2000 Syllabus and Proceedings Summary

52nd Institute on Psychiatric Services

American Psychiatric Association

October 25 – 29, 2000 ◆ Philadelphia, PA

CERTIFICATE OF ATTENDANCE

This certificate provides verification of your completion of educational activities at the 2000 Institute on Psychiatric Services.

This is to certify that

_____

Attended the 2000 Institute on Psychiatric Services of the
American Psychiatric Association
October 25-29, 2000
Philadelphia, PA

and participated in _____ hours of CME activities that have met the criteria for category 1 credit.

Daniel B. Borenstein, M.D.
APA President

Steven M. Mirin, M.D.
Medical Director

The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The APA takes responsibility for the content, quality and scientific integrity of this CME activity.

The APA designates this educational activity for up to 48 hours in category 1 credit towards the AMA Physician's Recognition Award and for the CME requirement of the APA. Each physician should claim only those hours of credit that he/she actually spent in the educational activity..

DAILY LOG FOR ATTENDANCE AT CME FUNCTIONS AT THE 52nd INSTITUTE ON PSYCHIATRIC SERVICES OCTOBER 25-29 • PHILADELPHIA, PA

NOTE: APA members are responsible for maintaining their own CME records. A copy of this Certificate may be forwarded to other organizations requiring CME verification. Reporting is on an honor basis.

DAY	TITLE OF SESSION	NUMBER OF HOURS/CME CATEGORY
	TOTAL	

HOW TO OBTAIN CME CREDIT FOR THE 2000 INSTITUTE ON PSYCHIATRIC SERVICES

The American Psychiatric Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education (CME) for physicians. The APA certifies that the continuing medical education activities designated as category 1 for the 2000 Institute sessions meet the criteria for category 1 of the Physician's Recognition Award of the American Medical Association and for the CME requirements of the APA.

The scientific program at the Institute offers a broad range of sessions designated for CME credit. The sessions that meet the criteria for category 1 credit include CME Courses, Full-Day Sessions, Industry-Supported Symposia, Innovative Programs, Lectures, Medical Updates, Multimedia Sessions, Symposia and Workshops. Other sessions, designated for category 2 credit, include Clinical Consultations, the Debate, Discussion Groups, Forums and Posters.

NOTE: **APA members must maintain their own record of CME hours for the meeting. To calculate credit, registrants should claim one hour of credit for each hour of participation in category 1 scientific sessions.** To document that credit, participants should record the session(s) attended on the back page of the **Certificate of Attendance found on page ii, in the front of this book.** This Certificate is for your personal records and may be forwarded to other organizations requiring verification. Documentation of all CME credit is based on the honor system.

CME REQUIREMENTS FOR APA MEMBERS

By referendum in 1974, the membership of the American Psychiatric Association (APA) voted that 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 reporting period. Of the 150 hours required, a minimum of 60 hours must be in category 1 activities. Category 1 activities are sponsored or jointly sponsored by organizations accredited to provide 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 the current method of 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. **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.

HOW TO EARN A CERTIFICATE FOR CME COMPLIANCE

As an APA member, you can obtain an APA CME certificate by using one of the following methods:

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

(Continued)

HOW TO FULFILL THE CME REQUIREMENTS OF THE APA

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 Kansas, New Jersey, 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 may also **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, DC 20005, or call (202) 682-6179 or filed electronically via the APA Home Page at http:/www@psych.org.

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 by organizations accredited for CME and meet 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 approved by the Accreditation Council for Graduate Medical Education (ACGME). Fifty hours of category 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: in Addiction Psychiatry, Child Psychiatry, Administrative Psychiatry, Forensic Psychiatry and Geriatric Psychiatry. The other 90 credits may be taken in additional category 1 activities or spread throughout activities in category 2.

CATEGORY 2:

Category 2 activities are those that have no accredited sponsor certifying them for Category 1 CME credit. Some programs are presented by accredited sponsors, but do not meet the criteria for category 1 and therefore, are designated as category 2. Other 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.

Any member who is inactive, retired, 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.

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

CONTINUING MEDICAL EDUCATION

SYLLABUS AND PROCEEDINGS SUMMARY

FOR THE

52ND
INSTITUTE ON PSYCHIATRIC SERVICES

October 25–29, 2000

Philadelphia, PA

The American Psychiatric Association
Institute on Psychiatric Services
1400 K Street, N.W.
Washington, DC 20005
1-888-357-7924

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52nd Institute on Psychiatric Services

American Psychiatric Association

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Course 1 **Wednesday, October 25**
8:00 a.m.-12 noon

PSYCHODYNAMIC PSYCHOTHERAPY SUPERVISION: A DEVELOPMENTAL PERSPECTIVE

Paul Rodenhauser, M.D., *Department of Psychiatry and Neurology, Tulane University, School of Medicine, 1440 Canal Street TB53, New Orleans, LA 70112-2715;* Ramona Dvorak, M.D., M.P.H.; Albert F. Painter, Psy.D.; John R. Rudisill, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify the principles of effective psychotherapy supervision; 2) summarize the levels of teaching/learning involved in the supervisory process; 3) recognize and apply appropriate supervision problem-solving strategies; and 4) demonstrate an improved capacity for use of multiple teaching methods in the supervisory process.

SUMMARY:

Effective supervision in psychotherapy involves approaches that are both intuitive and systematized. Little attention has been paid to the unique aspects of supervision and the need for professional development of supervisors. The transition from supervisee to supervisor, for example, is fraught with conflicts. Using a participatory design, this course will address the basic components of psychotherapy supervision. The faculty will review the current literature on various aspects of supervision, including skill development for the supervisor, skill development for the supervisee, stages of skill development, the relationship between the supervisor and supervisee, the human dimension of effective psychotherapy, as well as sexual, racial, ethnic, social, legal and ethical issues. Participants will be involved in tutorials focusing on the characteristics, principles, and models of supervision. Use of process notes, audiotapes, videotapes or direct involvement in a treatment process will be discussed. Scenarios from the APA tape, "Issues in Psychotherapy Supervision" will be used to simulate critical potential problems in the supervisory process. Discussion will be centered on a matrix of four modes of education, which enable supervision according to tasks and factors in the process. The modes to be taught are administrative, instructional, consultative and interactive. Examples of tasks and factors include stages in the therapeutic process as well as professional, organizational and personal factors. Handouts will include summaries of these multiple teaching approaches, which also serve as problem-solving strategies in the supervisor-supervisee relationship.

REFERENCES:

1. Bridges NA: Teaching psychiatric trainees to respond to sexual and loving feelings: the supervisory challenge. Journal of Psychotherapy Practice and Research. 1998; 7(3):217–226.
2. Kleinberg JL: The supervisory alliance and the training of psychodynamic group psychotherapists. International Journal of Group Psychotherapy. 1999; 49(2):159–179.

Course 2 **Wednesday, October 25**
9:00 a.m.-4:00 p.m.

DEPRESSION: INDIVIDUAL/GROUP INTERPERSONAL THERAPY
American Group Psychotherapy Association

K. Roy MacKenzie, M.D., *Department of Psychiatry, University of British Columbia, 201-1600 Howe Street, Vancouver, BC Canada V6Z 2L9*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) summarize indications for psychotherapy of depression; 2) list strategies of the interpersonal psychotherapy (IPT) model; 3) describe therapeutic techniques in IPT; 4) apply these techniques to individual psychotherapy; 5) describe therapeutic techniques for developing an effective group; and 6) list the structural strategies used in IPT group treatment of depression.

SUMMARY:

The goal of this course is to provide the clinician with an introduction to the IPT model developed by Klerman and Weissman et al, which has been well supported in the empirical literature. An overview will be presented in the IPT model with an emphasis on the theory connecting interpersonal functioning and depression. The indications and contraindications for psychotherapy as an augmentation strategy for major depression will be discussed. Detailed assessment methods used to develop a focus and prepare the patient will be outlined. The positioning of the therapist's activity on the supportive-interpretive continuum will be described along with a full discussion of appropriate techniques. Videotape examples will be used to illustrate treatment techniques in a variety of problem areas. An overview of the techniques for developing a working group environment will be discussed and how these are used to promote group development. The structural strategies used to adapt IPT for the context of the developing group will be reviewed, with an emphasis on promoting group development. The clinician should have some experience in psychotherapy with patients suffering from major depression.

TARGET AUDIENCE:

Psychiatrists, residents, psychologists, social workers, nurses and other mental health clinicians.

REFERENCES:

1. Phillips KA, Gunderson JG, Triebwasser J, et al: Reliability and validity of depressive personality disorder. American Journal of Psychiatry. 1998; 155:1044–1048.
2. Reynolds CF, Frank E, Houck PR, et al: Which elderly patients with remitted depression remain well with continued interpersonal psychotherapy after discontinuation of antidepressant medication? American Journal of Psychiatry. 1997; 154:958–962.

Course 3 **Wednesday, October 25**
1:00 p.m.-5:00 p.m.

THE EVALUATION AND MANAGEMENT OF PAIN

Steven A. King, M.D., *3401 North Broad Street, 7th Floor, Philadelphia, PA 19104*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand current concepts of pain; 2) understand the classification systems of pain; 3) identify the problem of pain in special populations; and 4) achieve proficiency in the management of pain.

SUMMARY:

Pain is among the most common reasons for which patients seek medical care. Unfortunately, multiple studies have shown that pain is often poorly managed. This course will review the evaluation and management of pain focusing on subjects of most relevance to psychiatrists with an emphasis on practical approaches to this problem. Topics presented will include: 1) an overview of current concepts about pain, including the differences between acute and chronic pain; 2) a review of the *DSM-IV* classification of pain and the relationship between pain and other mental disorders; 3) treating pain in special patient populations, including terminally ill patients, geriatric patients, and patients who are involved in worker's compensation systems or litigation; 4) the pharmacologic treatment of pain with special focus on antidepressant medications, opioid analgesics and nonsteroidal anti-inflammatory drugs; and 5) the use of other therapeutic modalities. The role of psychotherapeutic techniques and other commonly employed therapies, including nerve blocks, physical therapy, acupuncture and surgery will be discussed.

REFERENCES:

1. Gureje O, Von Korff M, Simon GE, et al: Persistent pain and well-being. JAMA. 1998; 280; 147–151.
2. King SA, Strain JJ: Pain Disorders. In: Talbott JA, Hales RE, Yudofsky SC, eds. American Psychiatric Press Textbook of Psychiatry, Third Edition. Washington, DC, American Psychiatric Press, 1999.

Course 4 **Thursday, October 26**
8:00 a.m.-12 noon

HELPING PARENTS SURVIVE THE ADOLESCENCE OF THEIR CHILD

Gordon R. Hodas, M.D., *Statewide Child Psychiatrist, Pennsylvania Department of Public Welfare, 214 East Gravers Lane, Philadelphia, PA 19118-2803;* Wendy Luckenbill; Doreen Barkowitz, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) recognize the primary stages of tasks of adolescence; 2) identify how a serious emotional disturbance (SED) can potentially alter normal development of the child; and 3) assist parents in addressing challenges of an adolescent with SED and maintain family balance.

SUMMARY:

This course enables psychiatrists to help parents survive the adolescence of their child with a serious emotional disturbance (SED). There is great need for parents to have such information and develop specific skills so that they can support their child, themselves, and their family during these years. Unfortunately, current information for parents is primarily disorder-specific, rather than addressing generic challenges of promoting the social and emotional development of adolescents with SED, while also maintaining balance in other important family areas. Psychiatrists working with adolescents and their families are in an ideal position to provide the necessary information and support to families. In an abbreviated form, this presentation was offered twice for families at the 1999 Federation of Families Annual Conference, with an extremely positive response. The course faculty consist of broad experience and expertise: 1) a child and adolescent psychiatrist who oversees public sector children's mental health in Pennsylvania, with an adolescent with SED; 2) a parent who is a family advocate for the Parent Involved Network (PIN) in Pennsylvania, with a child with SED; and 3) a parent who is a social worker in Pittsburgh, also with a child with SED. This comprehensive course will address the following issues: normal adolescence; the concept of "SED" and its effects on social-emotional development;

best clinical practices—emphasizing Child and Adolescent Service System Program (CASSP) principles and parent-professional partnerships—in evaluations and treatment development; gender differences in adolescence; adolescent suicidality; and promotion of positive survival skills to benefit adolescents, parents as caregivers, and individuals and the family as a whole.

