucid, enjoyable narratives of human physiology and pathology, written via the personal experiences and reflections of clinical physicians who deal with living, breathing patients each day, has become far greater than ever before. We should share with readers the simple truth known by every one of us; this body of ours is fascinating, in both sickness and health. In this talk, Dr. Nuland will tell the story of his own attempts to create a body of work that is useful to readers at the same time that its prose voice is one that might qualify as having some lasting literary value. He will discuss his methods of writing, approach to the material and own flirtations with the muse that we can all discover within us, only if we try. Finally, Dr. Nuland will touch on some of his experiences in the worlds of publishing, publicizing and public forums.

REFERENCE:

1. Nuland SB: The Wisdom of the Body. Alfred A. Knopf, New York, 1997.

LECTURE 16
APA'S ALEXANDRA SYMONDS AWARD
DR. ALEXANDRA SYMONDS' LEGACY OF ADVANCING WOMEN PSYCHIATRISTS AND PROMOTING WOMEN'S MENTAL HEALTH: SAILING TOWARD THE NEXT MILLENNIUM

Leah J. Dickstein, M.D., *University of Louisville, School of Medicine, Abell Administration Center, Suite 202, Louisville, KY 40202-3866*

SUMMARY:

Alexandra Symonds, M.D., co-founder in 1983 of the Association of Women Psychiatrists, and its first President and newsletter editor as well as a successful dual career wife and sailor. She pioneered a number of programs and processes to advance professional opportunities for women psychiatrist, locally in New York City and nationally. Concomitantly, she proposed new insights into women's unique psychiatric symptoms, syndromes, disorders and consequent effective psychodynamic treatment needs.

This lecture will first include insights into the history of Dr. Symonds and other ground breaking professional contributions to the understanding of women's unique psychiatric issues since the second women's movement beginning in the early 1960s. Based on two decades of professional contributions, Dr. Dickstein will present insights and recommendations pertaining to further increase understanding, by women and men at all levels of the power continuum, concerning needs for equitable waves of opportunities for women psychiatrists in all areas of professional activities in order to assume their roles for the next millennium.

REFERENCE:

1. Dickstein LJ, Nadelson CC (eds): *Women Physicians in Leadership Roles.* American Psychiatric Press, Washington, DC, 1986.

LECTURE 17
THE SURPRISING EFFICACY OF TREATMENT FOR ADDICTIVE DISORDERS
Collaborative Session With the National Institute on Drug Abuse

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

SUMMARY:

Almost everyone has contact with people suffering from addiction whether it be alcoholism, nicotine dependence, or illicit drug addiction. Most of these sufferers received some treatment at one time or another and most of them eventually relapse. Thus, there is a widely held belief among physicians and policy makers that treatment is ineffective. In reality, addiction is a chronic disorder much like diabetes, hypertension or asthma. We have a body of neuroscience that is beginning to explain the pathophysiology. Unfortunately, there is a natural tendency to think of detoxification (stopping the drug) as a treatment for addiction. This does nothing for the underlying "lesion" which can be compared to a memory trace. Modern treatments focus on the prevention of relapse using combinations of medications and behavioral approaches. Self-help groups such as Alcoholics Anonymous can be wonderful allies in comprehensive rehabilitation programs. Judged as a chronic disorder, controlled treatment outcome studies show consistent and significant benefits from many forms of treatment. A review of the data shows that treatment of addiction is comparable to the efficacy of treatment for other mental disorders and for other chronic medical disorders.

REFERENCE:

1. O'Brien CP: A Range of Research-Based Pharmacotherapies for Addiction. *Science*, 278:66–70, 1997.

LECTURE 18
SCHIZOPHRENIA, DOPAMINE RECEPTORS AND ANTIPSYCHOTIC DRUGS

Philip Seeman, M.D., Ph.D., *Department of Psychiatry and Pharmacology, University of Toronto, Medical Science Building, Room 4344, 8 Taddle Creek Road, Toronto, ON M5S 1A8, Canada*

SUMMARY:

All antipsychotic drugs block type 2 (or D2) dopamine receptors at clinical concentrations. The therapeutic concentrations of all antipsychotic drugs in the spinal fluid are identical to their concentrations which block D2. This also applies to clozapine. Hallucinations and delusions are blocked when an antipsychotic drug occupies about 75% of the D2 receptors. Because the D2 occupancy by clozapine depends on the radio-ligand used, and because clozapine is readily displaced by endogenous dopamine, the D2 occupancy by clozapine is generally lower than 50%, but clozapine may occupy high levels of D2 in the brain limbic regions which are low in endogenous

synaptic dopamine. The density of D2 is elevated in schizophrenia, using radiomethylspiperone in patients, but not when measured by radio-raclopride. The different findings are explained by the fact that D2 can exist as a monomer, a dimer or a tetramer, each having different affinities for these different radio-ligands. Using methylspiperone, it appears that D2 monomers increase in schizophrenia. Dr. Seeman will discuss how the above referenced factors effect how dopamine pathways are overactive in schizophrenia and in psychosis.

REFERENCE:

1. Seeman P: Dopamine Receptors and Psychosis. *Scientific American Science and Medicine* 2(5):28–37, 1995.

LECTURE 19
THE CONVERGENCE OF NEUROBIOLOGY AND PSYCHODYNAMICS

Maurice Dongier, M.D., *Douglas Hospital Research Center, 6727 Lasalle Blvd., Verdun, Quebec H4H 1R3, Canada*

SUMMARY:

Contrary to Freud's anticipation, it is no more likely that psychodynamics will be reducible by neurosciences than the contrary. The metaphysical problem of mind-body relationships cannot be solved by empirical evidence. Nevertheless, every psychiatrist adopts an implicit position in this respect. In his daily clinical work, he situates himself somewhere in the continuum which goes from biological (eliminative) reductionism to an overemphasis on the social dimension which would pay no attention to brain events.

Psychopathology has multiple facets: some of them are explained, more or less satisfactorily, by psychodynamics, some of them are better explained by neurosciences, others by cognitive sciences. Over the past decades, it is becoming clearer that psychodynamics and cerebral physiology have converged more than diverged, in spite of their differences in concepts and techniques. Neurobiology is transnosographic and more congruent with psychodynamic dimensions than with the diagnostic entities delineated by DSM-IV or ICD-10. Psychic reality, fantasy life, angiogenic conflicts can be simultaneously observed by their subjective and objective facets. They are regulated by genes and neurohormonal functions, and in turn modify brain structures and functions. Whether or not these apparent interactions are better understood in a monist or in a dualist framework is not resolved, and is unlikely to be resolved on empirical grounds alone. Arguably, the very core of psychiatric research goes beyond nosology and explores these convergences and their mechanisms.

REFERENCE:

1. Mayr E: Population Thinking and Neuronal Selection: Metaphors or Concepts. *Review of Neurobiology* 37:49–50, 1994.

LECTURE 20
APA'S SIMON BOLIVAR AWARD
IMMIGRATION AND PSYCHOPATHOLOGY: IS THERE A CONNECTION?

Javier I. Escobar, M.D., *UMDNJ-Johnson Medical School, Department of Psychiatry, 314 Sayre Drive, Princeton, NJ 08540*

SUMMARY:

In this presentation data will be reviewed first on the prevalence of mental disorders among immigrants and non-immigrants interviewed as part of surveys of the general population that had a major focus on Mexican-Americans. These data were surprising in that they showed that immigrants seemed to be better off (had a lower prevalence of mental disorders) than their US-born counterparts. These observations were counter to expectations born out from social theory and early research on immigration and acculturation. Data on other Health Indexes (infant health and mortality) including immigrant/non-immigrant comparisons will be then examined and taken to suggest that the "protective" effect of immigration may extend beyond the mental health realm. Next, the presenter will reveal his own data, recently obtained in a study of a large multi-ethnic sample using primary care services. Once again, interesting differences in psychopathology and disability that favored immigrants over non-immigrants were observed. Finally, Dr. Escobar will attempt to integrate these data, provide tentative explanations and highlight their relevance to mainstream psychiatry.

REFERENCE:

1. Escobar JI: Does Ethnicity Confer Any Advantages? A Brief Review of New and Provocative New Data. *Psychline* 2:16–18, 1997.

LECTURE 21
APA'S OSKAR PFISTER AWARD
SPIRITUAL AND RELIGIOUS ISSUES IN PSYCHOPATHOLOGY AND PSYCHOTHERAPY

Allen Bergin, Ph.D., *Brigham Young University, 284 Taylor Blvd., Box 28626, Provo, UT 84602*

SUMMARY:

This presentation begins with a review of the conflicts between assumptions of psychiatric/medical/behavioral sciences and spiritual perspectives. An account is given of how the gap between these domains is being bridged by changes in physics, philosophy, research on the brain and consciousness, evidence on religion and mental health, and spiritual conceptions of personality and therapeutic change. The disparity between traditional clinical approaches and the spiritual needs of patients is noted.

A schema is provided for resolving many realistic problems in applying spiritual perspectives to serious psychopathology. An outline of seven healthy and seven unhealthy ways of being religious comprises part of this discussion. Devices for assessing religiousness and its positive and negative aspects will be presented.

Summary data support conclusions that can be drawn about religious/spiritual dimensions and mild-to-moderate adjustment problems, pathological social conduct and serious mental illness. An outline will be presented of spiritual interventions that show promise when integrated with standard therapies. Case examples will be given and relevance of the clinician's own spirituality will be explored.

A concluding multi-dimensional perspective, which includes a spiritual/theistic theme will be offered.

REFERENCE:

1. Richards PS, Bergin AE: *A Spiritual Strategy for Counseling and Psychotherapy.* American Psychological Association, Washington, DC, 1997.

LECTURE 22
EMOTION, MEMORY AND THE BRAIN

Joseph LeDoux, Ph.D., *Center for Neural Science, New York University School of Medicine, 6 Washington Place, New York, NY 10003*

SUMMARY:

Considerable progress has been made in elucidating the brain pathways involved in detecting and responding to threatening stimuli and learning about novel threats. The pathways involve transmission of information from sensory processing areas in the thalamus and cortex to the amygdala. The lateral nucleus of the amygdala receives and integrates sensory information and sends the outcomes of its processing to the central nucleus, both directly and by way of intervening synapses in the amygdala. The central nucleus, in turn, is

the interface with motor systems controlling fear responses of various types (behavioral, autonomic, endocrine). Sites of plasticity within this circuitry, and the cellular mechanisms involved, have also been identified. We are beginning to uncover the neural mechanisms, from systems to cellular levels, underlying emotional processing, including emotional learning and memory, at least within the fear system. These advances may lead to more refined definitions of emotional disorders, and hopefully new, more specific approaches to treatment.

REFERENCE:

1. Quirk GJ, Armony JL, LeDoux JE: Fear Conditioning Enhances Different Temporal Components of Tone-Evokes Spike Trains in Auditory Cortex and Lateral Amygdala. *Neuron* 19:613–624, 1997.

LECTURE 23
COCAINE AND THE ADDICTED BRAIN
Collaborative Session With the National Institute on Drug Abuse

Nora D. Volkow, M.D., *Director, NIDA/DOE Imaging Center, Medical Department, Brookhaven National Laboratory, Upton, NY 11973*

SUMMARY:

We have used PET, an imaging method that enables the measurement of biochemical, metabolic, and pharmacologic processes to investigate the effects of cocaine in the human brain. We have investigated the pharmacological properties of cocaine as well as the brain biochemical changes associated with cocaine addiction. Analysis of the behavior of cocaine in the human brain revealed that though cocaine at the doses commonly abused is very effective in blocking most of the dopamine transporters, which are the molecular targets associated with its reinforcing effects, its fast pharmacokinetics are also required for its reinforcing effects to occur since similar levels of blockade were not reinforced when achieved slowly. The fast clearance of cocaine in the brain also appears to be important for enabling the frequent repeated administration of cocaine seen during a binge. Studies in cocaine addicts have shown decreased function of the dopamine system which is associated with dysfunction in cortical areas known to be modulated by dopamine. Decreased dopamine function in cocaine addicts is likely to account for the anhedonia associated with chronic cocaine use and its disregulation of cortical regions such as the orbitofrontal cortex and cingulate gyrus may account for the compulsive drug administration characteristic of cocaine addiction.

REFERENCE:

1. Volkow ND, Ding YS, Fowler JS, Wang GJ: Cocaine Addiction: Hypothesis Derived From Imaging Studies with PET. *J Addictive Diseases* 15:55–71, 1996.

LECTURE 24
APA'S BENJAMIN RUSH AWARD
THE EMPTY SELF: BORDERLINE PERSONALITY DISORDER IN HISTORICAL PERSPECTIVE

Elizabeth Lunbeck, Ph.D., *Department of History, Princeton University, 129 Dickinson Hall, Princeton, NJ 08544-1017*

SUMMARY:

For the past 50 years, both popular and scholarly studies of the American personality have painted a portrait of cultural and characterological decline, telling of the demise of a disciplined, patriarchal Victorianism that produced autonomous, inner directed individuals and the rise of a modernity that values appearance over authenticity. Yielding the superficial, other-directed, and fundamentally disturbed personality as its paradigmatic figure, the work of psychiatrists who since the 1940s have been registering the emergence of empty and unauthentic selves, has been central to the fashioning of this portrait. Together with social critics, they have noted the disappearance of classically neurotic patients and the proliferation of those suffering from vague conditions of maladjustment and discontent. Since the 1960s they have diagnosed these patients as borderlines.