REFERENCES:

1. Dryfoos J: Safe Passage: Making It Through Adolescence in a Risky Society: What Parents, Schools, and Communities Can Do. New York, Oxford University Press, 1998.
2. Garbarino J: Lost Boys: Why Our Sons Turn Violent and How We Can Save Them. New York, Free Press, 1999.

Course 5 **Thursday, October 26**
9:00 a.m.-4:00 p.m.

LEARN TO BUILD ELECTRONIC MEDICAL RECORDS

Daniel A. Deutschman, M.D., *18051 Jefferson Park Road, Middleburg Heights, OH 44130*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) build a basic EMR for use with their patients to capture medication data; 2) understand the value of EMRs in proving quality of care and office efficiency; 3) obtain assistance in further development of EMRs; and 4) recognize the added value of having the psychiatrist as the programmer.

SUMMARY:

This course, designed for clinicians at all levels of computer sophistication, will enable clinicians to understand the essential design and structure of EMR. Clinicians will be in a position to begin to build such systems for use with their own patients to capture medication data at the conclusion of the course. Clinicians will learn the role of fields, primary keys, tables, normalization of tables, table relationships, queries, click lists, data entry forms and reports. There will be discussion of automatic data entry using Look-up Tables and Value Lists. These will serve as the source for medication names, doses, directions, etc. Medication Trial Reports will be demonstrated. The format will be interactive and practice oriented with an opportunity for questions and answers. When clinicians take the time to program the software, they will be in a position to continually upgrade and strengthen the system as they grow in experience and sophistication. EMRs enhance quality and thereby have the potential to significantly enhance public health. They speed data entry, improve office efficiency, improve productivity and pay for themselves many times over.

TARGET AUDIENCE:

Practicing, research and administrative psychiatrists/ administrators.

REFERENCES:

1. Tang PC, LaRosa MP, Gorden SM: Use of computer-based records, completeness of documentation and appropriateness of documented clinical decisions. Journal of the American Medical Informatics Association. 1999; 6:245–251.
2. Zielstorff RD: Online practice guidelines. Journal of the American Medical Informatics Association. 1998; 5:277–236.

Course 6 **Thursday, October 26**
1:00 p.m.-5:00 p.m.

DEALING WITH RESISTANCE IN ADDICTION PATIENTS

David Mee-Lee, M.D., *Assistant Clinical Professor of Psychiatry, University of California, Davis, 4228 Boxelder Place, Davis, CA 95616*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify ways for clinicians to better deal with resistance in addiction; 2) demonstrate new skills in assessing readiness to change; and 3) recognize ways to develop different clinical tracks for patients at different stages of change.

SUMMARY:

Denial and resistance are expected parts of many addiction patients' presentation. Yet, the strategies to deal with resistance have traditionally been education, confrontation, and intensive and often inpatient services. The training of mental health professionals frequently neglects strategies on how to engage addiction patients into participatory treatment planning. Addiction treatment professionals often lack psychotherapy training to finesse counseling skills. This course is designed to help participants improve assessment and treatment of resistance in addiction patients and become better acquainted with how people change. It will teach skills that can help retain patients in treatment and encourage honesty, not game playing; accountability, not arguing and confrontation. Besides improving clinical approaches, this course will also discuss the changes needed to reconfigure treatment services to better match patients' readiness to change. The format of the course will provide the opportunity to build skills around the assessment, engagement and treatment of patients who are at varying

stages of readiness to change. Videotaped interviews, role play, participant exercises and case consultation will be the methods used along with didactic presentation.

REFERENCES:

1. Baer, JS, Kivlahan, DR, Donovan, DM: Integrating skills training and motivational therapies implications for the treatment of substance dependence. Journal of Substance Abuse Treatment 1999; 17:18–23.
2. Mee-Lee, D: Use of patient placement criteria in the selection of treatment. Chapter 7, 363–370, Section 5: Overview of Addiction Treatment in Principles of Addiction Medicine. Second Edition. American Society of Addiction Medicine, Inc., Chevy Chase, MD. 1998.

Course 7 **Friday, October 27**
8:00 a.m.-12 noon

INTEGRATED MODEL FOR TREATMENT OF CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS

Kenneth Minkoff, M.D., *Medical Director, Arbour Choate Health Management, 12 Jefferson Drive, Acton, MA 01720*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify five philosophical/clinical barriers to integrated treatment and describe how to resolve them; 2) describe the four phases of treatment/recovery in an integrated disease and recovery model for mental illness and addiction; 3) describe and implement a protocol for diagnosing psychiatric illness in the presence of substance use disorder and vice versa; and 4) describe integrated program models for treatment of dual diagnosis and specific populations addressed by each model.

SUMMARY:

This course provides a basic introduction to the complex topic of co-occurring psychiatric and substance disorders, with the goal of assisting the practitioner to develop a systematic, integrated conceptual framework that permits rational treatment planning and treatment matching. The course begins with a brief overview of the problem of "dual diagnosis" and the difficulties practitioners encounter in providing treatment. Basic principles of successful treatment and clarification of basic concepts and subtypes of the dual-diagnosis population, based on review of recent literature, are defined, and issues of implementation are illustrated, emphasizing the importance of empathic, hopeful, continuous and integrated treatment models with the capacity to provide individualized phase-specific treatment matching within a comprehensive system of care. Barriers to integration will be outlined, and an integrated parallel disease and recovery model will be utilized as a mechanism to address those barriers. Based on this model, strategies for treatment matching will be briefly described. The last section of the course will focus on the application of this model to basic clinical situations, particularly relating to psychopharmacologic assessment and intervention, that confront the psychiatric practitioner.

REFERENCES:

1. Minkoff K: Integration of Addiction and Psychiatric Services in Managed Mental Health Care in the Public Sector. A Survival Manual. Edited by Minkoff K, Pollak D. The Netherlands, Harwood Academic Publishers, 9–25, 1997.
2. Sciacca K: Removing barriers: dual diagnosis treatment and motivational interviewing. Professional Counselor 1997; 41–46.

Course 8 **Friday, October 27**
9:00 a.m.-4:00 p.m.

INTRODUCTION TO PSYCHODYNAMIC GROUP PSYCHOTHERAPY

Hillel I. Swiller, M.D., *108 East 96th Street, Suite 9F, New York, NY 10128-6220;* Milton L. Wainberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand the theory that underlies psychodynamic group psychotherapy; 2) recognize which psychotherapy patients are most likely to benefit from group psychotherapy; 3) prepare patients for a successful group experience; 4) recognize basic group themes; and 5) intervene productively.

SUMMARY:

Group therapy is the maximally efficient modality for utilizing psychodynamic principles in psychotherapy. The course will review relevant psychodynamic principles as they apply to group therapy, consider therapeutic factors particularly pertinent to group therapy and discuss productive group norms. The nature of transference and working through in group therapy will be discussed. Indications and contraindications for group therapy will be reviewed as will principles of patient preparation and the nature of the group therapy contract. Therapist technique, psychodynamic interventions, the concept of group as a whole, affect management, gender issues and termination will also be discussed. Relevant material relating to psychopharmacotherapy and to combined individual and group psychotherapy will be briefly reviewed. Participants will have the opportunity to observe and discuss a demonstration group therapy session.

REFERENCES:

1. Gans JS, Alonso A: Difficult patients: their construction in group therapy. International Journal of Group Psychotherapy 1998; 48:311–326.
2. Roller B: The Promise of Group Therapy: How To Build a Vigorous Training and Organizational Base for Group Therapy in Managed Care Behavioral Healthcare. San Francisco, Jossey-Bass, 1997.

Course 9 **Friday, October 27**
9:00 a.m.-4:00 p.m.

HERBAL MEDICINE IN PSYCHIATRY

Richard P. Brown, M.D., *30 East End Avenue, New York, NY 10028;* Lorraine Innes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) recognize common herbs, nutrients and hormones used by psychiatric patients and 2) identify indications, dosages, side effects and brands of such agents for anxiety, depression, sleep, cognitive and sexual enhancement, PMS and migraine (based upon recent research).

SUMMARY:

This course will be an overview of herbal treatments and psychiatry as well as some common medical indications for herbal remedies. The recent expanding, extensive use of herbs and nutrients in the general population in this country and in Europe will be reviewed. General principles and problems of herbal treatments also will be addressed as well as the safety of natural products. Segments will be devoted to natural treatments for depression, including St. John's wort and sadenosylmethionine, inositol, stabilium and other treatments. In addition, the following areas will be covered: 1) treatment of anxiety, including kava and other plant compounds; 2) approaches to the treatment of insomnia, including during pregnancy; 3) remedies for the treatment of migraine, premenstrual syndrome, stabilization of bipolar disorder, cognitive enhancement (such as in age-associated memory impairment, Alzheimer's disease and ADD; 4) sexual enhancing herbs; 5) discussion of nutrients used for athletic performance enhancement; 6) anti-aging alternatives in wide use; 7) the data surrounding melatonin and the current controversy about its use as well as other hormonal treatments; 8) prevention of cancer and relief of side effects of chemotherapy and radiation for cancer; 9) interactions of common herbal treatments; and 10) examples of reported herbal toxicities. Participants are encouraged to bring cases for discussion.

TARGET AUDIENCE:

Psychiatrists and neurologists in particular, in addition to general practitioners, psychologists and social workers.

REFERENCES:

1. Wolkowitz O, Reus V, Keebler A, et al: Double-blind treatment of major depression with dehydroepiandrosterone. American Journal of Psychiatry 1999; 156:646–649.
2. Wong AHC, Smith M, Boon HS: Herbal remedies in psychiatric practice. Archives of General Psychiatry 1998; 55:1033–1034.

Course 10 **Friday, October 27**
1:00 p.m.-5:00 p.m.

COMPUTER APPLICATIONS FOR THE MILLENNIUM

Robert S. Kennedy, M.A., *Program Director, P.O. Box 155, Bronx, NY 10464;* Thomas A.M. Kramer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand how the latest hardware and software meet the needs of the contemporary psychiatrist and 2) understand the current technologies that are important for obtaining and utilizing clinical and educational information.

SUMMARY:

The computer applications presented will prepare you for the millennium. The faculty will demonstrate the important computer applications (some hardware, some software) that the psychiatrist of today will need to see and know about to prepare for this decade. Each application will give the participant a demonstration of the technology, presentation of why each application is important, discussion of useful applications in clinical and academic psychiatry and opportunities for interactive discussions and demonstrations. The topics to be presented include: World Wide Web technology (Web searching, Web site creation, information access (Medline, libraries, books and journals), scanning (graphics, OCR), word processing for clinicians, speech technology, hand-held computers, and interactive table-top demonstrations.

REFERENCES:

1. Alessi, N, Milton H, Quinlan P: Information technology impacts psychiatry. American Psychiatric Press, Review of Psychiatry 1997; 16:69–79.
2. Kramer, T, Kennedy, R: The World Wide Web and Internet: on-line communication, collaboration and

collegiality, educational computing column. American Psychiatry 1998; v. 22.

Course 11 **Saturday, October 28**
8:00 a.m.-12 noon

COGNITIVE THERAPY FOR SEVERE MENTAL DISORDERS

Jesse H. Wright, M.D., *Professor of Psychiatry, University of Louisville, Norton Psychiatric Clinic, P.O. Box 35070, Louisville, KY 40232-5070;* Monica A. Basco, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) utilize cognitive therapy interventions for inpatients; 2) apply cognitive therapy techniques to symptoms of psychosis and bipolar disorder; and 3) address treatment adherence problems using a cognitive therapy approach.

SUMMARY:

In recent years, cognitive therapy methods have been developed to meet the special needs of patients with chronic and severe psychiatric symptomatology. This course presents these newer cognitive therapy applications for the treatment of inpatients, individuals with bipolar disorder and those experiencing psychotic symptoms. Cognitive-behavioral conceptualizations and specific treatment procedures will be described for these patient groups. Several modifications of standard cognitive therapy techniques will be suggested for the treatment of severe or persistent mental disorders. Participants in this course will learn how to adapt cognitive therapy for patients with problems such as psychomotor retardation, paranoia, hypomania and nonadherence to pharmacotherapy recommendations. Cognitive therapy procedures will be illustrated through case discussion, role plays, demonstrations and videotaped examples. Worksheets that can facilitate application of cognitive therapy techniques will be provided. Participants will also have the opportunity to discuss the application of cognitive therapy for their own patients.

REFERENCES:

1. Basco M, Rush, AJ: Cognitive Behavioral Therapy for Bipolar Disorder. New York, Guilford Press, 1996.
2. Scott J, Wright JH: Cognitive therapy for chronic and severe mental disorders. Dickstein LJ, Riba MB, Oldham JM (eds), American Psychiatric Press Review of Psychiatry 1997; 16:135–170.

Course 12 **Saturday, October 28**
8:00 a.m.-12 noon

HOW TO MEASURE OUTCOMES WITHOUT BREAKING THE BANK

Gabriel Kaplan, M.D., *Chairman, Department of Psychiatry, Franciscan Health, 25 McWilliams Place, Suite 606, Jersey City, NJ 07302-0000;* James R. Westphal, M.D., *Professor of Clinical Psychiatry, Louisiana State University Health Science Center, 1501 Kings Highway, Shreveport, LA 71130*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) enumerate available rating scales utilized for outcome measurements; 2) select appropriate scales for specific populations; and 3) summarize costs involved in setting up outcome systems.

SUMMARY:

This course is for mental health professionals wishing to learn about cost-effective outcome tools. Clinicians in both the public and private sectors are increasingly asked to demonstrate effectiveness of treatment. Measuring outcomes not only serve the purpose of demonstrating value to managed care and public agencies, but also allows clinicians to improve quality of care. Outcome systems costing thousands of dollars are now available; however, they are financially prohibitive for most clinicians. The faculty will discuss valid tools found in the public domain or those available at a reasonable price that can be combined to create an outcome system. This course is divided into four sections: 1) *Basic Concepts* will outline quality improvement notions such as cycle of quality, efficacy, effectiveness, dimensions, motivation, methodology and outcome theory; 2) *Adult Outcome Tools* will review scales used to measure health/function status (HSQ-12, GAS), symptoms (SCL-90, BPRS, Beck) and satisfaction (CSQ); 3) *Child Outcome Tools* will describe scales utilized with youngsters to determine general functioning (CBCL) and specific symptomatology (Conners, CDI); and 4) *Practicum* will provide participants an opportunity to apply principles obtained from this course.

TARGET AUDIENCE:

Clinicians in solo and group settings practicing in private and public systems.

REFERENCES:

1. Hunkeler EM, Westphal JR, William M: Computer assisted patient evaluation systems: advice from the trenches. Behavior Health Tomorrow 1996; 5:73–75.
2. Sederer L, Dickey B (eds): Outcomes Assessment in Clinical Practice. Baltimore, Williams and Wilkins, 1996.

Course 13 **Saturday, October 28**
9:00 a.m.-4:00 p.m.

DISORDERS OF THE SELF: DIFFERENTIAL DIAGNOSIS AND TREATMENT

James F. Masterson, M.D., *60 Sutton Place, South, New York, NY 10022-4168*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) diagnose the personality disorders as disorders of the self; 2) use intrapsychic structure to differentiate between the disorders and to choose the appropriate therapeutic intervention; and 3) identify the central psychodynamic triadic theme of the disorders of the self.

SUMMARY:

This course presents a developmental, self and object relations approach to the etiology, diagnosis and treatment of the personality disorders as disorders of the self. Etiology will be considered from both the psychological and neurobiologic perspectives. It will emphasize that the intrapsychic structure not only differentiates the disorders but also indicates what therapeutic interventions are crucial. The development of the self and the attainment of its capacities will be described. A diagnostic system based on the disorders of the self will be presented, its conceptual basis explained and compared with DSM-IV. The central triadic psychodynamic theme of these disorders, i.e., self activation leads to anxiety and depression which lead to defense will be described. The differing intrapsychic structures (self and object representations, ego defenses and functions) of the borderline, narcissistic, schizoid and sociopathic disorders of the self will be described. These structures, together with the clinical interventions they indicate, will be illustrated by a case presentation for each diagnostic category. Two 45-minute lectures will be followed by a 45-minute question period. This will be followed by a 30-minute videotape demonstration on the use of confrontation to establish a therapeutic alliance with a borderline disorder of the self. Lastly, a one-and-one-half-hour supervision period will ensue to further illustrate the concepts along with consideration of countertransference.

REFERENCES:

1. Bernstein D, Cohen P, Skodol A, et al: Childhood antecedents of adolescent personality disorders. American Journal of Psychiatry, 1996: 153:7.
2. Masterson JF, Klein R, eds: Disorders of the Self: New Therapeutic Horizons, The Masterson Approach. New York, Brunner/Mazel, 1995.

Course 14 **Saturday, October 28**
1:00 p.m.-5:00 p.m.

PSYCHIATRY AND PRIMARY CARE: SHARING CARE

Nick S. Kates, M.B., *Associate Professor, Department of Psychiatry, McMaster University, 43 Charleton Avenue, East, Hamilton, ON Canada L8N 1Y3;* Jonathan S. Davine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand the role of the family physician in delivering community mental health care and the principles underlying shared care and 2) work collaboratively and effectively with primary care physicians.

SUMMARY:

The increasingly prominent role of the primary care physician in delivering mental health care can be enhanced if supportive, collaborative partnerships can be established with psychiatrists and mental health services. This course will present a number of strategies for collaborative or shared mental health care between family physicians and psychiatrists to help psychiatrists and other mental health professionals develop the skills necessary to work effectively with primary care providers. It will review the prevalence, presentation and management of mental health problems in primary care and problems in the relationship between psychiatry and primary care. It will also outline principles to guide shared mental health care and present three different sets of implementation strategies designed to: 1) improve communication; 2) strengthen liaison linkages; and 3) bring mental health services to primary care. Examples of each will be provided. The implications of shared mental health care for residency training, research, academic departments of psychiatry and serving isolated or underserved populations will be discussed. Finally, the course will offer practical guidelines on how to work productively with primary care physicians, how to establish collaborative relationships and ways in which models of shared care can be adapted to different communities.

TARGET AUDIENCE:

Mental healthcare providers, especially psychiatrists.

REFERENCES:

1. Craven M, Cohen M, Campbell D, et al: Mental health practices of Ontario physicians: a study using qualitative methodology. Canadian Journal of Psychiatry, November 1997.
2. Kates N, Craven C, Bishop J, et al: Shared mental health care in Canada. Supplement to Canadian Jour-

nal of Psychiatry, 1997; 42:8 and Canadian Family Physician Vol. 43, October 1997.

Course 15 **Sunday, October 29**
8:00 a.m.-12 noon

LIMIT SETTING WITH PSYCHIATRIC PATIENTS

Donald A. Misch, M.D., *Director of Education, 1515 Pope Avenue, Augusta, GA 30912;* Lucy J. Puryear, M.D.; Linda B. Andrews, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify rationales for setting limits; 2) recognize the utility of the parent-child analogy in setting limits; 3) summarize and employ proper rules and techniques for limit setting; and 4) understand and take into account the factors that interfere with effective limit setting.

SUMMARY:

Limit setting is a necessary and frequent element of every psychiatrist's clinical work, but it is a subject in which most psychiatrists receive little formal training. This course will review the fundamental knowledge base and the specific techniques necessary to successfully set limits in clinical psychiatry. Topics that will be covered include the rationales for psychiatric limit setting, the value of the parent-child analogy, key strategies and techniques and the factors that interfere with appropriate limit setting. Both theoretical and practical aspects of these subjects will be addressed, giving participants relevant and immediately useful information that can be applied in their clinical work. In addition to didactic presentations, the course will consist of faculty-facilitated large and small group exercises involving limit setting with particular patients in specific situations. Participants will be introduced to a structured worksheet designed to foster effective limit setting. Course participants are also encouraged to present their own clinical vignettes. The course is designed primarily for beginning and intermediate-level clinicians.

REFERENCES:

1. Pam A: Limit setting: theory, techniques, and risks. American Journal of Psychotherapy, 48:432–40, 1994.
2. Rosenheck R: Substance abuse and the chronically mentally ill: therapeutic alliance and therapeutic limit-setting [comment]. Community Mental Health Journal, 31:283–5, 1995.

Course 16 **Sunday, October 29**
8:00 a.m.-12 noon

THE CLINICAL IMPACT OF DOING TIME: MENTAL ILLNESS AND INCARCERATION

Merrill R. Rotter, M.D., *Director, Division of Law and Psychiatry, Albert Einstein College of Medicine and Bronx Psychiatric Center, 1500 Waters Place, Bronx, NY 10461;* Michael F. Steinbacher, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify and assess corrections-related behavior in psychiatric settings; 2) differentiate patient care issues pertaining to correctional environments and patient attributes; and 3) reduce assault risk within the treatment setting through early intervention.

SUMMARY:

An increasing number of individuals in the mental health treatment system have a history of criminal incarceration. They arrive in mental health treatment facilities with needs and expectations quite different from those persons without experience in correctional settings. Many have acquired a spectrum of beliefs and behaviors that, while adaptive in prison and jail, impede their success in treatment settings. Staff who are unaware of the impact of incarceration, can misread early warning signs of difficult adjustment to place, program and treatment. They may even inadvertently escalate potentially dangerous situations, increasing risk to both staff and clients. Based on research initiated by New York State Office of Mental Health, New York State Department of Labor and the Albert Einstein College of Medicine, this course will provide essential information and skills training for providers through enhancing their understanding of the experience of correctional incarceration, its particular impact on individuals suffering from mental illness and its enduring effects on their attitudes beliefs and behaviors after release. In order to enhance treatment and maintain safety, it is important for providers to approach this population with "cultural competence"—an understanding of the culture of jail and prison and its impact on current behavior.

REFERENCES:

1. Lamb HR, Weinberger LE: Persons with severe mental illness in jails and prisons: a review. Psychiatric Services, 49, 483–492, 1998.
2. Rotter MR, Larkin S, Schare ML, et al: The Clinical Impact of Doing Time: Mental Illness and Incarceration. New York State Office of Mental Health, 1999.

Debate 1 **Wednesday, October 25**
3:30 p.m.-5:00 p.m.

SHOULD PSYCHIATRIC NURSE PRACTITIONERS HAVE INDEPENDENT PRESCRIBING PRIVILEGES?