The lecture examines the clinical and cultural emergence of the borderline personality disorder. It looks at the two competing historical narratives that psychiatrist call upon to account for its ubiquity. One holds that only the category is new while the patient is old and familiar, posting that today's borderlines are yesterday's hysterics. The other argues that both the patient and the category are altogether new products of a fragmented modernity. Finally, drawing on psychiatrists' own questioning of the category, the lecture considers the extent to which the new diagnosis is implicated in the production of new types of patients.

REFERENCE:

1. Lunbeck E: *The Psychiatric Persuasion: Knowledge, Gender and Power in Modern American.* Princeton University Press, 1994.

LECTURE 25
THE RELEVANCE OF JUSTICE TO THE VICTIMS OF HUMAN RIGHTS ABUSES

Justice Richard J. Goldstone, *Constitutional Court of South Africa, Private Bag X32, Braamfontein 2017, South Africa*

SUMMARY:

There will be a discussion of the options facing countries emerging from periods of serious violations of human rights ranging from impunity to criminal prosecution. A consideration of whether truth commissions are an appropriate mechanism, and the effect of impunity and how it has frequently resulted in a cancer in society leading to successive outbreaks of violence and further abuses (the former Yugoslavia and Rwanda are examples) will be addressed. The presenter will evaluate the South African Truth and Reconciliation Commission and how victims who are so frequently left out of account by the political decision-makers are affected.

REFERENCE:

1. Justice As a Tool for Peace-making: Truth Commissions and International Criminal Tribunals. *New York University Journal of International Law and Politics* 28(3), 1996.

MEDIA PROGRAMS

1: BLACKS & JEWS

PROGRAM DESCRIPTION:

The fault line between blacks and Jews is one of the most visible symbols of America's racial divide. Now a new film, *Blacks & Jews*, made collaboratively by Jewish and black filmmakers, goes behind the headlines and the rhetoric. It was acclaimed at 1997 Sundance Film Festival for initiating a frank yet constructive nationwide dialogue to overcome the mistrust. *Blacks & Jews* reexamines key conflicts, including the Crown Heights riots; "block busting" in Chicago and the interracial coalition that opposed it; the controversy around Louis Farrakhan and the Nation of Islam; and the press frenzy over a group of black students who laughed during a screening of *Schindler's List*.

Blacks & Jews offers no assurances of easy racial harmony. But screenings of this film can cut through the anger and emotion on both sides by demonstrating that dialogue and cooperation must be based in a serious effort to understand and value the experience of others.

2: DAUGHTERS OF THE TROUBLES: BELFAST STORIES

PROGRAM DESCRIPTION:

A personal narrative about the lives of two working-class Belfast women, told against the backdrop of the last 25 years of political turmoil in Northern Ireland. Women have been forced to transcend the traditional female roles assigned to them by a conservative, male-dominated society in order to meet the challenges of their shattered country. They painfully piece together different lives for themselves and their children as they tackle new problems today such as teenage pregnancy, drug use, and alienated youth caught in the inexorable cycle of dependency. With wit and humor, the women, Catholic and Protestant, convey a sense of hope.

3: COMPUTERIZED PATIENT RECORDS: STATE-OF-THE-ART

PROGRAM DESCRIPTION:

This is an all day workshop focusing on the use of computer technology in psychiatric practice. Waguih Ishak, M.D. of New York University, and Tal Burt, M.D. of Harvard University will demonstrate state-of-the-art software specifically created for psychiatry. Participants will have the opportunity to appreciate how user-friendly and comprehensive the new age of software is. Emphasis will be made on the specific ways in which the use of specialized software can improve the quality of psychiatric care, administration, education, research and communication. There will be no pre-registration required and there will be a number of power strips available for attendees who are encouraged to bring their own laptop computers and "plug in."

4: BREATHING LESSONS: THE LIFE AND WORK OF MARK O'BRIEN

PROGRAM DESCRIPTION:

According to the poet-journalist Mark O'Brien, "The two mythologies of disabled people break down to: one, we can't do anything, or two, we can do everything. But the truth is, we're just human." This award-winning documentary offers a challenging look into the mind of a man who can't do a lot of things that most of us take for granted, but who does other things superbly well.

O'Brien writes regularly for Pacific News Service, and contributes to National Public Radio. He is the author of a collection of poetry titled *Breathing* and has had poems featured in numerous literary publications and anthologies. O'Brien contracted polio in childhood. Due to post-polio syndrome as a young adult, he now spends much of his life in an iron lung. Yet for more than 40 years he has fought against illness and bureaucracy for his right to lead an independent life. By presenting life from O'Brien's point of view, this documentary provides an intimate window into the reality of a life with severe disability, as well as an illuminating portrait of a remarkable artist.

Best Short Documentary, South by Southwest Film Festival
Juror's Choice Award, Charlotte Film and Video Festival
Audience Award: Aspen Shortsfest
Golden Gate Awards, Silver Spire, San Francisco International Film Festival

5: UNTOLD DESIRES

PROGRAM DESCRIPTION:

Untold Desires highlights the struggle that people with disabilities face in their quest to be recognized as sexual beings, free to express their sexuality and lead sexually active lives. In the sometimes sensitive area of sexuality, people with disabilities find that their own needs are often subverted by the conservative values of those who provide essential care. They are also sharply conscious of how they are seen by others.

Untold Desires allows these people to speak about issues that confront them: choice, privacy, the right to have sexual relationships, and the right to have children. They speak frankly about their experiences in search of sexually fulfilled lives. Their honesty is sometimes raw, but always deeply moving. The film offers positive images for people with disabilities and breaks down stereotypes that render the disabled person nonsexual in the eyes of the nondisabled world.

Best Documentary, Human Rights Award, 1995
Best Documentary, Australian Film Institute Awards, 1995
Silver Medal, Prix Leonardo, Italy, 1995

6: CRY, THE BELOVED COUNTRY

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the healing process of forgiveness through compassion and courage, and to understand the historical context of transformation taking place in South Africa today.

PROGRAM DESCRIPTION:

On attending the world premier of *Cry, The Beloved Country*, President Nelson Mandela made an astounding statement: "A monument to the future. I enjoyed every moment of it. *Cry, The Beloved Country* and its message reinforce our friendship across the oceans and add value to the treasure house of culture. It vividly captures Alan Paton's eloquent faith in the essential goodness of people." The first feature film from the new democratic South Africa shows the healing process of forgiveness and reconciliation. Based on a 1946 worldwide best-selling novel, it depicts the sociopolitical forces that were already in existence in the preapartheid era, when blacks and whites existed in diametrically opposed worlds yet were completely oblivious to one another. The two main protagonists are played magnificently by James Earl Jones and Richard Harris; from the tragedy of one son killing the other's son arose compassion and forgiveness. *Cry, The Beloved Country* demonstrates parallels with the current process of the Truth and Reconciliation Commission in South Africa. Both the film and the Truth and Reconciliation

Commission can be regarded as guideposts in the history of South Africa spanning the preapartheid, apartheid, and postapartheid periods. The rest of the world yet may learn how the deep wounds of division and racism can be healed through forgiveness.

7: GIRLS LIKE US

PROGRAM DESCRIPTION:

In *Girls Like Us*, a documentary on female teenage sexuality, a fluid hand-held camera follows an ethnically diverse group of four working-class teenage girls over a period of four years (ages 14 to 18). Filmed in South Philadelphia, *Girls Like Us* exposes the conflicts of growing up female and the impact of class, sexism, and violence on the dreams and expectations of teenage girls. Exploring the intersection of cultural values and pop culture, family pressures and personal identity, *Girls Like Us* stimulates dialogue between youth, adults, and educators.

Grand Jury Prize Best Documentary, 1997 Sundance Film Festival
Golden Apple Award, National Educational Media Market
Grand Jury Prize, 1997 Charlotte Film Festival
Honorable Mention, 1997 Atlanta Film/Video Festival
Human Rights Watch Film Festival
Nationally Broadcast on Public Television (P.O.V.)

8: NOBODY'S BUSINESS

PROGRAM DESCRIPTION:

"My life is no different from, I don't know how many, billions of people, who the hell am I?" asks Oscar Berliner. "You're my father" his filmmaker son answers. And so begins a fascinating, if reluctant, partnership to create a portrait of a family by sifting through myth, memories, fact, and fiction—the cautious exchange of information and affection between father and son.

9: PENNIES FROM HEAVEN

PROGRAM DESCRIPTION:

Songs of the Great Depression momentarily offered hope and possibility to many who were otherwise filled with despair as they went from soup kitchens to apple stands. So did escapist movies such as those made by Astair/Rogers, Rooney/Garland, and Busbee Berkeley. Dennis Potter, the British TV dramatist wrote a six part series for the BBC called *Pennies From Heaven* which MGM made into an American musical directed by Herb Ross and starring Steve Martin, Bernadette Peters, and Cristopher Walken.

The movie *Pennies From Heaven* stands escapism on its head and offers the audience a musical tour into the unconscious lives of its characters. In a highly entertaining yet bleak comedy about a down-and-out liar and philanderer, we see how the unconscious is always active and experiencing the material world simultaneously with conscious experience.

In classical psychoanalytic therapy, one digs into the past, lifting repression, ultimately hoping to reveal psychic drives which underlie disturbed defenses. When characters burst into song we in the audience get a different view of how the mind works, as songs from the distant past suddenly illuminate the present while they simultaneously offer ways of escape from it. Suddenly the past feels alive in the present, something which puts therapists more in the mind of Betty Joseph's ideas about "The total situation" than Freud's of peeling an onion. Music offers immediate recall, reaction, and interpretation of events hitherto hidden. Discussion at the end of this film will examine new ways to think about unconscious process and means of accessing it.

Too often films depicting the painful realities of the 1930s lend themselves merely to sociological interpretation. In this film, however, the audience can explore the individual psychology of the leading characters and how they are each shaped in unique ways by overtly common cultural experiences. Dennis Potter said, "In any form of personal crisis, all kinds of memory and aspiration, hope and disappointment, grief and bloody-mindedness, fly up at you, and in that unbidden mix, as though out of a fever, I began to make links that I had furtively avoided making for too long." Potter quotes E.M. Forster who said, "only connect." That is what Pennis does: it connects the character both internally and to the audience though the people portrayed are radically different from those of us in the audience, something about knowing them allows us to know ourselves in new and fresh ways.

10: LICENSED TO KILL

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to: understand psychological and social causes of antigay violence.

PROGRAM DESCRIPTION:

Despite increasing societal acceptance of homosexuality, antigay violence remains one of the most frequently reported hate crimes. Attempts to understand the ubiquity of antigay violence includes an exploration of both societal and psychological underpinnings of homophobia, as well as prejudice in general. Arthur Dong, whose acclaimed films have documented historical episodes of antigay and anti-Asian discrimination, provides a unique and compelling perspective on antigay violence in *Licensed to Kill*. In this unsettling documentary, Dong interviews seven men imprisoned for murdering homosexuals. The interviews allow the convicts to describe in their own words their motivations for killing.

Winner of the Filmmakers Trophy and Best Documentary Director at the 1997 Sundance Film Festival, *Licensed to Kill* provides an unusual window into the minds of these seven men, allowing the psychiatric audience to draw its own conclusions about the psychology of the killers of gay men.

11: I SHALL NOT BE REMOVED: THE LIFE OF MARLON RIGGS

PROGRAM DESCRIPTION:

This loving biography chronicles the heroic life of black, gay filmmaker Marlon Riggs, who died of AIDS in 1994. A fierce advocate of free expression, Marlon created soul-searching art at a furious pace. Clips from all eight of Marlon's works are shown and discussed. Marlon was a lightning rod in the civil war over funding for the arts in America. He also waged a passionate battle against AIDS.

12: ALL GOD'S CHILDREN

PROGRAM DESCRIPTION:

All God's Children is a short documentary about the black church's embrace of African-American lesbians and gay men as dedicated members of its spiritual family. Prominent religious, intellectual, and political leaders, family members, and activists speak out about the role of the church and the importance of a commitment to equal rights and social justice for all people. Interwoven with music, the intricately layered stories unfold on the screen creating a tapestry with the theme of spiritual understanding. Rev. Jesse Jackson, Rev. Cecil L. Murray, Bishop Carl Bean, Rev. James Forbes, and Rev. Waylon Melton join theologian Cornel West in his call for fellow

Christians "to not confuse the blood of Calvary with the Kool-Aid of homophobia in America."

All God's Children includes strong statements of recognition and support from prominent African-American political leaders like Congresswoman Maxine Waters, Senator Carol Moseley-Braun, and Mayor Ken Reeves. They reiterate the need to build a better society based on the common ground of civil equality. Families, church members, and gay activists weigh in with heartfelt stories about exclusion and discrimination, then about inclusion and a call for healing. One mother, Dorothy Beam, says, "If most people could understand that if you're gay, you're beautiful! If you're straight, you're beautiful! Let's put all this beauty together. It would be a better world."

A Woman Vision Production in association with: The National Gay and Lesbian Task Force and The National Black Lesbian and Gay Leadership Forum; produced and directed by Academy Award nominees Dr. Dee Mosbacher, Frances Reid, and Dr. Sylvia Rhue.

13: SHINE

PROGRAM DESCRIPTION:

Shine is the mythical story of a Jewish father whose overbearing pride, possessiveness, and envy ruined his talented son, and an astrologer wife whose unconditional love eventually resurrected the victim and launched his professional career as a concert pianist. The film leaves no doubt that David Helfgott suffered a "nervous breakdown" and a very serious, prolonged mental illness. But much of the story is left implicit. We see Helfgott collapsing and passing out as he finishes a performance but are not told what led to his first hospitalization, which is crucial to our understanding of his illness. Various accounts of his diagnosis have been reported in the media; the film portrait suggests a major psychosis, schizoaffective disorder. The screenplay also suggests that David was further victimized by unseen psychiatrists who gave him shock treatment, and in their ignorance, ordered him to stay away from the piano, his only route to salvation.