American Association of Community Psychiatrists

Wesley E. Sowers, M.D., *Medical Director, Center for Chemical Dependency Treatment, and Chief Corporate Officer, Center for Addiction Services, Department of Psychiatry, St. Francis Medical Center, 400 45th Street, Pittsburgh, PA 15201;* Charles W. Huffine, Jr., M.D., *Assistant Medical Director for Child and Adolescent Programs, King County Mental Health Division, and Past President, American Association of Community Psychiatrists, 3123 Fairview Avenue, East, Seattle, WA 98102-3051;* Michael A. Silver, M.D., *Medical Director, The Providence Center, 530 North Main Street, Providence, RI 02904*

EDUCATIONAL OBJECTIVES:

At the end of the debate, those attending will have a greater appreciation of the issues for and against states sanctioning independent prescribing privileges for Advanced Registered Nurse Practitioners (ARNPs). Attendees will be better prepared to intelligently participate in social policy issues related to this topic.

AFFIRMATIVE SUMMARY:

The model for independent prescribing practice of ARNPs in psychosocial nursing exists in the state of Washington. Since 1977 ARNPs have practiced independently under strict scope of practice guidelines. Washington reports no unusual incidence of indicators of poor practice by ARNPs. Psychosocial nurses are required to have at least completed a masters program, followed by two years of supervised practice, providing adequate training to prepare nurses for independent practice. Scope of practice models in dentistry and primary care medicine will be compared with ARNPs. Well grounded in biological sciences, psychosocial nurses also have education in psychological treatments. This preparation is often more complete than what is offered to psychiatrists and vastly more than primary care doctors. Nursing education focuses on social contextual factors and functional issues as targets of clinical work. These are perspectives much valued by community psychiatrists who often lament the failure of medical education to adequately orient our colleagues in these perspectives.

Given adequate preparation of ARNPs in neurosciences, and their superior preparation to integrate psychosocial factors with biomedical treatment, it is a social advantage to license such practitioners independently given the shortage of psychiatrists in may communities in our country.

NEGATIVE SUMMARY:

It is quite obvious that nurses play a crucial role in the health care delivery system. Nurses and physicians have been interwoven in the fabric of the system in order to provide the best quality care for the people they serve. With the advent of the nurse practitioner and physician assistant roles, individuals without formal medical school training have been able to expand their medical responsibilities and provide efficient medical care, while maintaining the integrity and safety of a system that provides appropriate medical oversight. However, most good ideas taken to an extreme become bad ones. The idea to allow psychiatric nurse practitioners to prescribe medications independently is a distortion of a good concept. This change essentially redefines the nurse as physician, albeit one without the rigorous training and apprenticeship requirements.

How could one justify allowing another class of persons with less training and no required apprentice experience perform the identical task as the more qualified individual? Is it in this society's best interest to lower the standards in our health care system at this time when the drive for efficiency already poses threats to the quality of care? I think not.

REFERENCES:

1. Craig FJ: (1996). A review of prescriptive authority for nurse practitioners. J Perinat Neonata Nurs. 1996; 10(1):29–35.
2. Kaas MJ, Dahl D, Dehn D, Frank K: Barriers to prescriptive practice for psychiatric/mental health clinical nurse specialists. Clin Nurse Spec. 1998; 12(5):200–4. Citation IDS: PMID: 9987231 UI:99141704.
3. Bailey KP: Basic principles of psychopharmacologic treatment for advanced practice psychiatric nurses with prescriptive authority. Journal of Psychosocial Nursing & Mental Health Services 1999; 37(4):31–8.
4. Caverly SE: The role of the psychiatric nurse practitioner. Nursing Clinics of North America 1996; (31(3):449–63.

Debate 2 **Thursday, October 26**
1:30 p.m.–3:00 p.m.

PRESIDENT-ELECT CANDIDATES, APA BOARD OF TRUSTEES

Participants in this debate will be announced in the first issue of the *Daily Bulletin.*

Candidates for President-Elect, APA Board of Trustees, in the year 2001 will debate issues of interest to the membership and to psychiatry in general. Attendees will gain first-hand knowledge of each candidate's plat-

form and agenda prior to the election of APA officers. Take advantage of this opportunity to get to know APA's future President.

Debate 3 **Friday, October 27**
10:00 a.m.–11:30 a.m.

RESOLVED: OUTPATIENT COMMITMENT IS LIKELY TO DO MORE HARM THAN GOOD IN FACILITATING EFFECTIVE TREATMENT OF PERSONS WITH SERIOUS MENTAL ILLNESS

Paul S. Appelbaum, M.D., *Vice President, APA Board of Trustees, and A.F. Zeleznik Professor of Psychiatry, Chairman, Department of Psychiatry, and Director, Law and Psychiatry Program, University of Massachusetts Medical School, 55 Lake Avenue, North, Room S7-866, Worcester, MA 01655;* Howard H. Goldman, M.D., Ph.D., *Professor of Psychiatry, University of Maryland School of Medicine, 10600 Trotters Trail, Potomac, MD 20854-4241;* Ronald J. Diamond, M.D., *Professor of Psychiatry, Mental Health Center of Dane County, 6001 Research Park Boulevard, Madison, WI 53719-1179;* Jeffrey L. Geller, M.D., M.P.H., *Professor of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue, North, Worcester, MA 01655-0002;* Marvin S. Swartz, M.D., *Department of Psychiatry, Duke University Medical Center, Box 3173, Durham, NC 27710*

EDUCATIONAL OBJECTIVES:

At the conclusion of this debate, participants should be able to explore the advantages and disadvantages of the recent trend toward adoption of outpatient commitment statutes, including consideration of positive and negative consequences for patients and for systems that deliver mental health care.

AFFIRMATIVE SUMMARY:

Outpatient commitment imposes unnecessary coercion on individuals without offering them any benefit that cannot be provided with voluntary evidence-based services. Even for non-adherent patients, these effective services may be coupled with other legal means already available—without expanding coercive authority to outpatient commitment. Added coercion only serves to alienate patients from the help-seeking process and reinforces resistance to treatment. Coercive measures often are a substitute for providing evidence-based services. Emergencies, involving the threat of serious harm, can be handled with inpatient commitment; incompetence to make treatment decisions can be handled with probate proceedings. Outpatient commitment is rarely effectively implemented—even if the ends justified the means. Outpatient treatment cannot be enforced; police do not respond unless inpatient commitment is required because of imminent threat of danger. In the end—on balance—the result is more harm than good.

NEGATIVE SUMMARY:

The pressing need to improve community treatment outcomes for the hard-to-serve severely mentally ill, has led policymakers and clinicians to focus on legal mechanisms to improve treatment adherence, including court-ordered treatment in the community. We believe involuntary outpatient treatment is a potentially effective tool that not only can influence both individuals with mental illness and their families to adhere to treatment, but also exerts pressure on the mental health system to prioritize care for individuals under outpatient commitment orders. In our view outpatient commitment provides greater autonomy for its beneficiaries than would otherwise be expected for mentally ill individuals at risk for dangerous relapse and recidivism. Furthermore, if outpatient commitment effectively reduces hospital recidivism, it should conserve resources for reinvestment to extend and improve community-based services. We will review data from several groups that document the potential benefits of outpatient commitment.

REFERENCES:

1. Policy Research Associates Final Report on the Research Study of the New York City Involuntary Outpatient Commitment Pilot Program. Delmar, New York, 1998.
2. Monahan J, et al: Coercion in the provision of mental health services: the MacArthur Studies. Research in Community and Mental Health 1999; (10): 13–30.
3. Swartz MS, Swanson JW, Wagner HR, Burns BJ, Hiday VA, Borum R: Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial in severely mentally ill individuals. American Journal of Psychiatry 1999; 156:1968–1975.
4. Geller, J., Grudzinskas AJ, Jr., McDermeit M, The efficacy of involuntary outpatient treatment in Massachusetts. Adm Policy Ment Health 1998; 25:271–85.

Discussion Group 1 **Wednesday, October 25**
8:00 a.m.-9:30 a.m.

WHEN WORLDS COLLIDE: PSYCHODYNAMIC PSYCHOTHERAPY AND FORENSIC PSYCHIATRY

Jessica P. Byrne, M.D., *Clinical Assistant Professor of Psychiatry, Medical College of Pennsylvania-Hahnemann University, 347 Trevor Lane, Bala Cynwyd, PA 19004-2328*; Gary M. Flaxenburg, M.D., *Department of Psychiatry, Pennsylvania Hospital, 385 West Lancaster Avenue, Haverford, PA 19041*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the separate roles of the psychiatrist as psychodynamic psychotherapist and forensic valuator; and recognize the special treatment issues in the psychodynamic psychotherapy of patients who are also involved in civil litigation.

SUMMARY:

Psychodynamic psychotherapy encounters special difficulties when a patient is involved in a legal matter. When the patient is a plaintiff in a civil action, forensic issues may interfere with clinical care. Conversely, clinical judgments can affect the patient's legal situation in unexpected ways.

We will discuss the issues that arise at the interface between psychodynamic psychotherapy and forensic psychiatry. A representative case will be discussed in which a patient in psychodynamic psychotherapy is concurrently involved in suing her stepfather for childhood sexual abuse. Issues of confidentiality, record-keeping, third party contacts, therapeutic alliance, symptom exacerbation, transference, and countertransference will be addressed.

The presenters have extensive backgrounds in psychoanalytic/psychodynamic psychotherapy, as well as experience in forensic psychiatry. Attendees should have clinical experience in psychodynamic psychotherapy. Discussion group participants will be encouraged to present difficulties that have arisen in their own treatment of patients involved in litigation.

REFERENCES:

1. Strasburger LH, Gutheil TG, Brodsky A: On wearing two hats: role conflict in serving as both psychotherapist and expert witness. Am J Psychiatry 1997; 154:448–456.
2. Gutheil TG: True or false memories of sexual abuse? A forensic psychiatric view. Psychiatr Annals 1993; 3:527–531.

Discussion Group 2 **Wednesday, October 25**
10:00 a.m.-11:30 a.m.

PERSONS WITH SEVERE MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

H. Richard Lamb, M.D., *Professor of Psychiatry, University of Southern California School of Medicine, 1934 Hospital Place, Los Angeles, CA 90033-1071*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the need for monitoring persons with severe severe mental illness who are placed in the criminal justice system.

SUMMARY:

Clinical studies suggest that 6 to 15 percent of persons in city and county jails and 10 to 15 percent of persons in state prisons have severe mental illness. Offenders with severe mental illness generally have acute and chronic mental illness and poor functioning. A large proportion are homeless. It appears that a greater proportion of mentally ill persons are arrested compared with the general population. Factors cited as causes of mentally ill persons' being placed in the criminal justice system are deinstitutionalization, more rigid criteria for civil commitment, lack of adequate community support for persons with mental illness, mentally ill offenders' difficulty gaining access to community treatment, and the attitudes of police officers and society. Recommendations include mental health consultation to police in the field; formal training of police officers; careful screening of incoming jail detainees; diversion to the mental health system of mentally ill persons who have committed minor offenses; assertive case management and various social control interventions, such as outpatient commitment and court-ordered treatment; involvement of and support for families; and provision of appropriate mental health treatment.

REFERENCES:

1. Lamb HR, Weinberger LE: Persons with Severe Mental Illness in Jails and Prisons: A Review.
2. Lamb HR: Deinstitutionalization at the Beginning of the New Millenium.

Discussion Group 3 **Wednesday, October 25**
1:30 p.m.-3:00 p.m.

ADULT ADD

Harold I. Eist, M.D., *Past President, American Psychiatric Association, 10436 Snow Point Drive, Bethesda, MD 20814*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to identify and review the symptomology of ADD/ADHD, review comorbidity associated with ADD/ADHD throughout the life cycle, discuss and explore treatments for helping this biopsychosocial condition.

SUMMARY:

The adult ADD/ADHD patient suffers from the same problems of the disorder as children. The patient's problems with disorganization, distractibility, impulse control, restlessness or hyperactivity, prioritization, time management, and insensitivity to social cues can have profoundly negative impacts on work productivity, interpersonal interactions, marriage, and parenting. Comorbidity is common and requires evaluation and treatment. This quintessential, biopsychosocial condition requires combined treatments including some or all of the following: pharmacotherapy, psychotherapy, cognitive therapy, support groups, and coaching (particularly in the area of social skills).