For people who love David Helfgott's concerts and this movie, perhaps one important consideration is that Helfgott has made the journey from the back ward of a mental hospital to the stage of great concert halls. Helfgott's innocence is the psychological backbone of *Shine*. It insures that we see him as a pure victim. The tyrannical father tormenting his son out of his own egoism gives the audience its insight into how Helfgott was driven mad. In the film he relentlessly drives his only son to succeed at the piano, resents his success, and refuses to let him pursue studies abroad. He puts a father's triple curse on his son: no one will ever love you as I do; if you disobey me you will be punished for the rest of your life; you can never come home again. This is the family myth of the 20th century, where possessive love turns to hate and parents devour their own children.

Unfortunately, this film makes us weep for the wrong reasons. It is a docudrama that recycles old myths of mental illness.

14: PRACTICE MANAGEMENT SOFTWARE ON THE CHEAP!

Steven E. Hyler, M.D., *Unit #112WHCS, New York State Psychiatric Institute, 722 West 168th Street, New York, NY 10032*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to demonstrate how to use inexpensive, commercially available, off-the-shelf software to create a "Practice Management" program that works for his or her practice.

PROGRAM DESCRIPTION:

There is little argument against using computer programs to help manage your practice. One option is the purchase of an "all-in-one" practice management program. The disadvantages of this option are: (1) it can be expensive; (2) it may not be easy to customize for your practice; (3) it might be difficult or expensive to upgrade to keep up with the ever changing forms of insurance companies, managed care companies and government agencies; and (4) there is a good chance that the company who sold you the software may not exist as long as your practice does! A less expensive option for anyone who doesn't mind (or who even likes) tinkering with software programs is to create your own "Practice Management" program using commercially available software that is either already on your hard disc or inexpensive to purchase. Using the combination of a contact management program, scheduling program, office suite (word processor/spreadsheet), and database program you can create a program that will be custom tailored to your own practice. Such programs will be demonstrated.

15: COMPUTER PSYCHIATRIC RECORD CREATION AND USE FOR SOLO PSYCHIATRISTS

Cary L. Hamlin, M.D., *Department of Informatics, Fear Free Technology Inc., 385 Route 24, Chesterwoods, Chester, NJ 079301*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: understand a method to populate and use a clinical psychiatric database created from case notes using inexpensive equipment (Win-32Intel PC, Wordpad, DataJunction).

PROGRAM DESCRIPTION:

Psychiatric data input of observations and classifications requires a method that will not distract attention from the patient and will permit mapping to a normalized database. The CPR-CUSP method fulfills those goals and has been used to create a database of over 2000 patients. CPR-CUSP uses a Win32Intel PC, Wordpad.exe, DataJunction.Exe, and a single psychiatrist to create patient interview notes and to parse those notes into a database case repository. Procedures of CPR-CUSP include: how to type encounter notes in a text editor; how to write an extraction script in DataJunction Extraction Language, how to use extraction script .djp in DataJunction.exe to tokenize concepts in patient.txt and extract values from them; how to write a datamodel for the values; and how to populate the database with the values from patient.txt. Once created, a computer patient record is an argument to powerful functions, such as report macros, SQL queries, neural networks, and fuzzy cognitive maps. Insurance companies and other large corporations have spent millions of dollars to develop computer patient records. A solo psychiatrist can implement an office computer patient record for approximately two thousand dollars.

16: PSYCH SCRIPT: SOFTWARE TO CREATE TYPED PSYCH NOTES

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: demonstrate the creation of typed psych notes from handwritten ones using the Newton hand-held computer and the additional uses of the Newton in psychiatric practice.

PROGRAM DESCRIPTION:

This demonstration will show a new software (Psych Script) for the Newton hand-held computer. This software creates typed psychiatric consults and notes. This is done by a unique combination of templates and handwriting recognition, converting handwritten notes into type. These notes are created on the Newton hand-held computer and can be printed out directly or transferred to MacIntosh or PC. This allows

the user to quickly write a note and have a completed typed note for enhanced communication and medical record keeping. All this can be done with a computer that receives e-mail and Internet and fits in the palm of a hand.

17: SHATTERING THE SILENCES

PROGRAM DESCRIPTION:

"Diversity" may be the word of the hour on the nation's campuses but faculty of color remain a rare sight, making up only 9.2% of full professors. At the same time, affirmative action is under attack across the country. *Shattering the Silences*, tells the story of these academic pioneers, their scholarly contributions, how they've helped open campuses to students of color, and the singular stresses and challenges they face every day. *Shattering the Silences* wends its way through the culture wars and battles over multiculturalism to provide a unique look at campus life from the perspective of minority scholars from the humanities and social sciences, including Darlene Clark Hine, Alex Saragoza, Robin Kelley, Shawn Wong and others.

This video may have lessons for psychiatry where the underrepresentation of ethic minority faculty continues to exist in academic departments of psychiatry.

18: SCHIZOPHRENIA: THE COMMUNITY'S RESPONSE

PROGRAM DESCRIPTION:

This documentary describes the deinstitutionalization movement and its impact. It discusses the community's response from several viewpoints including those of clients, parents, medical and nursing professionals, law enforcement personnel, psychiatric personnel in the penal system and outreach workers. The program will examine issues such as importance of the family, adherence to medication regimens, stigmatization, dangerousness, and need for community outreach and support. Commentary by E. Fuller Torrey, M.D.

National Educational Film and Video Festival's Gold Apple award winner 1996, in the Mental Health category.

19: IN THEIR SHOES

PROGRAM DESCRIPTION:

In Their Shoes is a video documenting the prevalence and problems of persons with severe and persistent mental illness in the greater Houston area. It presents an overview of the nature of severe mental illness as well as problems associated with homelessness and involvement in the criminal justice system. It captures the first person perspectives of persons with mental illness, their families, clinicians and, public officials. Although primarily produced for lay audiences, this video has didactic value for students and faculty. It has received awards from the Texas Alliance for the Mentally Ill and the Houston Psychological Association.

20: NEVER TOO FAR: RURAL OUTREACH FOR SERIOUS MENTAL ILLNESS

PROGRAM DESCRIPTION:

Severely mentally ill individuals are often poorly served in rural areas. Lack of transportation and cultural barriers often make treatment inaccessible. This video depicts a model of mobile outreach treatment in rural South Carolina that visits the homes and communities of rural mentally ill individuals and aggressively mobilizes treatment efforts.

National Educational Media Network's Bronze Apple winner, 1997.

21: RAPE: A CRIME OF WAR

PROGRAM DESCRIPTION:

This documentary follows the story of some extraordinary women and their battle to ensure that rape is understood by the world as a crime against humanity. It has been estimated that between 20,000 and 50,000 rapes were committed during fighting in the former Yugoslavia. From the perspective of victims, prosecutors and perpetrators, we are drawn into the horrors of rape as a weapon of war. Four women tell their story of forced confinement, rape and degradation in Bosnia and share how their experiences have influenced their perceptions of their partners, their children, society as a whole, and themselves. The rapist claim that they were acting upon a higher authority. Legal consultants at The Hague where the International Tribunal is investigating war crimes, discuss the implications of the trial of a former camp boss, the first person to be indicated for rape as a war crime. Interviews and archival footage of war crimes hearings in Nurenburg, Nanking, Bosnia and Rwanda are interspersed with images of Western art and culture which have romanticized, eroticized and legitimized rape.

National Educational Media Network's Silver Apple Award, 1997

22: GLIMMER OF HOPE

PROGRAM DESCRIPTION:

The death of a child is tragedy enough, but when the cause of death is random, brutal murder, the pain can be insurmountable. In the aftermath of horror, the greatest challenge can be to come to terms with grief and get on with life. For those who can't, anger and vengefulness may take over, making them victims of a crime that never ends. *Glimmer of Hope* shows the Streufert family trying to come to terms with the rape and murder of their 19-year-old daughter, Carin.

Across North America, individuals and groups, many of them volunteer, are actively working to change the concept of justice through innovative, community-based initiatives such as offender community service programs, victim/offender mediation and healing circles. These people are part of the restorative justice movement, founded on the principle of individual and community responsibility, which brings healing to both victims and offenders.

The Streuferts are part of a growing movement of victims of violence. They are taking healing into their own hands by confronting those who have hurt them, to try to reach an understanding of the tragedy that has shattered their lives. By meeting the killers of their daughter they can ask the questions that plague them, hear the killers' version first-hand, and bring a monstrous act and its perpetrators into human focus, all in the hope of coming to terms with inexpressible loss and grief.

23: CONVERSATION AT THE CARTER CENTER: COPING WITH THE STIGMA OF MENTAL ILLNESS

PROGRAM DESCRIPTION:

This moving videotape is hosted by Mrs. Rosalynn Carter and features powerful testimony from author Kathy Cronkite and actor

Rod Steiger. This video is designed to educate and to be used as a tool to reduce stigma and discrimination against persons with mental illness and their families.

24: MENTAL ILLNESS: THE FAMILY'S STORY

PROGRAM DESCRIPTION:

The anguish of living with a family member who has a serious mental illness is described by four parents. This video moves from the initial shock, disbelief and grief that accompany a diagnosis of a loved one's serious mental illness to an eventual acceptance and a hope for a brighter future, recognizing the ongoing benefits of research, including the availability of new and better medications.

25: I'M STILL HERE: THE TRUTH ABOUT SCHIZOPHRENIA

PROGRAM DESCRIPTION:

I'm Still Here: The Truth About Schizophrenia strips away the ignorance and fear associated with schizophrenia, reminding us that, despite the distortions of personality and perception induced by a chemical imbalance of the brain, many of those living with this illness lead lives of extraordinary courage and accomplishment, deserving of our compassion and admiration.

26: COMPREHENSIVE CLINICIAN'S DESKTOP

Waguih Ishak, M.D., and Tal Burt, M.D., *Department of Psychiatry, New York University Medical Center, 564 First Avenue, #16-X, New York, NY 10016*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to: 1) describe all-in-one computer applications in psychiatric practice and 2) recognize the role of these systems in improving patient care, diagnostic and management skills, and documentation in addition to access to references and communication.

PROGRAM DESCRIPTION:

This presentation will demonstrate how computer technology can be used in the service of the ultimate goal of medicine, which is to alleviate patient suffering. The introduction of computers in the second half of the 20th century has led to the development of tools that can help achieve this goal by optimizing patient care, enhancing psychiatric education, and promoting meaningful research. The Comprehensive Clinician's Desktop will be demonstrated. This application provides an all-in-one tool of charting, reference and communication, reducing the time spent on paperwork and repetitive tasks, and improving diagnostic and management skills in addition to performing billing functions. Participants will learn how to make use of stored data in generating information useful for administrative decision making, meeting educational requirements in training and simplifying managed care demands. There will be an opportunity to learn about the use of computers in education and training, including promises and limitations. Participants will have the opportunity to participate in a debate over the future of such systems and their benefits and limitations including, but not limited to, confidentiality.

27: AN ELECTRONIC MEDICAL RECORD FOR PSYCHIATRY

Jesse H. Wright, M.D., *Department of Psychiatry, University of Louisville, Norton Psychiatric Clinic, Post Office Box 35070, Louisville, KY 40232*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: 1) describe methods for using an electronic medical record in psychiatric practice and 2) identify specific needs for psychiatric documentation in electronic medical records.

PROGRAM DESCRIPTION:

The adaptation of commercially available software for a psychiatric electronic medical record is described and demonstrated. This system is based on Logician™ (produced by Medicalogic®), an electronic medical record widely used in general medical practice. Logician® had not previously been equipped with modules for recording psychiatric evaluations and treatment records, but this software has several important advantages including a Windows format and the potential to be used in general hospital settings and multidisciplinary clinics.

The psychiatric version of Logician™ presented here has been in use in a networked group of outpatient services in Louisville, Kentucky, for over one year. Clinicians and patients have responded very favorably to the introduction of this electronic medical record. Psychiatric records for Logician,™ including initial evaluations, treatment session notes, prescription writing, laboratory testing, and managed care reports are demonstrated. Results of clinician and patient surveys are also described.

28: COMPUTER ASSISTED SERVICE PLANNING

Kemal Sagduyu, M.D., *Department of Psychiatry, University of Missouri, WMMHC 600, East 22nd Street, Kansas City, MO 64108*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: write their own treatment plans within 10–15 minutes with the assistance of the CASP program.

PROGRAM DESCRIPTION:

Computer Assisted Service Planning (CASP) is a new Windows-based software application, created for use by mental health clinicians, MR/DD staff, physicians, or anyone who needs to write plans for patients or clients. It is designed specifically to assist in the development of treatment and service plans that can be completely individualized for each patient or client. CASP is easy to learn and makes the writing of plans simpler and faster.

CASP helps you from start to finish by providing a structured planning environment, targeting specific problem areas, suggesting treatments, and allowing the staff to develop individualized plans while continuously monitoring the progress. CASP meets all JCAHO and HCFA treatment plan requirements.

CASP supports both clinical and nonclinical staff. It helps you to create a treatment plan that fits each individual by offering a variety of suggestions for possible diagnosis, associated problems, probable symptoms and potential treatments, all from a database that has been customized for your program. CASP has a multilevel security access system and a user-controlled plan-locking system.