Discussion Group 4 Wednesday, October 25 1:30 p.m.-3:00 p.m.

PSYCHIATRIST LEADERSHIP IN SYSTEMS OF CARE

American Association of Psychiatric Administrators

Christopher G. Fichtner, M.D., *Medical Coordinator for Health Services, State of Illinois Department of Human Services, Office of Mental Health, 160 North La Salle Street, 10th Floor, Chicago, IL 60601*; Paula G. Panzer, M.D., *Member, APA Institute Scientific Program Committee, and Associate Chief Psychiatrist for Adult Trauma Services, Jewish Board of Family and Children Services, Inc., 500 West End Avenue, Suite GR-J, New York, NY 10024*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participants should be able to demonstrate knowledge of current leadership issues, trends, and solutions in terms of both commonalities and distinctions evident across diverse systems of care.

SUMMARY:

As health care systems continue to evolve, leadership issues are at the center of professional development for many physicians, as evidenced by growing interest in the American College of Physician Executives, which provides continuing education and networking opportunities for physicians in the areas of leadership and management. The American Association of Psychiatric Administrators (AAPA) fosters exchange among psychiatrists working in various leadership roles within public and private systems of care. A recent AAPA-sponsored discussion group successfully drew together psychiatrists from state hospitals and agencies, VA networks, community mental health centers, and managed care and other private systems, for focused conversation on common themes involving psychiatrist leadership. This discussion group continues that effort. Salient issues for psychiatrists in leadership positions include evolving models of service delivery, the relationship of psychiatrists to other mental health professionals, tensions between clinical service standards and fiscal accountability, academic affiliations, interfaces between public and private systems, collaboration with consumer initiatives, continuity of care issues and public policy. By facilitating exchange of examples of successful leadership activity within organized systems of care, this discussion group will enhance awareness of existing leadership models and create opportunities for further learning and problem-solving in these and related leadership areas.

REFERENCES:

1. Morgan G: Images of organization. Thousand Oaks, Sage Publications, 1997.
2. Klein EB, Gabelnick F, Herr P: The psychodynamics of leadership. Madison, Connecticut, Psychosocial Press, 1998.

Discussion Group 5 Thursday, October 26 8:00 a.m.-9:30 a.m.

PREVENTION OF SCHOOL VIOLENCE

Carl C. Bell, M.D., *President and Chief Executive Officer, Community Mental Health Council, Inc., and Professor of Psychiatry and Public Health, University of Illinois School of Medicine, 8704 South Constance Avenue, Chicago, IL 60617-2746*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to learn seven field principles necessary to prevent school violence and initiate health behavior change.

SUMMARY:

Based on work in the Chicago Public School system, Dr. Bell will highlight seven field principles designed to prevent violence in schools: 1) re-establishing the village, 2) providing access to health care, 3) improving bonding, attachment, and connectedness dynamics within the community and between stakeholders, 4) improving self-esteem, 5) increasing social skills of target

recipients, 6) re-establishing the adult protective shield and monitoring, and 7) minimizing the residual effects of trauma.

TARGET AUDIENCE:

This discussion should be of interest to health care professionals who are interested in health behavior change.

REFERENCES:

1. Bell CC (Ed): Psychiatric Perspectives on Violence San Francisco, Jossey-Bass, in press.
2. Bell CC, Gamm S, Vallas P, Jackson P: Strategies for the Prevention of Youth Violence in Chicago Public Schools. In press.
3. Shafii & S. Shafii (Eds): School Violence: Contributing Factors Management, and Prevention, Washington, D.C. American Psychiatric Press, in press.

Discussion Group 6 **Thursday, October 26**
1:30 p.m.-3:00 p.m.

COLLABORATION IN CREATING A BEHAVIORAL HEALTH SYSTEM: MENTAL HEALTH AND DRUG AND ALCOHOL ADMINISTRATIVE SERVICES WORKING TOGETHER

Philadelphia Behavioral Health System

Michael Covone, *Deputy Health Commissioner, Philadelphia Behavioral Health System, 1101 Market Street, Suite 700, Philadelphia, PA 19107*; Mark Bencivengo, *Assistant Health Commissioner, Philadelphia Behavioral Health System, 1101 Market Street, Suite 700, Philadelphia, PA 19107*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to understand the collaboration and necessity of collaboration between mental health and substance use administrators and treatment providers.

SUMMARY:

The presenters are senior officials within the Philadelphia Behavioral Health System, responsible for mental health services and drug and alcohol services, respectively. They will discuss administrative and clinical issues involved in implementing services for individuals with co-occurring mental health and substance use disorders within a Medicaid managed care environment. For the past three years, the Philadelphia Behavioral Health System has been a national leader in creating the cooperative administrative processes that allows for design and implementation of research findings into effective integrated mental health and drug and alcohol services. As the designated leaders of the mental health and drug and alcohol services, their leadership, spirit of cooperation and sharing of knowledge and expertise has been essential in a timely and meaningful integration of mental health and drug and alcohol services. They will highlight the advantages and opportunities involved in engaging in this type of comprehensive system change in a managed care environment.

TARGET AUDIENCE:

Clinicians and administrators who are involved in designing, implementing and monitoring services for individuals with co-occurring mental health and substance use issues.

REFERENCES:

1. Drake RE, Mercer-McFadden C, Muesser KT, McHugo GM, Boyd GR: Treatment of substance abuse in patients with severe mental illness: a review of recent research. Schizophrenia Bulletin 24:1–37, 1998.
2. Kessler RC, Nelson CB, McGonagle KA, Edlund MJ, Frank RG, Leaf PJ: The epidemiology of co-occurring addictive and mental disorders: implications for prevention and service utilization. American Journal of Orthopsychiatry 66:17–25, 1996.

Discussion Group 7 **Thursday, October 26**
1:30 p.m.-3:00 p.m.

LESBIAN AND GAY PARENTING

Marshall Forstein, M.D., *Medical Director, HIV/Mental Health and Addiction Services, Department of Psychiatry, Fenway Community Health Center, and Assistant Professor of Clinical Psychiatry, Harvard University, 24 Olmstead Street, Jamaica Plain, MA 02130*; Margery Sved, M.D., *Department of Psychiatry, Dorothea Dix Hospital, 3601 Mail Service Center, Raleigh, NC 27699-3601*

EDUCATIONAL OBJECTIVES:

At the end of this discussion group, participants will be able to identify the psychological and social issues facing gay and lesbian parents and their children.

SUMMARY:

Lesbian and gay men have been parents for as long as people have had children, but until recently predominantly in the guise and context of a heterosexual relationship. Since the increased awareness and visibility of lesbian and gay people in the post-Stonewall era of gay liberation, increasing numbers of ''out'' lesbians and gay men have become parents, through a variety of techniques and configurations of families.

This discussion group will be led by a lesbian and a gay male, both of whom are parents. We will discuss the variety of ways that gay and lesbian people become parents and the social and legal context in which this occurs. We will discuss the psychological and social process that gay and lesbian people go through to become parents, looking at developmental issues for individuals and for couples who decide to parent. We will share our experience of parenting in terms of our children's development issues aroung the process of adoption, having gay parents, and experience with schools and health and social agencies. A program for the support of lesbian and gay parents at the Fenway Community Health Center will be presented.

REFERENCES:

1. Patterson CJ, Chan RW: Gay fathers and their children, in Textbook of Homosexualtiy and Mental Health. Edited by Cabaj R, Stein TS. American Psychiatric Press, Washington, D.C., 1996.
2. Kirkpatrick M: Lesbians as parents, in Textbook of Homosexuality and Mental Health. Edited by Cabaj R, Stein TS. American Psychiatric Press, Washington, D.C., 1996.

Discussion Group 8 **Thursday, October 26 3:30 p.m.-5:00 p.m.**

DEMENTIA CARE

Paul A. Kettl, M.D., *Professor of Community Psychiatry, and Chair, Department of Psychiatry, Milton S. Hershey Medical Center, Penn State University, P.O. Box 850, Hershey, PA 17033-0850*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand both the pharmacologic and family treatment issues in dementia care.

SUMMARY:

As America ages, dementia care is evolving into a growing subspecialty in psychiatric care delivery. The fastest growing segment of the U.S. population is the "old-old" who are most at risk for developing dementia.

In this discussion group, we will examine new and evolving treatments of Alzheimer's disease and other dementias. The importance of diagnosis of different types of dementias will be discussed as well as the current role of treatment in early and late dementia. Psychiatric problems of agitation, psychosis, and depression emerging in the course of the dementing illnesses will also be discussed.

Dementia care involves not only care for the patient, but also care for the family who is often suffering through the long course of the disorder. Managing the family caring for the demented individual will also be discussed.

REFERENCES:

1. Kettl PA: Management of Alzheimer's disease in the home care setting. Home Health Care Consultant 1999; 6:30–34.
2. Kettl PA. Alzheimer's disease: an update. Hospital Med 1997; 33:10, 12–20.

Discussion Group 9 **Thursday, October 26 3:30 p.m.-5:00 p.m.**

RELIGION AND PSYCHIATRY: FROM CONFLICT TO COLLEGIALITY

David M. Blass, M.D., *Resident in Psychiatry, Johns Hopkins Hospital, 6600 Sanzo Road, #A, Baltimore, MD 21209-2449*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify a number of issues that have hindered, and may continue to hinder, a constructive relationship between the fields of psychiatry and religion. Participants will be able to reflect upon the values implicit in psychiatric theory and treatment, as well as their relevance for religion and its practice.

SUMMARY:

The relationship between the fields of psychiatry and religion has been complex and dynamic. The biases and suspicions of each toward the other have at times interfered with a productive collaboration between them. This discussion group will attempt to briefly review some of this history as well as some of the steps that have been taken to improve the relationship between the disciplines. A framework for a productive interface between the two that avoids some of the historical conflicts will be reviewed as well. The literature references highlight some of the values of science in general, and psychiatry in particular, that have contributed in part to the difficulties in viewing religion as an ally in patient care. Participants can share their experiences with religious patients, clergy, and religious communities and look at the positive and negative aspects of these interactions. Mental health professionals from any discipline as well as members of the clergy would benefit from this discussion.

REFERENCES:

1. Bergin AE: Psychotherapy and religious values. Journal of Consulting and Clinical Psychology 1980; 48:95–105.
2. Ellis A: Psychotherapy and atheistic values: a response to A.E. Bergin's "psychotherapy and reli-

gious values''. Journal of Consulting and Clinical Psychology 1980; 48:635–639.
3. Jones SL: A constructive relationship for religion with the science and profession of psychology. American Psychologist 1994; 49:184–199.

Discussion Group 10 **Friday, October 27**
8:00 a.m.-9:30 a.m.

THE FUTURE ROLE OF PSYCHIATRISTS IN URBAN PLANNING OF COMMUNITIES FOR THE POOR

Mario Cruz, M.D., *Clinical Assistant Professor and Associate Head of Clinical Services, Department of Psychiatry, University of Arizona, 1501 North Campbell Avenue, Tucson, AZ 85724*; Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute; Assistant Professor of Psychiatry, University of Pennsylvania Medical Center; and Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Room E-516, Pittsburgh, PA 15213*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the role of psychiatry in urban planning and identify specific skills training for community psychiatrists.