29: PARANOIA

PROGRAM DESCRIPTION:

This innovative and thought-provoking visual essay explores one of the most intriguing and characteristic aspects of the American national psyche: our propensity to distrust virtually everything around us. The film examines the forces that influence our everyday lives and ponders the extent to which we should, or should not, feel threatened by them.

Distrust of authority is a traditional part of the American psyche. But today, people seem more disillusioned that ever with the institu-

tions and values that underpin our society and more disposed than ever to take a jaundiced view of what they are told by the powers that be. Yet at the same time all of us each day accept hundreds of dubious assumptions without ever questioning their legitimacy.

A Henri Langlois International Film Festival (Poitiers, France) honoree.

30: STEP ON A CRACK

PROGRAM DESCRIPTION:

Obsessive-compulsive disorder or OCD was once thought to be rare. It is now estimated to affect between two and four percent of the population, nearly five million people in this country alone. In this outstanding new video six individuals with OCD talk about their feelings of isolation and lack of control and about being misunderstood by families, friends and the community. But they also discuss the ways they have come to manage the disorder through medication, psychotherapy and behavioral therapy. Speaking out about the disease has helped them to educate an often skeptical public and empower others to seek help, so that they can live more effectively with the disorder. *Step on a Crack* will be a valuable resource for patient and staff education, counseling and support groups, community outreach, and for schools of nursing, psychology, and social work.

31: DECEPTION: MUNCHAUSEN'S DISORDER

PROGRAM DESCRIPTION:

People with Munchausen's disorder invent illnesses in order to be admitted to a hospital. They repeatedly turn up in emergency rooms, claiming to be in acute distress and falsifying their medical histories. So convincing is their deception that they may even be operated on needlessly.

This powerful documentary follows 41-year-old Nina and 26-year-old Simon. Nina has made over 500 hospital visits in her lifetime. Having once suffered a genuine ectopic pregnancy, she has faked many such emergencies and been operated on seven times. While Nina's case is tragic, Simon is an even more complex individual who exhibits a dangerous combination of medical obsessions and habitual lying. He often goes directly from the medical library, where he researches symptoms, to the hospital.

Psychiatrist Dr. Ben John admits the medical profession is largely defeated by Munchausen's disorder. These people divert valuable health resources from the truly sick in their endless drive to gain attention. Psychiatrist Dr. Michael Murphy of Queen Mary's Hospital observes that the typical Munchausen patient has few peer relationships and uses nursing and medical staff for social contact that does not become too intimate.

32: TURNING THE TABLES

Janice Russell, M.D., *Department of Psychological Medicine, University of Sydney, 2 Greenwich Road, Greenwich, Australia NSW 2065*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participants should be able to: consider the use of video technology in addressing psychotherapeutic concerns in the early treatment of anorexia nervosa patients in the hospital setting.

PROGRAM DESCRIPTION:

This presentation is conveyed in the form of an in-house video documentary conceived after discussions with the family therapist and realized by Sally and Amanda, two participants in the inpatient program for eating disorders at the Northside Clinic, Greenwich, an affiliated teaching hospital of the University of Sydney. Sally and Amanda interview members of the clinical team while the latter eat a meal chosen for them by the interviewers. Through the role of competent journalist, these young women who have spent much of their adolescence in the thrall of anorexia nervosa, formulate searching questions, articulate a stronger voice and display a caring, if at times mischievous, attitude towards the staff interviewed. Their challenging voices are heard more strongly through their self-edited commentary where they reflect on the dilemmas of power and affiliation between clients and staff in the inpatient situation. The use of video technology can provide temporary, safe and creative spaces where young women in our care can engage in effective dialogue with their captors in the war about weight. Although other patients were initially reluctant to participate, some provided the graphics that effectively illustrate the questions posed. Staff were required to welcome the unexpected and to reveal something of themselves in the scrutiny of Sally and Amanda, turning the tables.

33: CONTACT

PROGRAM DESCRIPTION:

Contact tells the story of Ellie Arroway (Jodie Foster). A scientist who has devoted her life to the search for extraterrestrial life (SETI) and finds it. Based on the late Carl Sagan's 1985 novel, *Contact* originates from the distinguished astronomer's life-long study of planetary science and the radio search for extraterrestrial intelligence. Early in the film we come to understand Ellie's ambition as poignantly related to despair arising from the early loss of her father, who had encouraged her interest in radio communication. She perseveres against infinite odds in her hope of discovering radio signals of extraterrestrial life, which actually happens one day in the Arizona desert.

Their signals provide blueprints for a machine that will transport one person to that world. After fate intervenes, Ellie takes that remarkable journey out to the very edge of the universe where her fondest hope is realized. When she returns to Earth, she (as well as we, the audience) is left to ponder with reverence the magnificence of the universe.

34: RESPONSES IN MUSIC TO VIOLENCE AGAINST WOMEN

Keith Cheng, M.D., *Department of Adolescent Psychiatry, Emanuel Hospital, 3001 Gantenbein Avenue, Portland, OR 97227*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, attendees should be able to: 1) recognize that popular music has been written and performed by women to express the strong emotional responses that result from being victims of violence and 2) demonstrate knowledge of common themes in songs written about women's experience of violence.

PROGRAM DESCRIPTION:

This media presentation is composed of 10 songs that depict women's responses to the subject of women as victims of violence. Eight songs will be presented using compact discs accompanied by 35 mm slides of album cover art and two songs will be presented on videotape. Some common themes in these songs are: 1) feeling helpless and passive; 2) fighting violence with violence; 3) victimization by society; and 4) advocation of self-defense. All 10 songs were written by women and include a variety of views, including the self-experiences of victimization to being a bystander while another woman is harmed. Songs have been collected from rap, popular, and alternative music genres. Artists include Tori Amos, Bikini Kill,

Tracy Chapman, Dionne Farris, Hole, Joan Jett, Sara McLachlan, Heather Nova, Queen Latifah, and Tribe 8. Some songs graphically describe violent acts or contain adult language.

35: PACKING HEAT

PROGRAM DESCRIPTION:

In a culture of fear where women are assaulted by images of themselves as victims, the idea of picking up a gun and getting even is tempting. Women who carry firearms don't fit stereotypes: they can be soft-spoken liberals, doctoral students, or nurses. They see the right to pack a gun as an issue of women's empowerment. Many call themselves feminists. *Packing Heat* profiles women of this emerging gun culture, from self-styled guru Paxton Quigley, to a University of Toronto psychology professor who spends her weekends at the gun club. This video also features self-defense advocates and anti-gun feminists who say that security doesn't come from the barrel of a gun, and that weapons makers are profiting from fear. Most of the women featured in *Packing Heat* say they feel safer armed. But with guns far more likely to kill a child than an intruder, is that sense of safety or illusion? This lively documentary looks at why women want to carry firearms, and at the ethical and practical implications of a gun in every purse.

36: TRAINSPOTTING Collaborative Session with the National Institute on Drug Abuse

PROGRAM DESCRIPTION:

Based on a cult novel by Scottish author Irvine Welsh, *Trainspotting* is a riveting character study of five junkies who drift in and out of an uncharmed circle of losers, liars and thieves in a rundown English suburb. Directed by Danny Boyle (*Shallow Grave*) and featuring Jonny Lee Miller (*Hackers*), this emotional drama of betrayal and friendship is also a humorous tale of morality.

37: PSYCHOTHERAPY ON THE INTERNET

Russell F. Lim, M.D., *4832 Cowell Blvd., Davis, CA 95616*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to 1) describe the Internet, the equipment necessary to connect to the Internet, the World Wide Web, Web browsers, 2) explain how Internet Relay Chat (IRC), USENET Newsgroup, video conferencing, and electronic mail can be used to augment or provide individual and group therapy, as well as consultations.

PROGRAM DESCRIPTION:

The Internet is a dynamic, rapidly evolving and enlarging international computer network that enables the exchange of most forms of data, including text, graphics, audio, and video among geographically distant mental health clinicians and their patients. The recent development of graphical interfaces to the Internet has made access to its resources much easier for individual users. In addition, the Internet's explosive growth has given consumers and mental health service providers greater access to its resources and capabilities. In this presentation, the Internet and how it can be used to provide treatment to patients will be described and demonstrated.

In particular, I will focus on the use of electronic support groups on the USENET, the use of Internet Relay Chat (IRC) for real time support groups run by consumers, the use of video conferencing in psychiatry and the use of specialized software for treatment of specific groups of patients. In addition, consultation and psychotherapy are available on the Internet, and websites for both will demonstrated. Issues of security and confidentiality, liability, and licensure will be discussed.

38: CYTOCHROME INTERACTIONS VIA THE WEB

Robert D. Patterson, M.D., *21 Blossom Street, Lexington, MA 02173*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants will better understand the use of Web-based information for clinical decision making specifically in regard to cytochrome enzyme interactions.

PROGRAM DESCRIPTION:

Psychiatric and other drugs frequently interact with the cytochromes. The interactions has the potential to increase or decrease blood levels and therefore seriously affect drug benefits and side effects. The numerous interactions and rapidly emerging knowledge about them are too much for clinicians to keep in mind. This program aims to provide a means to sort this information for use in clinical situations.

The program searches a comprehensive database about cytochrome interactions for potential effects among drugs. It can help spot potential problems when a new drug is added and it can help to choose the best drug to add from a group (such as antihypertensives). Ratings, clinical relevance and confidence are included as are references.

The program accesses the latest information via the Web. The database can be updated at the time a search is made or periodically when a Web connection is convenient. The "engine" for using the database is downloaded only once from the Web. This affords rapid program response, no necessity to be connected to the Web at the time of use, and yet completely updated information. This program can be incorporated into clinical record keeping or other large programs.

39: COMPUTER-ASSISTED PSYCHOTHERAPY

Jesse H. Wright, M.D., *Department of Psychiatry, University of Louisville, Norton Psychiatric Clinic, P.O. Box 35070, Louisville, KY 40232*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to: 1) describe major forms of computer-assisted psychotherapy including computer-assisted instruction, behavioral programs, and multimedia; and 2) identify methods of integrating computer tools into the practice of psychotherapy.

PROGRAM DESCRIPTION:

Recently developed software for computer-assisted psychotherapy may offer opportunities for improving efficiency and reducing cost of treatment. Early attempts to stimulate traditional therapeutic interviews have been supplanted with computer programs that use the unique features of computers to assist the human therapist. Contemporary programs for computer-assisted psychotherapy typically employ easy-to-use interfaces that are suitable for a wide range of patients. Examples include multimedia computer programs, behavioral systems to promote exposure and response prevention, and interactive voice response.

This program will provide an overview of programs that have been developed for computer-assisted therapy and will demonstrate methods for clinical use of therapeutic software. Advantages and limitations of the different forms of computer-assisted psychotherapy will be discussed. Participants will be able to gain experience in using a multimedia program for cognitive therapy through a CD-ROM demonstration and discussion of cases of patients treated with

this type of computer-assisted therapy. The final segment of this program will focus on advances in technology and software development that may lead to increased use of computer tools in psychotherapy.

40: PREVENTION OF SUBSTANCE ABUSE: RISK FOR FAMILIES AT RISK Collaborative Session With the National Institute on Drug Abuse

Lawrence J. Hatterer, M.D., *Department of Public Health, 167 East 79th Street, Off Campus Office, New York, NY 10021*

PROGRAM DESCRIPTION:

Three urban multiethnic families at substance abuse risk on Thanksgiving, Easter and New Years Day holidays respond to their adolescent members' drug-related auto accident. Their common interactions and resolutions educate the viewer to etiologic factors that raise their consciousness of their denials of the multiple dimensions of the addictive process. These videotapes are currently in use for a National Institute on Drug Abuse prevention research study of Caucasian, African-American and Hispanic populations in New York City over a three-year period.

41: A MOTHER'S GRIEF

PROGRAM DESCRIPTION:

This intensely moving documentary follows a support group for mothers struggling to deal with the unthinkable—the death of a child. In this support group, you meet courageous women of various ages and backgrounds and watch as they are bound together by their sense of loss. Excellent for bereavement counselors, support groups, and staff training.

Winner, Loss & Transition Category, Aquarius Film Festival

42: GROWN-UP TEARS

PROGRAM DESCRIPTION:

Losing a parent can be one of the most difficult and painful times in our lives, regardless of how old we are. This video explores how adults feel about, and cope with, the loss of a parent through the eyes and experiences of seven individuals who are supported by three professionals. The participants share stories of what life was like at the actual moment of their parent's death as well as their anticipation of the death of the parent. Excellent for professionals, training, bereavement groups, and area agencies on aging.

43: STRAIGHT DOPE

PROGRAM DESCRIPTION:

Straight Dope document homeless punk youth as they design projects that educate their community about HIV. Faced with IV drug use and the harsh reality of life on the street, these youths prove the effectiveness of empowering the individuals within a community to speak for themselves. By documenting this outreach from its inception, *Straight Dope* explores the many levels of working with a high-risk subculture. The video is designed to be used as an inspirational training tool for those interested in working with youth at risk today.

National Educational Media Network Gold Apple Winner, 1997

44: THE DARK SIDE OF THE MOON

PROGRAM DESCRIPTION:

This moving documentary weaves together the stories of three mentally disabled men, formerly homeless, who have overcome despair, stigma and isolation to become valued members of their community. Joe, diagnosed with paranoid schizophrenia, now provides peer counseling and manages an apartment complex for homeless men. After years of hospitalization for schizophrenia, Ron now advocates for patients' rights and is raising his six-year-old son as a single parent. John still struggles with paranoia, but now lives independently and works as an artist and poet. After years of feeling hopeless and helpless, through their relationships with understanding friends and community resources, they now help others.