SUMMARY:

In the United States, our modern ''post-industrial'' economy has increased the disparity in social, political, and financial advantages afforded middle-class and wealthy citizens versus the poor. Economic decline and political disempowerment in poor urban communities have resulted in social conditions that perpetuate mental disorders in community members. Although impoverished social conditions are recognized as catalysts for disease promotion and progression, treatment interventions specifically geared to reducing their impact on the functioning of mentally ill patients are rarely considered essential aspects of psychiatric service delivery. It is the presenters' opinion that these disease-promoting social conditions warrant the development of additional skills training in order for future community psychiatrists to be effective. Specifically, community psychiatrists must become active participants in local social policy, urban planning, and development. The panelists are two community psychiatrists with more than 20 years of combined administrative/clinical experience working with marginalized populations. They will share their views on this topic and provide examples where interventions at the local community level reduce poverty's impact on the mentally ill.

REFERENCES:

1. North C, Smith E, Pollio D, Spitznagel E: Are the mentally ill homeless a distinct homeless subgroup? Annals of Clinical Psychiatry 1996; 8:117–128.
2. Shapiro S: Need and demand for the mental health services in an urban community, in J Barrett and R Rose (Eds). Mental Disorders in the Community: Progress and Challenge. NY, NY, Guilford Press, pp. 307–320, 1986.

Discussion Group 11 **Friday, October 27**
1:30 p.m.-3:00 p.m.

THE TRANSFORMATION OF CASE MANAGEMENT SERVICES FROM A MENTAL HEALTH TO A BEHAVIORAL HEALTH APPROACH: THE ROAD LESS TRAVELED

Philadelphia Behavioral Health System

Sandra Vasko, *Director of Operations, Philadelphia Behavioral Health System, 1101 Market Street, Suite 700, Philadelphia, PA 19107*; Mary Rose Cunningham, *Program Analyst, Philadelphia Behavioral Health System, 520 North Delaware Avenue, Suite 7-D, Philadelphia, PA 19123*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to increase understanding in the practices of case management services serving the persistently mentally ill and to increase understanding of the psychiatrist's role within the treatment team.

SUMMARY:

The participants will discuss their experience and research with traditional models of case management. The group will then outline the process of change and growth involved in transforming case management services from an individual model to a team approach and in increasing integration of drug and alcohol services and expertise in the traditional mental health model of case management. Psychiatric support of this change will be highlighted as essential to the process. The group will also discuss the process of moving case management services and providers from a traditional program funded model to a Medicaid managed care environment. Clinical and administrative issues will be discussed throughout, as well as the interaction and competing demands of these two essential concerns. The focus of the session will be on real life, day-to-day challenges that face all clinicians using any type of case management model.

TARGET AUDIENCE:

Psychiatrists and other clinicians involved in treating severely and persistently mentally ill individuals using case management as an integral component of treatment.

REFERENCES:

1. Kanter J: Clinical case management: definitions, principles, components. Hospital and Community Psychiatry 1989; 40:361–369.
2. Muesser KT, Bond GR, Drake RE, Resnick S: Models of community care for severe mental illness: a review of research on case management. Schizophrenia Bulletin 1998; 24:37–74.

Discussion Group 12 **Friday, October 27**
3:30 p.m.-5:00 p.m.

ISSUES IN COMMUNITY PSYCHIATRY

American Association of Community Psychiatrists

Charles W. Huffine, Jr., M.D., *Assistant Medical Director for Child and Adolescent Programs, King County Mental Health Division, 3123 Fairview Avenue, East, Seattle, WA 98102-3051*; Jacqueline M. Feldman, M.D., *Director, Division of Public Psychiatry, University of Alabama, Birmingham, and President, American Association of Community Psychiatrists, 4-CCB 908 20th Street, South, Birmingham, AL 35294*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to learn about updated diagnosis and treatment techniques for persons who are seen by psychiatrists in a community practice.

SUMMARY:

The current and past presidents of the American Association of Community Psychiatry will lead a discussion of issues in community psychiatric practice. Topics will be determined by the attendees. Participants will be encouraged to bring problems from their own practice. The presenters will facilitate a discussion drawing from the various experiences of the group participants. This model is the same as that offered at recent past IPS meetings in similar discussion groups. Topics discussed in detail at the 1999 meeting included recent changes in regulations regarding restraints and seclusion and the potential impact of legislation in this area. Participants also dealt with issues of inter-professional relationships, psychiatric roles on treatment teams and the impact of managed care on public mental health systems. Dr. Huffine brings experience from his community practice focused on children and adolescents in Seattle, Washington. Dr. Feldman draws on her teaching and practice in the care of severe and persistently mentally ill adults at the University of Alabama at Birmingham.

TARGET AUDIENCE:

The discussion will be open to all attendees, but will be oriented to those with experience in community practice or who have an interest in careers in community practice settings.

REFERENCES:

1. Dual Diagnosis of Mental Illness and Substance Abuse, Collected Articles from Hospital and Community Psychiatry, Wash. DC, American Psychiatric Association, 1993.
2. Stroul BA, Friedmen RM: A System of Care for Children and Youth with Severe Emotional Disturbances, 2nd Ed. CASSP Technical Assistance Center, Wash. DC, 1994.

Discussion Group 13 **Saturday, October 28**
8:00 a.m.-9:30 a.m.

INVOLUNTARY COMMITMENT: BEST PRACTICES

Elizabeth Galton, M.D., *Member, APA Institute Scientific Program Committee, and Department of Psychiatry, UCLA, 2901 Wilshire Boulevard, #421, Santa Monica, CA 90403-4907*; Carla Jacobs, *Board of Directors, National Alliance for the Mentally Ill, 203 Argonne, B-104, Long Beach, CA 90803*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to help establish a well-thought-out policy or severe/chronic mental illness in their home states.

SUMMARY:

Many states still have involuntary commitment laws based on the now 30-year-old California LPS Act, which prevents involuntary treatment of severe mental illness in any case other than danger to self or others or grave disability, the last of which has been so tightly interpreted as to not include eating from dumpsters and sleeping under bridges when mental disorder has deteriorated to the level of non-function. This law, together with emptying of state hospitals, has led to our current disastrous situation of untreated mentally ill people homeless and incarcerated, with even families with means unable to get their loved ones treated. Three years ago, a Los Angeles–based multidisciplinary group of family members, psychiatrists, psychologists, attorneys, nurses, social workers, clients, policemen, and others began a monthly series of meetings in an effort to solve the problem of the untreated mentally ill. It produced a white paper with recommendations to reform current law on

the basis of facts which were not known then, but are now known, including: schizophrenia and other major mental illness are true neurobiologic conditions and not moral weakness or eccentricity. Further, these illnesses are treatable. Therefore, it was our feeling that the laws should be updated to reflect new understandings. Criteria for involuntary treatment should reflect need for treatment. We also recommended that one element in this era of short hospitalizations should be commitment to outpatient treatment, which, if properly funded and "commitedly" carried out, would provide ongoing care, and thereby stability in the otherwise roller-coaster lives of patients with episodes of psychosis. We present this model as our experience in dealing with a difficult problem, and invite others to share their experiences with reform and thoughts about how best to shape our thinking about mental health policy with regard to serious and chronic mental illness.

TARGET AUDIENCE:

Psychiatrists, family members, researchers, legislators, law enforcement and attorneys.

REFERENCES:

1. APA: 1999 Revision: Resource document our mandatory outpatient treatment.
2. Applebaum P: Almost a Revolution.

Discussion Group 14 **Saturday, October 28**
8:00 a.m.-9:30 a.m.

TEACHING TRAINEES IN THE PSYCHIATRIC EMERGENCY ROOM

American Association for Emergency Psychiatry

Rachel L. Glick, M.D., *Associate Dean for Student Programs, Clinical Assistant Professor of Psychiatry, University of Michigan Medical School, and President, American Association for Emergency Psychiatry, 1301 Catherine Street, Ann Arbor, MI 48109-0611*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the educational goals of a psychiatric emergency expert for a variety of trainees. The participant should also have ideas about creating settings in which students can learn about crisis management in the absence of a formal psychiatric emergency service.

SUMMARY:

The American Association for Emergency Psychiatry has recently developed guidelines for psychiatric residency training in the emergency setting. This discussion group will begin by reviewing these guidelines. Then the group will discuss which training goals and objectives apply to other groups of trainees in the emergency setting, including medical students, social workers, nurses, psychologists, and other mental health providers. Finally, the group will discuss ways in which crisis management can be taught effectively in the absence of a formal psychiatric emergency service. This discussion is targeted toward psychiatric educators. Participants should come to the group with ideas about what has and has not worked in teaching crisis and emergency room management at their home institutions.

REFERENCES:

1. Brasch JS, Ferencz JC: Training issues in emergency psychiatry. Psych Clin of North America. 1999; 22:941–954.
2. Glick RL, et al: Proposed AAEP Model Curriculum. Emergency Psychiatry 1998; 4:18–19.
3. Muhlbaurer HG: Teaching trainees in turbulent settings: A practical guide. Emergency Psychiatry 1998; 4:28–30.

Discussion Group 15 **Saturday, October 28**
10:00 a.m.-11:30 a.m.

DO I NEED A MASTERS IN BUSINESS ADMINISTRATION TO TRANSFORM MY CAREER?

Arthur L. Lazarus, M.D., M.B.A., *Vice President of Behavioral Health, Humana, Incorporated, 6830 Windham Parkway, Prospect, KY 40059*; Marie L. Zecca, *Director, Executive M.B.A. Program, LaSalle University, 1900 West Olney Avenue, Philadelphia, PA 19141-1199*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the importance of graduate business education for aspiring clinician executives and evaluate the advantages and disadvantages of an executive MBA program.

SUMMARY:

Behavioral health administration promises to be an area of growth and opportunity for many clinicians including psychiatrists, psychologists, and social workers. Increasingly, clinician-executives are turning to graduate level business training to learn effective management skills. Executive MBA programs, which can be completed in less than two years, offer clinicians an opportunity to obtain an MBA degree without interrupting their career.

Discussion group 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 marketplace opportunities for clinician-executives. The careers of clinicians who recently graduated from one executive MBA program (Temple University) will be profiled. There will be ample time to ask questions and discuss personal experiences to help plan for a career in behavioral health administration.

REFERENCES:

1. Lazarus A: The educational needs of physician executives: why an MBA? Physician Executive 1997; 23:41–44.
2. MD/MBA: Physicians on the New Frontier of Medical Management. Edited by Lazarus A. Tampa, Florida, The American College of Physician Executives, 1998.

Discussion Group 16 **Saturday, October 28**
3:30 p.m.-5:00 p.m.

OFFICE-BASED TREATMENT OF ADDICTIONS

Frederic M. Baurer, M.D., *Medical Director, Kirkbridge Center, 111 North 49th Street, Philadelphia, PA 19139*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: 1) differentiate symptomatic substance abuse from the autonomous illness of addiction; 2) describe addiction and recovery as dynamic independent processes within the addicted patient; 3) differentiate supportive vs. enabling behaviors on the part of an involved significant other in the treatment of the addicted patient; 4) cultivate the constructive clinical utilization of an involved significant other in the treatment of the addicted patient; and 5) appreciate the unique wisdom and clinical utility of 12-step programs as a formidable treatment ally.

SUMMARY:

The substance-abusing patient presents unique clinical challenges. One difficulty facing the clinician results from conflicting conceptual models for addictive illness, which often leave the clinician struggling over whether or not to "trust" the patient with traditional treatment approaches. Another difficulty is the question of how and when to appropriately engage significant others in a pro-therapeutic way.

The presenter utilizes a model of addictions treatment in which the clinician maintains a dual focus at all times. Essentially, addiction is seen as a malignant process which must be *contained,* while recovery is viewed as an antithetical process which must be actively *cultivated.* Inasmuch as addiction and recovery are dynamic processes, treatment requires ongoing attention to the containment system for addiction and the nascent recovery process. This view contrasts with widely held belief systems that place containment of addiction first, as a precursor to recovery. The presenter holds that addictive tendencies are invariably active for a long time, whether or not actual substance use has ceased. He believes as well that this conceptual formulation is entirely consistent with the model espoused in 12-step programs.