45: PSYCHOTIC DISORDERS

46: ANXIETY DISORDERS

47: MOOD DISORDERS

PROGRAM DESCRIPTION:

This series of three clinical programs reveals additions and changes from DSM-III-R to DSM-IV for mood, psychotic, and anxiety disorders. Each videotape focuses on one particular area of psychiatric diagnosis and contains enactments of three outstanding clinicians' actual patient interviews. Nancy C. Andreasen, M.D. is Andrew H. Woods Professor of Psychiatry, University of Iowa College of Medicine and is the interviewer for *Psychotic Disorders*; Andrew E. Skodol II, M.D. is Associate Professor of Clinical Psychiatry at the College of Physicians and Surgeons of Columbia University and is the interviewer for *Anxiety Disorders*; and Ellen Frank, Ph.D. is Professor of Psychiatry and Psychology at the University of Pittsburgh School of Medicine and is the interviewer for *Mood Disorders*. Each videotape begins with an introductory discussion between the clinician and the moderator. The clinician then conducts three 10-minute psychiatric diagnostic interviews. Following each interview, the clinician and the moderator discuss the taped segments and comment on issues illustrated during the interviews. These issues include: how the DSM-IV diagnostic criteria were utilized in the interview; how diagnostic markers were elicited and how interpersonal issues as well as diagnostic markers were identified.

The interviews utilize reference data to examine conclusions reached during the interviews. Each tape also demonstrates good interviewing techniques and highlights the development of a good doctor-patient relationship.

48: CAN'T YOU HEAR THE WIND HOWL?

PROGRAM DESCRIPTION:

Can't You Hear the Wind Howl? Shows the life and music of Robert Johnson. Over 50 years of mystery have surrounded this gifted bluesman who lived in the rural South of the 1920s and 1930s. Few details of his life were known; in fact, only two photographs of him are known to exist. He was a loner, who supposedly shook hands with the devil for his extraordinary talent, and who was murdered when he was just 27 years old. He could charm young women

into a night's shelter and warmth as he drifted from town to town playing a circuit of juke joints, country picnics and street corners. He performed his original songs with unmatched intensity and style: songs about shady women, nights of terror, and walking with the devil—*Hellhound On My Trail, Dust My Broom, Crossroad Blues, Walkin' Blues, Sweet Home Chicago and Come On In My Kitchen.* Johnson recorded only 29 songs, but they constitute the most astonishing, influential body of work any bluesman has ever committed to wax.

Now award-winning actor Danny Glover takes us on an evocative and enthralling journey through Robert Johnson's short life by revealing for the first time his true story, based upon new factual information along with exclusive interviews with people who knew him and by vividly recreating Johnson's life from boyhood to his death in 1938. Robert Johnson is portrayed by W.C. Handy Award-winning blues musician, Kevin Moore (aka Keb' Mo'), who mimes both Johnson's guitar and voice to the original *Vocalion* recordings.

49: BOOTING UP YOUR PRACTICE

Theron C. Bowers, Jr., M.D., *10600 Fondren 217, Houston, TX 77096*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: recognize barriers, in establishing a computer-based record-keeping system and recognizing benefits and areas for using a clinical electronic database system in a psychiatric practice.

PROGRAM DESCRIPTION:

Although the computer is a common tool in many or most psychiatric practices, its use remains confined to primarily administrative jobs such as billing and scheduling. As a cognitive-based specialty with a primary task of collecting and evaluating patient information, electronic database management has numerous potential benefits for psychiatrists in all areas of practice. This presentation will explore issues regarding computerized clinical database management in psychiatric practices.

This program will examine potential barriers and challenges in maintaining electronic records. The presentation will also illustrate the benefits and goals of an efficient computerized clinical system by demonstrating a patient-tracking computer program based on a relational database. Using this program we will show the basic requirements of a patient-tracking system, such as records of progress notes, mental status examinations and medications. We will also demonstrate more advanced and specialized features in tracking a patient's progress and monitoring medication side effects. Finally there will be instructions on implementing a computerized record keeping system in private practice.

50: A COMPUTER ASSESSMENT USING SCORES AND NARRATIVES

Elliot D. Luby, M.D., *Department of Psychiatry, Sinai Hospital, 14800 West McNichols Road, Detroit, MI 48235*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to: display a biopsychosocial evaluation model in a computer presentation that demonstrates how a PC can be used for patient assessment and charting.

PROGRAM DESCRIPTION

The basic model is first described using a computerized slide show with a laptop PC and an LCD projector. Although the model is very simply based upon expectations and performances, it is a transformation of Erikson's theory of the psychosocial development of children. Our research has shown that to acquire confidence in self (autonomy) and confidence in others (trust), expectations of self and others have to be met through performances in 16 life vectors or basic biopsychosocial needs. The model identifies the cognitive distortions (erroneous expectations) and patterns of reaction (destructive performances) that prevent a person from functioning in the community, and even more to the point, how to correct them.

The interview protocol is made up of checklists and open-ended questions and recorded in paper form. In the second part of this demonstration an example will be entered into the laptop, and the machine will then interactively construct a short summary of numerical scores, such as imbalances between expectations and performances, the number of serious problems noted and narratives transcriptions when they occur. The resulting summary will be distributed.

51: RELATIONAL DATABASE IN CLINICAL PRACTICE

James H. Grubbs, M.D., *Cleo Wallace Center, 4400 East Cliff Avenue, Denver, CO 80222*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: search and fill fields in the database, perform simple queries, access reports, merge documents with the data, and analyze data with a spreadsheet program.

PROGRAM DESCRIPTION:

Commercially available relational database programs, such as Microsoft Access, can be readily adapted to psychiatric practice for the collection and analysis of clinically relevant data. Those data can then be used to fulfill multiple purposes, including the rapid preparation of clinical documents and reports, the analysis of patient populations and practice patterns, and quality improvement. The presentation will demonstrate the basic functions of a relational database and the associated word-processing and analytical programs. Participants will be able to discuss the use of these programs in their own practices. Simple queries will be produced on demand and more elaborate functions, such as merging documents and analyzing parts of the database, will be demonstrated. The presentation will be visible to participants on a large screen connected to a PC containing the programs.

52: DEALING WITH THE DEMON: A THREE-PART SERIES

PROGRAM DESCRIPTION:

After 75 years of a concerted global fight to restrict the supply of addictive drugs, the world is currently facing unprecedented levels of illicit drug production, with 10 times more heroin produced now than during the last ''plague'' of the 1970s. *Dealing with the Demon* is the story of opiates in three chapters which gives a powerful insight into society's epic struggle with all drugs of addiction.

Episode One: The Seeds of War

The Seeds of War traces the growth of the international drug trade and the failure of the United States-led process of international prohibition to contain it. The film opens with a bumper opium harvest in Afghanistan and links this to the recent rise in middle-class heroin use in the United States. This provides the launching point for an inquiry into the history of the drug trade, which takes us to former British opium factories on the banks of the Ganges and through the archives of Persia and China.

Episode Two: An Unholy Alliance

This episode examines the relationship between the drug trade and war, detailing the involvement of the CIA in Vietnam and Afghanistan during the Cold War. From the time of Chiang Kai

Shek in China, through the front lines of the Cold War, in South East Asia, the Golden Triangle, and later in Vietnam, *An Unholy Alliance* examines how priorities designed to defeat Communism led to the protection and spread of illicit drugs.

Episode Three: Containing the Fallout

The final film in the series investigates the spread of heroin use, its role in fueling the AIDS epidemic, and the most effective means for dealing with illicit drugs. In a remote village in Thailand, the film shows the devastating move by villagers away from traditional opium to the much more dangerous use of heroin, a widespread occurrence that is contributing to Asia's massive AIDS epidemic. The film then examines (in the United States and overseas) the historical evolution of what is called a harm-reduction strategy for dealing with drug use. In the United States, harm reduction is strongly resisted, because some have labeled it a form of "legalization." *Containing the Fallout* observes how the historical tussle between the criminal view and the medical view of illicit drug use is played out against a world-wide plague of opiate addiction. AIDS is finally forcing many nations., including our own, to confront the reality of failed drug policies.

53: HEALING WOUNDED HEARTS

PROGRAM DESCRIPTION:

This outstanding new video is an excellent teaching tool for parents going through divorce and for their children, mental health professionals and divorce mediators. Fears, confusion, loss and just plain sadness often interfere with our ability to communicate feelings with loved ones about this painful process. *Healing Wounded Hearts* invites healthy discussion of the typical feelings associated with divorce. Listening to the thoughts and feelings of other children and parents about divorce gives us a window through which to explore our own feelings and begin the healing process.

54: WHEN THE BOUGH BREAKS

PROGRAM DESCRIPTION:

Current theory holds that if a child does not properly attach itself to a caregiver in the first three years, the implications for later life are profound. This can show up in the form of overly aggressive behavior, serious learning problems, and delinquency.

The film crew followed three mothers and their problem children, ages 10 months to three years. All represent middle-class, low-risk, intact families. The film traces them through three months of therapy at the C.M. Hincks Treatment Centre in Toronto.

Two of the children have never slept through the entire night, and one child has a serious eating disorder. She holds food in her mouth for up to three hours, refusing to swallow. The families of these children are pushed to the edge of despair in trying to manage them. Cameras were placed in the homes of the families and tapes of therapy sessions were used to observe the behavior of the children and their interaction with their parents. It becomes clear that children, even before they can speak, give out signals of disturbance. If there is not proper intervention, the entire family can be thrown into turmoil.

55: BREAKING THE CYCLE

PROGRAM DESCRIPTION:

This film looks at families struggling with preschoolers who have serious behavior problems: such as tantrums, rages, persistent disobedience, whining and hyperactivity. Many children with early antisocial behavior grow up to be persistent offenders in later life. Once they get into the criminal justice system, it is often too late to rehabilitate them.

This video demonstrates how early interventions at a special needs preschool can help parents learn positive reinforcement tactics to break the cycle of oppositional behavior. Parents learn the techniques to control their children and teach them to control themselves. We watch the unflappable teachers interact with these difficult children, putting boundaries on their disruptive behavior. While the film is set in Great Britain, the emotions of the parents, behaviors of the children, supports offered by professionals, and behavior-modification methods reveal universal themes.

56: MOMIJI: JAPANESE MAPLE

PROGRAM DESCRIPTION:

The filmmaker offers an intimate, and moving documentary about three generations of her Japanese-Canadian family. We see the psychological issues raised from her grandparents' immigration to Canada, internment during WWII (similar to the fate of Japanese-Americans), the prosperous but intolerant 1950s and 1960s, and the present multicultural family.

57: KIM'S STORY: THE ROAD FROM VIETNAM

PROGRAM DESCRIPTION:

If there was one photograph that captured the horrific nature of the Vietnam War, it was that of a nine-year-old girl running naked down a road, screaming in agony from napalm burns that had eaten into her flesh. The photographer who took that picture of young Kim Phuc was awarded a Pulitzer Prize. Four years ago, she and her husband defected to Toronto, Canada, where they were given initial sanctuary by Quaker activist Nancy Pocock. In telling Kim's story, award-winning filmmaker Shelley Saywell has filmed doctors and journalists who ensured her survival 25 years ago. In order to confront her past, Kim comes to America where she meets many people who help fill in the holes of her story, the things she cannot remember or knew only from the perspective of an injured child.

The climactic end shows her speaking at a Veterns' Day ceremony at Washington's Vietnam War Memorial and meeting a veteran who claimed responsibility for ordering the napalm strike that almost killed her.

58: THE SHOT HEARD ROUND THE WORLD

PROGRAM DESCRIPTION:

When Yoshi Hattori, a Japanese high school exchange student, was shot to death in 1993 by a suburban homeowner, the whole world was shocked once again at American's gun culture. Christine Choy, director of the multiaward-winning film *Who Killed Vincent Chin?*, spent three years researching the event and the ensuing criminal and civil trials. The result is this searing study on the pathology of urban fear, gun violence, criminal justice and cultural miscommunication.

Yoshi had approached the Baton Rouge home of Rodney and Bonnie Peairs seeking directions to a Halloween party. Bonnie feared the stranger walking up her driveway and summoned her husband. Gun in hand, Rodney shouted "freeze" to which Yoshi, unfamiliar with the idiom, did not comply. Rodney then pulled the trigger.

Yoshi's parents, who had raised their son to admire America, suffered their loss with dignity. They recall their son as an honor student who enjoyed life with his host family and was well liked by his new classmates. Rodney Peairs had an extensive gun collection. The film does not take sides regarding his claim that he was defending his rights as a homeowner. Avoiding simple answers, it

serves up a complex picture, letting the audience draw their own conclusions about one of the most controversial criminal cases in recent years.

59: WHEN WE WERE KINGS

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to: demonstrate an understanding of some of the historical, identity, black, white, african and African-American ethnic issues that characterized this period in the 1960s and 1970s in the United States and the world.

PROGRAM DESCRIPTION:

This award-winning documentary is the untold story of the events and activities leading up to the boxing match between Mohammed Ali and George Foreman in Zaire in 1974. This program will address how the issues presented in this film impact upon the 1990's United States' racial relationships as seen in the world of sport. How sporting events transcend many societal boundaries will be discussed and the importance of role models from professional sports will be evaluated. At the conclusion of this film the panel will also discuss the role, of a violent sport such as boxing, plays and what impact it has on the collective consciousness of the United States.

This media session, presented by members of the International Society for Sport Psychiatry, will explore the issues in the film *When We Were Kings* with a focus on the response to the film by different demographic groups in the United States.