This discussion group will explore the application of this model to clinical dilemmas encountered in office-based practice. Attention to the containment system challenges the clinician to discover and utilize all available tools to confront the addicted patient with the consequences of her addiction. This frequently involves the use of concerned significant others who generally bring both pro- and anti-therapeutic agendas to the table. The challenge to the clinician is to maintain focus on the processes of addiction and recovery and to actively engage significant others as needed in the service of therapeutic goals.

As the format selected is that of discussion group, participants are encouraged to bring clinical material as well as their own questions and ideas pertaining to the topic. While a theoretical formulation will be briefly presented, the focus will be on practical clinical matters.

REFERENCES:

1. Khantrian EJ, Mack JE: AA & contemporary psychodynamic theory, in Recent Development in Alcoholism, Vol 7. Edited by N Golater. New York, Plenum, 1987.
2. Kaufman ER: Countertransference and other mutually interactive aspects of psychotherapy with substance abuse. Am J Addiction 1992; 185–200.

Discussion Group 17 **Sunday, October 29**
8:00 a.m.-9:30 a.m.

RESPONSIBILITIES OF THE PSYCHOTHERAPY SUPERVISOR

E. Gardner Jacobs, M.D., *Clinical Assistant Professor of Psychiatry, University of Pennsylvania, 5400-10 Wissahickon Avenue, Philadelphia, PA 19144*; Sarah M. Whitman, M.D., *Assistant Professor of Psychiatry, Medical College of Pennsylvania, Hahnemann University, 1427 Vine Street, Philadelphia, PA 19102*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: 1) recognize the levels of responsibility of the supervisor; 2) understand parallel process as it applies to supervision; and 3) apply the knowledge clinically.

SUMMARY:

Psychotherapy supervisors are teachers and standard setters in our profession, yet psychiatric supervision is rarely taught and the complexity of the task is generally not considered. The supervisor has multiple levels of responsibility, which include responsibility to the supervisee, to the patient, to the training program and profession, and to the supervisor himself or herself.

The multiple levels of responsibility will be considered and discussed by the group, as will parallel process, whereby difficulties or impasses in supervision may arise because of unconscious factors in any of the participants—patient, therapist, or supervisor. They may move up or down in the triad. Recognition of such difficulty may lead to valuable insight and progress in the supervision. Participants, primarily those doing supervision, will be encouraged to present vignettes of supervision problems they have encountered.

REFERENCES:

1. Whitman SM, Jacobs EG: Responsibilities of the psychotherapy supervisor. Am J Psychotherapy 1998; 52:166–175.
2. Baudry FD: The personal dimension and management of the supervisory situation—special note on parallel process. Psychoanal Q 1993; 588–614.

Discussion Group 18 **Sunday, October 29**
10:00 a.m.-11:30 a.m.

UNDERSTANDING AND TREATING IMMIGRANT PATIENTS IN PSYCHODYNAMIC PSYCHOTHERAPY

Salman Akhtar, M.D., *Department of Psychiatry, Jefferson Medical College, 1201 Chestnut Street, 15th Floor, Philadelphia, PA 19107*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to determine whether or not psychoanalysis and psychoanalytic psychotherapy are applicable to non-Western, immigrant patients.

SUMMARY:

After briefly commenting upon whether psychoanalysis and psychoanalytic psychotherapy are applicable to non-Western, immigrant patients, I will argue that these treatment modalities are useful for this clinical population. I will then outline eight technical guidelines for such work. These include (1) developing and maintaining cultural neutrality, (2) respecting cultural differences in the experience of time and in the degrees of deference, (3) adopting a developmental stance and conducting developmental work, (4) helping the patient disengage cultural from intrapsychic conflicts, (5) validating feelings of dislocation and facilitating mourning, (6) interpreting defensive functions of nostalgia as well as defenses against the emergence of nostalgia, (7) accepting seemingly inoptimal individuation and involvement of relatives, and (8) facing the challenge posed by the patient's polyglottism and polylingualism. I emphasize that these are only guidelines and not rules. In psychologically minded and more individuated patients, where treatment method can approach psychoanalysis proper, their use recedes to the background. In less sophisticated patients with symbiotic identities and marked propensity toward cultural rationalization, these guidelines demand greater attention.

REFERENCES:

1. Garza-Guerrero AC: Culture shock: its mourning and the vicissitudes of identity. Journal of the Amer Psychoanalytic Assoc 1974; 22:408–429.
2. Akhtar S: A third individuation: immigration, identity, and the psychoanalytic process. J Amer Psychoanalytic Assoc 43:1051–1084.

Full-Day Session 1 **Thursday, October 26**
8:30 a.m.-5:00 p.m.

DAVANLOO'S INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY IN CLINICAL PRACTICE

James Q. Schubmehl, M.D., *Clinical Associate Professor of Psychiatry, University of Rochester, 2541 Monroe Avenue, #B-7, Rochester, NY 14618-3123;* Tewfik Said, M.D.; Deborah Lebeaux, M.S.W.; Alan R. Beeber, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will acquire a vivid sense of the forces underlying human psychopathology and a view of crucial elements of the healing process. They will be able to describe main elements of Davanloo's technique and should find many aspects of the presentation useful to their clinical practice.

SUMMARY:

Highly resistant, poorly motivated patients are a major challenge to every clinician, especially when the clinical picture includes a complex mixture of character pathology and symptom disturbances. Davanloo's Intensive Short-Term Dynamic Psychotherapy has shown rapid effectiveness with difficult-to-treat conditions, including functional disorders, depression, panic, and other anxiety disorders. This workshop, for those who practice or make referrals to psychotherapy, will demonstrate the range of applications of this technique, with specific technical interventions for particular conditions. There will be extensive use of videotapes to demonstrate the innovative techniques and metapsychology underlying the activation of the therapeutic alliance even with hard-to-engage patients. In addition, the catalytic role of the "unlocking of the unconscious" in freeing the patient from the destructive forces of the punitive superego will be clearly shown. There will be time for discussion. The workshop will provide participants with an overview of this uniquely powerful way of understanding human psychic functioning. It will further demonstrate how these techniques are used to help individuals free themselves from the crippling effects of their psychopathology.

REFERENCES:

1. Davanloo H: Unlocking the Unconscious. West Sussex, England, John Wiley and Sons Ltd, 1990.
2. Beeber A: The perpetrator of the unconscious in Davanloo's new metapsychology parts I-III. International Journal of Intensive Short-Term Dynamic Psychotherapy 1999; 13: 151–189.
3. Lebeaux D: The rise in the transference in Davanloo's intensive short-term dynamic psychotherapy: principles, technique and issues for training. International Journal of Intensive Short-Term Dynamic Psychotherapy 1999; 13: 3–16.
4. Said T: Current status of criteria for selection for patients for short-term dynamic psychotherapy. International Journal of Short-Term Psychotherapy 1996; 11: 99–127.
5. Schubmehl JO: Technique and metapsychology of the early working through phase of Davanloo's intensive short-term dynamic psychotherapy. International Journal of Short-Term Psychotherapy 1996; 11: 225–251.

Full-Day Session 2 **Friday, October 27**
8:30 a.m.-5:00 p.m.

NEW CHALLENGES FOR STATE HOSPITAL PSYCHIATRISTS

APA Caucus of State Hospital Psychiatrists

Beatrice M. Kovasznay, M.D., M.P.H., *Director for Clinical Services, New York State Office of Mental Health, 44 Holland Avenue, 8th Floor, Albany, NY 12229;* Yadollah M. Jabbarpour, M.D., *Department of Psychiatry, Catawba Hospital, P.O. Box 200, Catawba, VA 24070;* Alan D. Miller, M.D.; Miles F. Shore, M.D.; Christopher G. Fichtner, M.D.; Christie A. Cline, M.D.; Molly T. Finnerty, M.D.; Fred C. Osher, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and strategize solutions for key issues facing state hospital psychiatrists.

SUMMARY:

As state hospitals continue to downsize, the state hospital psychiatrist is left to care for an increasingly challenging patient population, while often feeling insufficiently involved in administrative decision making at the facility. This full-day session will focus on issues of particular interest to state hospital psychiatrists. The planned schedule is as follows:

Morning session:

1) **The Changing Role of the Psychiatrist Administrator.** Discussants will represent various leadership roles in the state hospital system.

2) **Practical Issues in Implementation of Practice Guidelines.** Presenters will share experiences from several states including New York, New Hampshire, and Virginia.

Afternoon session: Selected topics that have recently generated considerable controversy.

1) **Assessment and Treatment of the Mentally Ill Sex Offender in the State Mental Health System.** We will present New York's approach to this problem.

2) **Outpatient Commitment: How Is it Working?** A discussion of four states' experience with outpatient commitment and its impact on state hospitals.

3) **Reducing the Use of Seclusion and Restraint: The Role of Psychiatric Leadership.** Presentation of the experience in Pennsylvania and New York.

REFERENCES:

1. Ranz J, Stueve A: The role of the psychiatrist as program medical director. Psychiatric Services 1998; 49: 1203–1207.
2. Quinsey VL, Harris GT, Rice ME, Cormier CA: Violent Offenders: Appraising And Managing Risk. Chapter 7: Sex Offenders. Washington DC, American Psychological Association, 1998.
3. Miller R: Coerced treatment in the community. Psychiatric Clinics of North America 1999; 22: 183–196.
4. Geller J, Grudzinkas AJ, McDermeit M, et al: The efficacy of involuntary outpatient treatment in Massachusetts. Administration and Policy in Mental Health 1998; 25: 271–285.
5. Rush JM, Crimson LM, Toprac MG, et al: Implementing guidelines and systems of care: experiences with the Texas Medication Algorithm Project (TMAP). J. Practical Psychiatry and Behavioral Hlth 1999; 5: 75–86.
6. Visalli H, McNasser G, Johnstone L, Lazzaro CA: Reducing high-risk interventions for managing aggression in psychiatric settings. J Nursing Care Qual 1997; 11:54–61.

Full-Day Session 3 **Friday, October 27**
8:30 a.m.-5:00 p.m.

TREATMENT AND CARE IN THE THIRD DECADE OF AIDS

APA AIDS Education Project and Center for Mental Health Services

Marshall Forstein, M.D., *Medical Director, HIV/Mental Health and Addiction Services, Department of Psychiatry, Fenway Community Health Center; and Assistant Professor of Clinical Psychiatry, Harvard University, 24 Olmstead Street, Jamaica Plain, MA 02130;* J. Stephen McDaniel, M.D., *Grady Infectious Disease Program, and Associate Professor of Psychiatry, Emory University, 341 Ponce De Leon Avenue, Atlanta, GA 30308;* Francine Cournos, M.D.; Richard Herman, M.A.; Meg Kaplan, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the parallel significance of HIV prevention and treatment, recognize the psychiatric and psychosocial dimensions of HIV disease, acknowledge and apply successful models and components of successfully integrated interdisciplinary care, and assist patients in accessing integrated mental health, primary care, and support services.

SUMMARY:

Mental health clinicians must be prepared for the challenges of HIV care. Treatment of neuropsychiatric and psychiatric problems is becoming increasingly more sophisticated as the body of knowledge on pharmacological interventions, drug-drug interactions, assessment and prevention strategies, successful coping approaches, techniques for enhancing adherence, and a host of other new advances expands. In addition, clinicians are often forced to navigate complex, fragmented, and uncoordinated health care systems to help patients access the services they need.

This session will address these challenges by bringing practitioners up to date on the latest clinical treatment information, introducing practical approaches to case management, and discussing the vital role of psychiatrists and mental health professionals in HIV patient care. An interdisciplinary faculty will provide specific models and applications on prevention and education, diagnosis and treatment, and integrated care for people living with HIV disease. Didactic and case presentations will provide the foundation for in-depth participant discussion. A practical guide, lists of resources, and practice guidelines will also be presented to participants.