60: A HEALTHY BABY GIRL

PROGRAM DESCRIPTION:

In 1963 filmmaker Judith Helfand's mother was prescribed the synthetic hormone diethylstilbestrol (DES), meant to prevent miscarriage and ensure a healthy baby. But technology is rarely a benign midwife. For more than 30 years pharmaceutical companies sold DES to millions of pregnant women in the United States, even though they knew the drug was ineffective and carcinogenic.

At age 25, Judith was diagnosed with a rare form of DES-related cervical cancer. She went home to her family to heal from a radical hysterectomy and picked up her camera. Her video diary, *A Healthy Baby Girl*, is an intimate, humorous and searing exploration of what happens when science, marketing and corporate power come together with our deepest desires to reproduce ourselves.

Shot over five years, *A Healthy Baby Girl* goes beyond loss to document a story of mother-daughter love, family renewal, survival, political awakening and community activism. An invaluable resource for anyone interested in the relationship between women's health, public policy, medical ethics and corporate responsibility. An ITVS production.

Sundance Film Festival, 1997

61: DIALYSIS: LIVING WITH CHOICES

Lewis M. Cohen, M.D., *Department of Psychiatry, Baystate Medical Center, 759 Chestnut Street, Springfield, MA 01199*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate some of the barriers that affect completion of advance directives by patients with end-stage renal disease.

PROGRAM DESCRIPTION:

We are unaccustomed to thinking of end-stage renal disease (ESRD) as a terminal illness, yet its mortality rate is higher than that associated with HIV or many types of cancer. While dialysis or transplantation sustain life, the underlying disease responsible for causing renal failure often continues its inexorable progress. The adjusted mortality rate for hemodialysis patients is 21.3/100 dialysis years, and the risk of death for a 45-year-old maintained with dialysis is 20 times that of someone of the same age not on dialysis. Treatment can become a Sisyphean ordeal, and cessation of dialysis is increasingly an option; in New England, 24% of ESRD patient deaths are now preceded by dialysis discontinuation.

Advance directives, such as living wills or health care proxies, are completed by only about 4% of our patients with ESRD. Perhaps not surprisingly, in a survey of the nephrologists and surgeons who care for these patients, only one out of 11 doctors had completed his/her own advance directive.

We propose to establish a Renal Palliative Care Initiative to improve the terminal treatment of individuals with ESRD. As part of the program, this videotape will be used to promote discussion of end-of-life issues between patients, their families and staff.

62: THE NICHOLAS EFFECT

PROGRAM DESCRIPTION:

In 1994, seven-year-old Nicholas Green was murdered during a robbery while vacationing in Italy with his parents and sister. This moving video recaptures the decision of Californians Maggie and Reg Green to donate some of their son's organs (and tissue) to enable others to live and to have a future that Nicholas was denied. Footage of the boy at school, his funeral services and the Greens revealing facts about some of the individuals who benefitted from their altruism is sure to encourage others to emulate this charitable deed. These parents have transformed their private pain into increased public awareness of the need for organ donation.

63: BEAUTIFUL DREAMERS

PROGRAM DESCRIPTION:

This film is based on historical events.

The superintendent of the London, Ontario, insane asylum, Dr. Maurice Bucke, despairs of the treatment methods in use during the Victorian era, which consisted essentially of restraint and electroshock. At a conference in Philadelphia, he makes the acquaintance of poet Walt Whitman. This meeting will radically change his life, and that of his wife and patients. Whitman, who travels to London at Bucke's invitation, has avant-garde ideas on the subject of mental illness, sexuality, the emotions and life in general, ideas that are also profoundly humanistic and enlightened.

64: WHOSE CHILD IS THIS?

PROGRAM DESCRIPTION:

After the Indian tribes were vanquished in North America, the governments of the United States and Canada systematically destroyed their cultures as well. Young children were taken away from the tribes and sent to missionary and government residential schools where they were not allowed to use their native language. By the time the schools closed in the 1960s, six generations had grown up without their parents, in alien environments. Having no parental models, they became poor parents themselves, prey to alcoholism and apt to be abusive. Often their babies would be whisked away for adoption by stable white families by social workers who deemed their Indian families unlikely to provide an appropriate environment. Thus the tribes would lose many of their children.

This film looks at several families in which adults have been repatriated. Katrina at 16 months was adopted by a loving Scottish

family, which returned with her to Scotland. As she grew up, she felt increasingly alienated from the White society that surrounded her. Now a mother of a four-year-old, she returns to Alert Bay to find her roots. The film shows that it is a complicated emotional process to re-establish native ties on a reservation. In Idaho a young Lakota boy is being claimed by his biological father. The White adoptive parents fear the trauma of separation could be devastating. There is an active tribal organization that scours the world for lost Native-American children and fosters repatriation. The film revels both well-meaning and exploitive adoptive families and the wrenching process of trying to heal old wounds.

65: WHERE HAVE ALL THE CHILDREN GONE?

PROGRAM DESCRIPTION:

Focusing on North Dakota, this thoughtful documentary takes a look at the crisis facing many rural communities. What these communities are facing is the abandonment of farms, the departure of young people, closures of local schools, and failures of small business. This is a poignant portrait of people who love their land but are being forced out by economic circumstances beyond their control. The attachment to the land is expressed by author Kathleen Norris, who evokes the unique beauty of the prairie.

The filmmaker was one of the 12 children who grew up in North Dakota. Only two remain in the state. She shows the hard economic reality with which the farmers struggle as family farms no longer support a new generation. The broader implication is that an entire region of our country could become a wasteland. How can this trend be reversed? Among the possible solutions shown are the more profitable business of processing the farm products locally rather than shipping such commodities to out-of-state-food-processing plants. We see one coop that is starting to do this. But there is no single solution to this problem, which demands national attention.

66: MS. CONCEPTIONS

PROGRAM DESCRIPTION:

What makes a vibrant, college-educated, and single 30-something woman decide to pack in the search for Mr. Right and pick up a $250 vial of sperm instead? Over the past decade, the birth rate among this group of women has nearly tripled. They may have given up on relationships but are unwilling to sacrifice motherhood. In their models of family, men are superfluous.

Lea is 32 and has chosen artificial insemination, even though it makes her feel "dirty" and leaves her wondering "who will really be the father of this child." Rebecca, 38, is tired of her "party girl" life and scours personal ads for a suitable "live donor." And Anne, 39, who was "accidentally" impregnated by her ex-boyfriend, must cope with a wanted, but solitary, pregnancy.

The film also looks at the burgeoning sperm industry from artificial insemination trade shows to custom-ordered sperm ("the specimen is available in standard or prewashed"), to the suppliers of raw materials, the anonymous donors who are helping to create children they will never know.

As it examines both side of the "single mother by choice" controversy, *Ms. Conceptions* charms as it lends invaluable insight into the "family values" debate raging in the political arena, the media, and the hearts of three women who decide to go it alone.

1996 Gemini Award Winner, Best Documentary, Academy of Canadian Cinema & Television
Silver Apple Winner, 1996 National Educational Media Network Competition 1995 International Women's Film Festival (Madrid)

67: YOU DON'T KNOW DICK

PROGRAM DESCRIPTION:

This film portrays the journey of six men who were once women. Its examination of gender transformation causes all of us to reexamine our own search for identity.

The National Educational Media Network's Gold Apple Award winner 1997

MEDICAL UPDATES

1. CONGESTIVE HEART FAILURE

Howard R. Levin, M.D., *Chief Scientific Officer, Cardio Technologies, Inc, 960 Broadway, New York, NY 10032*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have an overview of current advances in drug therapy for congestive heart failure. In addition, a brief overview of novel medical and surgical therapies for end-stage congestive heart failure will be presented.

SUMMARY:

Congestive heart failure is a major health problem for the United States affecting more than 4.7 million people. This population is growing at a rate of more than 400,000 cases per year. New advances in medical therapy have been able to significantly decrease mortality and increase quality of life. Recent advances in therapy have been able to show significant benefit across all classes of heart failure. Unfortunately, drug therapy alone is insufficient for a large number of patients with end-stage congestive failure. Cardiac transplantation has been the gold standard for treatment of these patients. However, new advances in the surgical treatment of heart failure have made the prospect of a permanent mechanical alternative to heart transplantation feasible. A brief review of the current clinical and experimental methods for cardiac replacement therapy will be presented.

REFERENCES:

1. Chen JM, Levin HR, Rose EA, Addonizio LJ, Landry DW Sistino JJ, Michler RE, Oz MC: Experience with right ventricular assist devices for perioperative right-sided circulatory failure. Ann Thorac Surg 61:305–310, 1996.
2. Tsitlik JE, Levin HR, Halperin HR: Measurements in Cardiopulmonary Resuscitation Research. In: Paradis NA, Halperin HR, Nowak RM (eds). Cardiac Arrest: The Science and Practice of Resuscitation Medicine. William and Wilkins, MD, 11(A):218–238, 1996.

2. HERBAL MEDICINE

Richard P. Brown, M.D., *Psychopharmacology, 30 East End Avenue, New York, NY 10028–7053*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be aware of recent surveys that indicate one-third of the U.S. population is taking herbal remedies for common health problems. Some herbal treatments are marketed primarily for their psychotropic properties, for example, in depression, anxiety or insomnia. These may have helpful or harmful psychiatric effects, with significant side effects and interactions. In addition, other herbal or alternative treatments may have significant cognitive or mood altering effects. The physician should be aware of these new alternatives in order to avoid significant interactions with existing psychotropics, in order to enhance the therapeutic alliance with patients who rely on these remedies, and because these remedies are likely to increase our knowledge of pathophysiology of underlying psychiatric disorders.

SUMMARY:

This session will be an overview of herbal treatments in psychiatry, as well as some common medical indications for herbal remedies. The presenter will review the recent expanding extensive use in the general population in this country and in Europe. General principles and problems of current herbal use will then be reviewed. A segment will be devoted to natural treatments for depression, including St. John's wort and S-adenosyl-methionine, as well as other treatments. Treatment of anxiety including kava and other plant compounds will be reviewed. Various approaches to the treatment of insomnia, including during pregnancy, will be covered. Some of the data surrounding melatonin and current controversy will be reviewed. Remedies for treatment of migraines, premenstrual syndrome, bipolar disorder stabilization, cognitive enhancement (such as in age-associated memory impairment, Alzheimer's disease, and ADD) and sexual enhancing herbs will be covered. There will be a brief presentation on herbs used for athletic performance enhancement, treatment of side effects of cancer chemotherapy and radiation, prevention of cancer, and anti-aging alternatives in wide use. Interactions of common herbal treatment will also be reviewed. Finally, some examples of reported herbal toxicities will be shown as well as a review of how safe natural products are.

REFERENCES:

1. Upton R et al.: American Herbal Pharmacopoeia, St. John's wort. Herbalgram 40:36, 1997.
2. Kagan BL et al.: Oral S-adenosyl-methionine in Depression: A Randomized, Double-Blind, Placebo-Controlled Trial. Am J Psych, 147:591–595, May, 1990.

3. NOT RECEIVED

4. PREGNANCY OUTCOME FOLLOWING THE USE OF ANTIDEPRESSANTS

Irena Nulman, M.D., *Division of Clinical Pharmacology, Hospital for Sick Children, 555 University Avenue, Toronto Ontario, M5G 1X8, Canada*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants understand that a large number of depressed pregnant women require pharmacotherapy with either tricyclic antidepressants or serotonin reuptake inhibitors. The decision of treatment is complicated by the need to balance maternal well-being with fetal safety.

SUMMARY:

Depressive disorders are common in women of childbearing age and often require drug therapy. Depression is associated with significant economic costs, morbidity, and if left untreated, the rate of suicide may be as high as 15%. The decision to continue or initiate pharmacotherapy in a pregnant woman with an affective disorder is complicated by the need to balance maternal well-being with fetal safety. Because more than one-half of the pregnancies are unplanned, and many fetal exposures may occur, it is essential that the safety of antidepressants in pregnancy be properly addressed.

The tricyclic antidepressants (TCA) and agents that selectively inhibit the reuptake of serotonin are the drugs of choice in controlling depressive mood disorders. Although these medications cross the placental barrier and reach fetal circulation, they have not been found to produce major malformations in humans. The recent "Motherisk" study concluded that in utero exposure to either TCAs or fluoxetine does not affect global IQ, language, or behavioral development in preschool children. As a result of these studies, the "Motherisk" program and other Teratogen information services suggest that first trimester exposure to TCAs or fluoxetine does not appear to pose a significant reproductive risk and should not be an indication for an elective termination of pregnancy. Therefore antidepressant therapy should be considered during pregnancy if clinically indicated.

REFERENCES:

1. Pastuszak A, Schick-Boschetto B, Zuber C, et al.: Pregnancy Outcome Following First Trimester Exposure to Fluoxetine. JAMA 269:2246–2248, 1993.
2. Nulman I, Rovet J, Stewart DE, et al.: Neurodevelopment of Children Exposed in Utero to Antidepressant Drugs. The New England Journal of Medicine 336:358–262, 1997.

NIDA/NIMH WORKSHOP

Collaborative Session with the National Institute on Drug Abuse

DOS AND DON'TS IN WRITING YOUR FIRST NIH GRANT

Co-Chps.: Andrea Baruchin, Ph.D., and Lucinda Miner, Ph.D.
Participants: Teresa Levitin, Ph.D., and David Shore, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1) have a deeper understanding of the NIH grant review and funding process, 2) write and submit a research grant to NIH.

SUMMARY:

This workshop is designed to orient junior or seasoned investigators unfamiliar with NIDA and NIMH grants to the granting process. The critical elements of grant writing and the NIH review and funding process will be discussed. Participants will become familiar with grant opportunities available to psychiatrists at both NIDA and NIMH. Staff members from both NIDA and NIMH will discuss grant mechanisms available to new investigators as well as research training opportunities. Time will also be available for questions and discussion of funding opportunities.

REFERENCES:

1. Oetting, ER: Ten fatal mistakes in Grant Writing. Prof. Psych.: Res. and Prac. 17: 570–573, 1996.
2. National Institutes on Health: Preparing a Research Grant Application to the NIH. US Govt Printing Off. 1995.

PRACTICE GUIDELINES UPDATE: APA STEERING COMMITTEE ON PRACTICE GUIDELINES
PRACTICE GUIDELINES: DELIRIUM AND HIV/AIDS

Co-Chairpersons: John S. McIntyre, M.D., Deborah A. Zarin, M.D.
Participants: Sara Charles, M.D., Stephen McDaniel, M.D., Paula Trzepacz, M.D., Philip Wang, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will have an update concerning the overall progress of the APA practice guidelines effort and will obtain feedback on a wide variety of issues relating to the project in general and the development of the Delirium and HIV/AIDS guidelines.

SUMMARY:

The APA practice guidelines project has moved forward according to a previously approved process designed to result in documents which are both scientifically sound and clinically useful to practicing psychiatrists. On the basis of nationally recognized standards for the development of practice guidelines (sometimes termed "practice parameters"), APA guidelines reflect the following: 1) comprehensive literature reviews; 2) classifications of supporting evidence; 3) a framework for clinical decision making; and 4) a series of recommendations.

The session will focus on the new practice guidelines on Delirium and HIV/AIDS. The guidelines present data on pharmacologic and psychosocial treatments. In addition, highlights of other practice guidelines will be discussed. Practice guidelines on Eating Disorders, Major Depressive Disorder, Bipolar Disorder, Substance Use Disorders, Psychiatric Evaluation, Nicotine Dependence, Schizophrenia, Alzheimer's Disease, and Panic Disorder were published from 1993–1997. Four more guidelines are in development on Geriatric Care, Delirium, Borderline Personality Disorder and HIV/AIDS. Attendees will be invited to comment on the broad array of issues relating to practice guidelines including guideline content, overall development procedures, dissemination and evaluation strategies, future guideline topics and implications for the field.

REFERENCES:

1. Zarin DA, Pincus HA, McIntyre JS: Editorial on Practice Guidelines. Am J Psych 150:2, 1993.
2. APA: Practice Guideline for Treatment of Patients with Bipolar Disorder. Am J Psych 151:12(suppl), 1994.

RESEARCH ADVANCES IN PSYCHIATRY

RESEARCH ADVANCES IN PSYCHIATRY: AN UPDATE FOR THE CLINICIAN

Chairperson: Herbert Pardes, M.D.
Co-Chairperson: Daniel K. Winstead, M.D.
Participants: Alan Leshner, Ph.D., Jimmie C. Holland, M.D., Stuart Yudofsky, M.D., Harold A. Sackeim, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will become familiar with new advances in research, especially those covered at the 1998 Annual Meeting. In addition, participants will learn about new research in substance abuse, psychiatrists' role in medical illness, neuropsychiatry, and the use of transcranial magnetic stimulation in psychiatry.

SUMMARY:

Disseminating information in a timely fashion about advances in new research is critical to the practice of clinicians. This session will not only highlight the topics that are being covered at the 1998 Annual Meeting, but will attempt to give participants some notion of the national priorities in research.

REFERENCE:

1. Dickstein LJ, Riba MB, Oldham JM (eds): Review of Psychiatry Volume 16, Washington, DC, American Psychiatric Press, Inc., 1997.

REVIEW OF PSYCHIATRY

SECTION I OF THE REVIEW OF PSYCHIATRY

CHILD PSYCHOPHARMACOLOGY

Chairperson: B. Timothy Walsh, M.D.

1. **Tics and OCD**
   F. Xavier Castellanos, M.D.
2. **ADHD**
   Laurence L. Greenhill, M.D.
3. **Psychosis**
   Sanjiv Kumra, M.D.
4. **Affective Disorders**
   Stanley P. Kutcher, M.D.
5. **Anxiety Disorders**
   Daniel S. Pine, M.D.
6. **Eating Disorders**
   Laurel Mayer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have an overview of child psychopharmacology and be familiar with the current knowledge of the usefulness of medication in the following areas: tics, OCD, ADHD, disturbances of mood, psychosis, anxiety disorders and eating disorders.

SUMMARY:

The safety and utility of medications for children and adolescents are of critical concern to psychiatry. There are compelling data from controlled studies supporting the use of medications for some disorders (such as ADHD, OCD and psychosis). Even for these disorders, side effects can be seriously problematic and concerns are sometimes raised about the overuse of medication. For other disorders of childhood and adolescence, including mood disturbances, other anxiety disorders, and eating disorders, there are limited controlled data supporting the utility of medication in the pediatric age range.

This session will summarize recent progress in this rapidly developing area. Leading investigators will provide a critical synopsis of the research data base supporting the use of psychotropic medications in children and adolescents, including stimulants, antidepressants, antipsychotics, antianxiety agents and mood stabilizers. The limitations of our knowledge in this area, and studies currently underway will be highlighted. The integration of pharmacological treatments with psychosocial interventions will be noted, and side effects of medications and concerns about overuse will be discussed. Guidelines for the use of medication, given the currently available information, will be provided.

REFERENCES:

1. Vitiello B, Jensen P: Medication Development and Testing in Children. Arch Gen Psychiatry 54:871–876, 1997.
2. Wiener JM(ed): Diagnosis and Psychopharmacology of Childhood and Adolescent Disorders, Second Edition. John Wiley and Sons, New York, 1996.
3. Werry JS, Aman MG(eds): Practitioner's Guide to Psychoactive Drugs for Children and Adolescents. Plenum Medical Book Company, New York, 1993.

SECTION II OF THE REVIEW OF PSYCHIATRY

PSYCHOPATHOLOGY AND VIOLENT CRIME

Chairperson: Andrew E. Skodol II, M.D.

7. **Violent Crime and Axis I Psychopathology**
   James C. Beck, Ph.D.
8. **The Personalities of Murderers: Sadistic Personality Revisited**
   Michael H. Stone, M.D.
9. **Violent Crime and Axis II Psychopathology**
   Jeremy W. Coid, M.D.
10. **Biology of Aggression: Relevance to Crime**
    Emil F. Coccaro, M.D.
11. **Psychopathology, Crime and Law**
    Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will understand the relationship of Axis I and Axis II psychopathology to violent crime, the neurobiological basis for a relationship and the implications for the legal system.

SUMMARY:

Although rates of serious crime across the nation have decreased over the past five years, the number of prison inmates has grown significantly. The economic and social costs of violent crime threaten to overwhelm our capacity to absorb them. The relationship between mental disorder and serious violent crime is both controversial and complex. Studies conducted before the 1990s failed to show any increased risk of violent crime among persons with mental disorders. Since 1990, however, new data have accumulated and a consensus is emerging that violent crime and psychopathology are strongly linked.

This section reviews recent studies on the relationship of violent crime to Axis I psychopathology, on violent crime and personality disorders, on genetic and neurobiological studies of aggression, and on the implications of these findings for the legal system. Dr. Beck presents the case for the association of violent crime and major mental disorders, such as schizophrenics, from epidemiologic, prison and treatment samples. Dr. Stone argues for the importance of Axis II psychopathology for understanding the motivations of murderers and for predicting recidivism. Dr. Coid presents a study of Axis I and Axis II disorders and motivation for serious crime based on a sample of violent offenders from prisons and secure hospitals in the United Kingdom. Dr. Coccaro reviews twin and adoption studies of criminal behavior and studies of neurotransmitter, metabolic and hormonal mediators of aggression. Finally, Dr. Appelbaum cautions that psychiatry will need to go far to effect change in the judicial or penal systems in this country.

REFERENCES:

1. Monahan J, Steadman HJ: Crime and Mental Disorder. University of Chicago Press, Chicago, 1994.
2. Raine A: The Psychopathology of Crime: Criminal Behavior As a Clinical Disorder. Academic Press, San Diego, CA, 1993.
3. Coccaro EF, Bergeman CS, Kavoussi RJ et al.: Heritability of Aggression and Irritability: A Twin Study of the Buss-Durkee Aggression Scales in Adult Male Subjects. Bio Psychiatry 41:273–284, 1997.
4. Appelbaum PS: *Almost a Revolution: Mental Health Law and the Limits of Change.* Oxford University Press, New York, 1994.

SECTION III OF THE REVIEW OF PSYCHIATRY

PSYCHOBIOLOGY OF PERSONALITY DISORDERS

Chairperson: Kenneth R. Silk, M.D.

12. **Genetics and Psychobiology of the Seven-Factor Model of Personality**
    C. Robert Cloninger, M.D.

13. **Psychopharmacologic Management of Personality Disorders: An Outcome-Focused Model**
Paul S. Links, M.D.

14. **The Significance of Biological Research for a Biopsychosocial Model of Personality Disorders**
Joel F. Paris, M.D.

15. **New Strategies for Psychobiologic Investigation**
Larry J. Siever, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will have knowledge of the latest developments in the biological study of personality disorders and how to begin to apply some of these new discoveries to clinical practice.

SUMMARY:

The study and treatment of personality disorders were once thought to reside in the domain of the psychodynamically oriented psychotherapist. Personality disorders were thought to be primarily the result of the culmination of repeated experiences that the individual had with the environment, especially in the years of infancy, as a toddler, and in early childhood. Over the last 10–15 years, there has been significant progress made in exploring the biological underpinnings of personality traits as well as personality disorders. Upon reflection, this new emphasis on the biological aspects of personality would appear to make logical sense, since if personality traits are life long patterns of perceiving and reacting to the environment, these traits must have some significant underlying constitutional or biological elements. Initially, the biological study of personality disorders explored how specific personality disorders differed from each other and/or from their near neighbor Axis I disorders. More recently, however, biological approaches to personality disorders have explored dimensions of personality and personality traits that cut across a number of specific personality disorder diagnoses (and a number of Axis I disorders as well). The five papers in this presentation explore different facets of the biology of personality disorder and include papers on neurotransmitters, other biological research strategies, genetics and psychopharmacology. The final paper brings together these biological approaches with environmental issues to provide us with an integrated biopsychosocial approach to the consideration as well as the treatment of personality disorders.

REFERENCES:

1. Cloninger CR: A Systematic Method for Clinical Description and Classification of Personality Variants. Arch Gen Psychiatry 44:579–588, 1987.
2. Coccaro EF, Siever LJ, Klar HM et al.: Serotonergic Studies in Affective and Personality Disorders: Correlates with Suicidal and Impulsive Aggressive Behavior. Arch Gen Psychiatry 46:587–599, 1989.
3. Paris J: Nature and Nurture in Psychiatry. American Psychiatric Press, Washington, DC, In Press.
4. Silk KR: Biological and Neurobehavioral Studies of BPD. American Psychiatric Press, Washington, DC, 1994.

SECTION IV OF THE REVIEW OF PSYCHIATRY

INTERPERSONAL PSYCHOTHERAPY

Chairperson: John C. Markowitz, M.D.

16. **Interpersonal Psychotherapy: An Overview**
Myrna M. Weissman, Ph.D.

17. **Maintenance Interpersonal Psychotherapy: A Preventive Treatment for Depression**
Cynthia Spanier, Ph.D.

18. **Interpersonal Psychotherapy for the Treatment of Depression in HIV-Positive Men and Women**
Holly A. Swartz, M.D.

19. **Interpersonal Psychotherapy for Depressed Adolescents**
Laura Mufson, Ph.D.

20. **Interpersonal Psychotherapy for Patients with Bulimia**
Denise E. Wilfley, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be familiar with the general principles and recent research advances in interpersonal psychotherapy (IPT), including its use as an acute treatment for depressed adolescents, depressed HIV-positive patients, bulimic patients, and its utility as a maintenance treatment for patients with recurrent major depression.

SUMMARY:

Developed in the 1970s as a research intervention, IPT has demonstrated efficacy for major depression in randomized controlled trials. This success led to its adaptation and testing for other diagnostic groups. These presentations highlight some recent research on IPT as well as its recent translation from research use into clinical practice. Dr. Weissman will review the breadth of IPT research and its clinical expansion. IPT has been successful in landmark studies. It has been adapted to couples, group and other therapy formats. Increasing numbers of clinicians and trainees are learning IPT, and interest is growing abroad. Dr. Mufson will discuss IPT as treatment for depressed adolescent patients (IPT-A). This information is very important, as there has been only one positive controlled pharmacological trial for adolescent depression. Collaborating with Dr. Weissman, the late Gerald L. Klerman, M.D., and others, Dr. Mufson adapted and successfully tested IPT-A in open and controlled trials. Dr. Spanier will describe the groundbreaking work on maintenance treatment of recurrent depression of the group led by Ellen Frank, Ph.D. and David J. Kupfer, M.D. This represents the only long-term research of antidepressant prophylaxis using psychotherapy. The investigators treated highly recurrent major depression using high dose imipramine and weekly IPT, then randomized stabilized remitted patients to five three-year maintenance treatment conditions, including a monthly maintenance IPT (IPT-M). Even this relatively dilute form of IPT protected against relapse. Dr. Wilfley will discuss her important studies comparing IPT and cognitive behavioral therapy as treatments for bulimic patients. Her results indicate the efficacy of IPT and represent a conceptual advance in demonstrating that IPT can treat a non-mood disorder. Finally, Dr. Swartz will describe work at Cornell adapting IPT for treatment of depressed HIV-positive patients. In a controlled study, IPT-HIV appeared a good "fit" for these patients facing life crises.

REFERENCES:

1. Klerman GL, Weissman MM, Rounsaville BJ, Chevron ES: Interpersonal Psychotherapy of Depression. Basic Books, New York, 1984.
2. Elkin I, Shea MT, Watkins JT, Imber SD, Sotsky SM, Collins JF, Glass DR, Pilkonis PA, Leber WR, Docherty JP, Fiester SJ, Parloff MB: National Institute of Mental Health Treatment of Depression Collaborative Research Program: General Effectiveness of Treatments. Arch Gen Psychiatry 46:971–982, 1989.
3. Frank E, Kupfer DJ, Perel JM, Cornes C, Jarrett DB, Mallinger AG, Thase ME, McEachran AB, Grochocinski VJ: Three-year Outcomes for Maintenance Therapies in Recurrent Depression. Arch Gen Psychiatry 47:1092–1099, 1990.
4. Fairburn CG, Jones R, Peveler RC, Hope RA, O'Connor M: Psychotherapy and Bulimia Nervosa: Longer-term Effects of Interpersonal Psychotherapy, Behavior Therapy and Cognitive Behavior Therapy. Arch Gen Psychiatry 50:419–428, 1993.

SECTION V OF THE REVIEW OF PSYCHIATRY

PSYCHOLOGICAL TRAUMA: Prevalence, Course, Psychobiology and Treatment

Chairperson: Rachel Yehuda, Ph.D.

21. Epidemiology of Trauma and PTSD
Naomi Breslau, Ph.D.

22. Longitudinal Development of Post-traumatic Disorders
Arieh Y. Shalev, M.D.

23. Evaluating the Effects of Psychological Trauma Using Neuroimaging Techniques
Scott L. Rauch, M.D.

24. Neuroendocrinology of Trauma and PTSD
Rachel Yehuda, Ph.D.

25. Psychosocial Treatments for PTSD
Edna B. Foa, Ph.D.

26. Pharmacotherapy of PTSD
Randal D. Marshall, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will have a detailed knowledge of the literature about the prevalence, course, psychobiology and treatment of PTSD. Clinicians will also be able to evaluate the impact of psychological trauma in the expression of other psychiatric disorders and will learn important tips for treating the sequelae of trauma in these other illnesses.

SUMMARY:

PTSD is one condition that can occur following exposure to psychological trauma. However, it is not an inevitable outcome of exposure to trauma, nor is it the only outcome. This session will summarize existing knowledge about the effects of trauma on the development, expression and course of PTSD and other stress-related psychiatric illnesses, as well as current knowledge about treating the sequelae of trauma as they occur in psychiatric patients. In the first of six presentation, Dr. Naomi Breslau will summarize epidemiologic studies demonstrating the high prevalence of trauma and PTSD in our society, and will illustrate that the risk factors for trauma exposure are different from the risk factors associated with PTSD. Dr. Arieh Shalev will discuss findings from recent prospective, longitudinal studies of trauma survivors that demonstrate that trauma exposure results not only in the development of PTSD, but also of numerous other psychiatric disorders. Dr. Scott Rauch will summarize neuroimaging findings including observations of hippocampal atrophy and results of PET activation studies in trauma survivors with and without PTSD. Dr. Rachel Yehuda will discuss neuroendocrine findings in PTSD, which are now known to be distinct from those observed in other mood and other anxiety disorders. Dr. Randall Marshall will provide a comprehensive review of the reasons for utilizing medications and PTSD and summarize the entire literature on psychopharmacology of trauma and PTSD. Dr. Edna Foa will review nonbiological treatments for trauma and PTSD with an emphasis on cognitive and behavioral approaches.

REFERENCES:

1. Kessler RC, Sonnega A, Bromet E et al.: Posttraumatic Stress Disorder in the National Comorbidity Survey. Arch Gen Psychiatry 2:1048–1060, 1995.
2. Yehuda R, McFarlane AC (eds): Psychobiology of Posttraumatic Stress Disorder. Annals of the New York Academy of Sciences, Vol. 821, 1997.
3. Foa EB, Rothbaum BO: Female Assault Victims: A Treatment Program for Clients Suffering from PTSD. New York, Graywind, 1997.
4. Nathan PE, Gorman JM (eds): A Guide to Treatments That Work. Oxford University Press, New York, 1998.

SECTION VI OF THE REVIEW OF PSYCHIATRY Collaborative Session With the National Institute on Drug Abuse

ADDICTIONS

Chairperson: Elinore F. McCance-Katz, M.D.

27. Substance Abuse and HIV Disease: Entwined and Intimate Entities
Robert P. Cabaj, M.D.

28. Contemporary Issues in Dual Diagnosis
H. Westley Clark, M.D.

29. Alcohol Dependence: Sex Gender and Medications
Myroslava K. Romach,.M.D.

30. Opiate Dependence and Current Treatments
Susan M. Stine, M.D.

31. Current Issues in Nicotine Dependence and Treatment
Douglas M. Ziedonis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have an overview of the current epidemiological trends in patients with nicotine dependence, opiate dependence, alcohol dependence, dual diagnoses (including psychotic disorders, affective disorders, anxiety disorders personality disorders and other comorbid substance use disorders), and HIV disease complicated by drug and alcohol abuse.

SUMMARY:

The session on ''Addictions'' focuses on several issues of growing importance in the treatment of patients with substance use disorders. The increasing recognition of nicotine dependence as both a major health risk, a gateway drug, and a trigger to relapse to other abused substances underscores the importance of treatment of this addiction. Treatment issues will be discussed by Dr. Douglas Ziedonis. Opiate dependence is increasing in prevalence and the pharmacological options for treatment of these patients has recently increased with the addition of LAAM, buprenorphine and increasing use of naltrexone. Dr. Susan Stine will give an overview of this area. The pharmacological treatment of alcoholism is an expanding area and new research has yielded important findings regarding gender differences in responses to alcohol which are important considerations in the clinical treatment of these patients. This research will be reviewed by Dr. Edward Sellers. The prevalence of dually-diagnoses patients in the psychiatric population is well-known as is the challenge which these patients present to the treating clinician. Dr. H. Westley Clark will review the diagnostic issues, psychotherapies and pharmacotherapies and other factors important to the care and treatment of these patients. The incidence of HIV disease is rapidly increasing in patients with substance use disorders. These individuals represent some of the most challenging of patients in psychiatric practice as they need coordination of care of both their significant medical illnesses and substance use disorders. Dr. Robert Cabaj will review the important treatment factors in this group including prevention, intervention and treatment modalities.

REFERENCE:

1. McCance-Katz EF, Kosten TR (section eds): Addictions. In: Oldham J, Riba M (eds). Review of Psychiatry, Volume 17. American Psychiatric Press, Washington, DC, in press.

ROUND TABLE DISCUSSION

COERCION IN PSYCHIATRY

Moderator: Robert Michels, M.D.
Participants: Alan D. Felix, M.D., Katherine Falk, M.D., Laurie M. Flynn, M.A., Lewis A. Opler, M.D., Joseph Rogers, Marvin S. Swartz, M.D., Howard W. Tolson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will be able to define "coercion" in the context of psychiatric treatment, particularly in community settings, and will become aware of the clinical, ethical, and legal issues involved in psychiatric interventions that might be deemed "coercive."

SUMMARY:

Coercion may enter the treatment setting in psychiatry in any number of ways ranging from the obvious (committing a patient to hospitalization) to the subtle (offering a homeless patient food to entice them into a drop-in center). While patients and their families tend to be quite sensitized to the issue of coercion, only recently have mental health professionals begun to examine the ethical, legal and clinical complexities involved in delivering mental health care to involuntary or "less-than-voluntary" patients. Questions of coercion no longer center exclusively on involuntary inpatient hospitalization, but arise in much more varied and complex ways. Under the policy of deinstitutionalization, severe mentally ill patients are treated in community settings where there often exists a huge gap between the treatment recommended and that which the patient is willing to accept (if any at all). This round table discussion will focus on this gap, examining related terms used in the field, for example, persuasion, leverage, outreach, and assertive treatment, and the fine line that often exists between these and coercion. The panel will explore specific interventions, such as involuntary outpatient commitment, street outreach, assertive community treatment, and case management (including the management of entitlements) to see how decisions about the use of coercion arise in the 'real world' of community psychiatry.

REFERENCES:

1. Dennis DL, Monahan J (eds): Coercion and Aggressive Community Treatment: A New Frontier in Mental Health Law. Plenum Press, New York, 1996.
2. Group for the Advancement of Psychiatry: Forced into Treatment: The Role of Coercion in Clinical Practice. The American Psychiatric Press, Washington, DC, 1994.

SOCIAL SECURITY WORKSHOP

JOINTLY SPONSORED BY THE SOCIAL SECURITY ADMINISTRATION, APA OFFICE OF PSYCHIATRIC SERVICES, AND THE APA CONSORTIUM ON ORGANIZED SERVICE SYSTEM

Disability Evaluation Under Social Security: A Presentation for Treating Psychiatrists

Chairperson: Jerome E. Shapiro, M.D.
Co-Chairperson: Dale N. Cox, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to: 1) define the kinds and extent of medical evidence SSA needs to make disability determination, 2) understand how SSA processes claims and determines that applicants meet the definition of disability, using medical information provided by treating psychiatrists, and 3) recognize how their medical records assist their patients who apply for disability benefits.

SUMMARY:

This workshop was developed by the SSA, in cooperation with the APA and AMA, to educate the treating psychiatrist in the clinical and administrative process required by the SSA to make an appropriate, prompt evaluation of an applicant's psychiatric impairment and eligibility for SSA disability benefits. This includes the process of collecting sufficient clinical evidence based on symptoms, signs and functional assessments to permit a State's Disability Determination Service to make a disability decision based on SSA's Child and Adult Listing of Impairments. The workshop is presented in four segments: 1) the history of SSA's Disability Programs, including recent legislation affecting claimants disabled by drug abuse and/or alcoholism and Welfare Reform legislation affecting disabled children; 2) how psychiatrists can best serve patients who apply for SSA disability benefits; 3) a review of the clinical information required to expedite the disability determination process and the administrative steps in the adjudication of a claim; and 4) an interactive discussion using the clinical experience of participants in the application of the listing of mental impairments.

REFERENCES:

1. Social Security Administration: Disability Evaluation Under Social Security, 1995.
2. Meyerson, A.T., Fine, T. (eds): Psychiatric Disability: Clinical, legal and Administrative Dimensions. American Psychiatric Press, Inc., Washington, DC, 1987.

WORKSHOP ON PRIVATE PRACTICE ISSUES

APA COMMITTEE ON PRIVATE PRACTICE

The Future of Private Practice

Chairperson: Michael C. Hughes, M.D.
Participants: Herbert S. Sacks, M.D., Ronald A. Shellow, M.D., Norman A. Clemens, M.D., and Tracy R. Gordy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: Recognize the current status for the private practice of psychiatry in the context of economic issues affecting its present and future; Demonstrate developments and opportunities for the private practice of psychotherapy, psychopharmacology, hospital psychiatry as well as other forms of psychiatric services; Compare and contrast the roles of government, health care industrial complex, and individual private payment in the present and future for psychiatric services.

SUMMARY:

Traditionally private practice has been the modus operandi and identity for American psychiatrists. Sigmund Freud and his colleagues were private practitioners. It is seen by many as the bulwark of psychiatry, the fullest expression of the talents and capacities of our profession; to some critics as a system of care that inadequately serves significant socioeconomic and ethnic groups; for others as a part time opportunity for professional and economic fulfillment while working at a salaried job in the public sector; and by many beginning psychiatrists as beyond their reach because of perceived financial risks, professional demands, and future uncertainty. About 50% of psychiatrists currently consider themselves in private practice, a number in steady decline. The current maelstrom of change in the economics of medical care has particularly impacted here. Our panel of prescient augurers- all of whom are in the private practice of general psychiatry, with a specialty focus- will consider past and present practices to discuss future trends, possibilities, and pitfalls for private practice. Herbert S. Sacks, M.D., President of the American Psychiatric Association and a child and adolescent psychiatrist will survey our past and present to preview future clinical and economic issues in the context of the needs of our patients and the burgeoning capabilities of our profession. Ronald Shellow M.D., Chairman of the Joint Commission on Government Relations and a forensic and adolescent subspecialist will consider government and the health care industrial complex in psychiatric care while surveying alternative practice opportunities. Norman Clemens M.D., Chairman of the Commission on Psychotherapy by Psychiatrists and a psychoanalyst will present current issues and recent innovations in psychotherapy to look to future possibilities, particularly for psychotherapy by psychiatrists. Tracy Gordy M.D., member of the American Medical Association CPT Editorial Board and a neuropsychiatrist will discuss coding and payment but focus on developments for neuropsychiatry, psychopharmacology, and hospital psychiatry in private practice. The formal presentation will be relatively brief to allow for an interactive colloquy, initiated through questions from the Committee on Private Practice. Audience questions and discussion concludes.

REFERENCES:

1. APA Guidelines: ". . . for Psychiatrists who Admit Patients to Hospitals" [BOT 9/19/92]; ". . Regarding Psychiatrists' Signatures" [BOT 6/23/89]; ". . . on Confidentiality" [BOT 6/87]; ". . . for Psychiatrists in Consultative, Supervisory, or Collaborative Relationships with Nonmedical Therapists" [BOT 6/20/80]. American Psychiatric Association, Washington, D.C.
2. Starting a Medical Practice. American Medical Association, Ed., Chicago, IL., 1996.

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