REFERENCES:

1. Acuff C, Archambeault J, et al: Mental Health Care for People Living With or Affected by HIV/AIDS: A Practical Guide. Research Triangle Park, NC: Research Triangle Institute, 1999.
2. Kwasnik B, et al: HIV mental health services integrated with medical care. In HIV Mental Health for the 21st Century, New York University Press, 1997.
3. Meredith K, Larson T, et al: Building comprehensive HIV/AIDS care services. AIDS Patient Care 1998; 12:5.
4. Wright ER, Shuff MI: Specifiying the integration of mental health and primary care services for persons with HIV/AIDS. Soc Networks, 1995; 17:319–40.

Presidential **Saturday, October 28**
Full-Day Session 4 **8:30 a.m.-5:00 p.m.**

THE PRACTICAL APPLICATION OF PSYCHODYNAMIC TECHNIQUES ON THE FRONT LINES

Norman A. Clemens, M.D., *Member, APA Board of Trustees, and Clinical Professor of Psychiatry, Case*

Western Reserve University, 1611 South Green Road, Suite 301, Cleveland, OH 44121; Bernard D. Beitman, M.D.; Barbara Milrod, M.D.; Eva M. Szigethy, M.D., Ph.D.; Jerald Kay, M.D.; Andrew Siegel, M.D.; Marcia K. Goin, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

To describe the application of psychodynamic concepts and therapeutic techniques to 1) transference phenomena in the doctor-patient relationship; 2) integrated psychotherapy and psychopharmacology; 3) acute-care evaluation and treatment planning; 4) structured treatment of panic disorder; 5) treatment of difficult patients with multiple symptoms and personality disorders; 6) selection of cases requiring intensive, long-term psychotherapy.

SUMMARY:

The vitality of psychodynamic psychotherapy (PDP) lies in its versatility and adaptability to the needs of individual patients. This full-day session for practicing clinicians demonstrates key aspects of PDP and their application to a wide range of clinical situations. Most of the presenters will engage the audience in active learning exercises to stimulate thinking about therapeutic strategies with patients.

We open with the active use of ubiquitous transference and countertransference phenomena in the service of therapeutic goals, with implications for the doctor-patient relationship in any clinical situation.

We present new research on manual-based, short-term PDP of panic disorder. Preliminary findings suggest striking effectiveness for both symptom reduction and broader gains.

A challenging adolescent patient demonstrates the value of a developmental perspective and psychodynamic formulation in an acute-care setting.

Addressing common practice patterns, we explore how psychodynamic understanding enhances integrated pharmacotherapy and psychotherapy.

Another case illustrates how PDP helped an adolescent girl surmount multiple symptoms and borderline personality traits and move on into early adulthood, a cost-effective outcome.

Longer-term PDP or psychoanalysis remain essential to the effective treatment of some patients. Through the evolution of a treatment case, we address issues of case selection, theoretical basis of technique, and realistic prognosis.

REFERENCES:

1. Beitman BD: Integration of pharmacotherapy and psychotherapy: an exacting field of study. Bulletin of the Menninger Clinic, 1996; 60:160–173.
2. Beitman BD, Yu D: Learning Psychotherapy. Norton, 1999.
3. Kay J: Is psychoanalytic psychotherapy relevant in the treatment of OCD? JPPR 1997; 6:239–248.
4. Milrod B, Bush F, Cooper A, Shapiro T: Manual of Panic-Focused Psychodynamic Psychotherapy, Washington, D.C., APPI, 1997.
5. Extended Dynamic Psychotherapy: Making the Case in an Era of Managed Care. Psychoanalytic Inquiry, supplement, edited by Lazar S, The Analytic Press, 1997.

Industry-Supported Symposium 1 **Wednesday, October 25 12 noon-1:30 p.m.**

CHOOSING AN ANTIDEPRESSANT FOR THE LONG HAUL

Supported by SmithKline Beecham Pharmaceuticals

Adam K. Ashton, M.D., *Department of Psychiatry, Buffalo Medical Group, 295 Essjay Road, Williamsville, NY 14221*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be familiar with the efficacy of the new generation antidepressants and long-term treatment of major depression, risk/benefit ratio and tolerability profile of the new generation antidepressants, special issues in treating depression in medically ill populations.

SUMMARY:

Seventeen percent of the U.S. population will report a life-time history of major depression. Depression is a chronic lifelong illness with up to 85% of patients experiencing a recurrence over a 15-year follow-up period. With the availability of at least nine new generation antidepressant the clinician faces a difficult choice when deciding the appropriate antidepressant for the long haul in patients with major depression. The symposium will address recent data from the depression collaborative study looking at the risk of recurrence in patients with major depression and also evaluating the long-term efficacy of the different new generation antidepressants in patients with major depression. The long-term side effects of the antidepressants including sexual dysfunction, discontinuation syndromes, and weight gain amongst others will be discussed. Since depressive syndromes are often comorbid in patients with medical illnesses including cardiovascular disease, neurological diseases, cancer, gastrointestinal disorders, etc., the symposium will also discuss special issues in the treatment of depression in medically ill populations including specific side effects that pertain to these subpopulations as well as the clinical relevance of drug/drug interactions.

No. 1A
LONG-TERM EFFICACY OF ANTIDEPRESSANTS IN MAJOR DEPRESSION

Prakash S. Masand, M.D., *Director, Psychiatric Consultation Services, SUNY Health Sciences Center, 750 E. Adams Street, Syracuse, NY 13210*

SUMMARY:

Up to 17% of the population will have a lifetime episode of major depression. Recent data from the depression collaborative study has found that approximately 85% of patients who have an index episode of major depression will suffer a recurrence during a 15-year follow-up period. With each subsequent recurrence there is approximately a 15% likelihood of non-response to treatments. Data also suggest that with each subsequent recurrence there is greater likelihood of having future recurrences. Hence, long-term maintenance treatment is the goal for most patients with major depression. Patients with three or more episodes of major depression, in particular, will benefit from lifelong maintenance treatment. The new-generation antidepressants have demonstrated superiority to placebo in preventing recurrences over the long term in patients with major depression. However, differences in side-effect profile and tolerability may affect compliance in these patients, thereby indirectly increasing the likelihood of relapse or recurrence. The talk will address recent data on the risk of recurrence, the efficacy of the antidepressants in preventing recurrence, and compliance issues in treating patients with major depression.

No. 1B
LINKING ANTIDEPRESSANT THERAPY TO MEDICAL OUTCOMES

P. Murali Doraiswamy, M.D., *Department of Psychiatry, Duke University, Box 3018, DUMC, Durham, NC 27710*

SUMMARY:

Comorbidity of depression with medical illness is frequent in the elderly, and conditions such as stroke, chronic lung disease, and myocardial infarction are associated with high rates of depression. Depression has been reported to increase the risk for adverse medical outcomes in a variety of conditions including coronary disease, congestive heart failure, diabetes, stroke, AIDS, obstructive lung disease, and irritable bowel syndrome. Recent data also suggest that depression may be a risk factor for new-onset cardiac disease, type 2 diabetes, and some forms of cancer even after adjusting for other known risk factors for each of these conditions. The Osteoporotic Fractures Research Group Study (1998) of 7,518 women during a seven-year follow up found that a higher number of depressive symptoms was a significant predictor for increased mortality. Accumulating data also suggest that depression may be associated with alterations in biological risk factors for various disorders, such as platelet function, immune markers, heart rate variability, and glucose metabolism. We recently completed a 12-week study of elderly depressed patients

with serious medical illnesses in which quality of life, rather than depression score, was the primary outcome.

REFERENCES:

1. Masand PS, Gupta S: Selective serotonin-reuptake inhibitors: an update. Harvard Rev Psychiatry, 1999; 7(2):69–84.
2. Montgomery SA, Henry J, McDonald G, et al: Selective serotonin reuptake inhibitors: meta-analysis of discontinuation rates. Int Clin Psychopharmacol 1994; 9:47–53.
3. Ashton AK, Rosen RC: Bupropion as an antidote for serotonin reuptake inhibitor-induced sexual dysfunction. Journal of Clinical Psychiatry 1998; 59(3):112–115.
4. Ashton AK, Hamer R, Rosen RC: Serotonin reuptake inhibitor-induced sexual dysfunction and its treatment: A large-scale retrospective study of 596 Psychiatric outpatients. Journal of sex and marital therapy. 1997; 23(3):165–175.
5. Masand P, Gupta S: Selective serotonin-reuptake inhibitors: an update. Harvard Rev Psychiatry, 1999; 7(2):69–84.
6. Dunningham LA: Depression in the medically ill: choosing an antidepressant. J Clin Psychiatry 1994; 55(suppl A): 90–7.

No. 1C
ANTIDEPRESSANT-INDUCED WEIGHT GAIN AND SEXUAL DYSFUNCTION

Adam K. Ashton, M.D., *Department of Psychiatry, Buffalo Medical Group, 295 Essjay Road, Williamsville, NY 14221*

SUMMARY:

Patients can only obtain and maintain remission of symptoms on antidepressants if they continue taking them at therapeutic doses. Long-term side effects that most commonly limit compliance include weight gain and sexual dysfunction. This symposium will provide clinicians assistance in recognizing and treating these difficulties. In addition, potential risk from serotonin discontinuation syndrome will be described along with strategies to manage this phenomenon.

Industry-Supported Symposium 2 **Wednesday, October 25 6:00 p.m.-9:00 p.m.**

MANAGING PSYCHOSIS IN POPULATIONS AT HIGH RISK FOR EPS

Supported by AstraZeneca Pharmaceuticals

Henry A. Nasrallah, M.D., *Professor of Psychiatry and Neurology, University of Mississippi Medical Center, 1500 E. Woodrow Wilson Drive, Jackson, MS 39216*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize several psychotic populations at high risk for extrapyramidal side effects (EPS) secondary to antipsychotic drug treatment, and how compliance in these patients can be enhanced by minimizing EPS by using the new antipsychotic drugs.

SUMMARY:

Extrapyramidal side effects (EPS) are frequently associated with conventional antipsychotic medications (AP) but significantly less so with the new generation (atypical) AP. There are many adverse consequences of EPS including secondary negative symptoms, cognitive slowing, tardive dyskinesia, and poor compliance. This symposium will focus on several psychotic populations that are particularly vulnerable to developing EPS with AP therapy and the importance of minimizing the risk of EPS by using novel AP.

Dr. Kopala will focus on first-episode psychosis and bipolar disorder, where patients are particularly susceptible to AP-induced EPS. Dr. Jeste will then discuss elderly psychotic patients and those with neurodegenerative disorders such as Parkinsonism and Huntington's chorea where psychosis often occurs and AP-induced EPS is a high risk. Dr. Nasraliah will review the ethnopharmacology literature indicating that African-American and Asian populations are particularly sensitive to neuroleptics and more likely to develop EPS with AP therapy. Dr. Tandon will discuss the evidence that acute EPS in a given patient is a strong predictor for developing tardive dyskinesia (TD). Finally, Dr. Weiden will address the issue of compliance in patients receiving AP therapy and how reducing or avoiding EPS with novel AP may significantly improve long-term outcomes by enhancing compliance. The symposium will sensitize practitioners to the importance of avoiding EPS in all psychotic patients, but particularly in the populations discussed above, where the novel AP have been shown to be safer than the older conventional neuroleptics.

No. 2A
EPS AND SYMPTOMS IN EARLY PSYCHOSIS

Lili C. Kopala, M.D., *Department of Psychiatry, Dalhousie University, 5909 Jubilee Road, Halifax, NS Canada B3H 2E2;* David Whitehorn, P.M.D.

SUMMARY:

Attention to extrapyramidal signs and symptoms (EPSS) is a key component in the care of patients receiving antipsychotic medications. This is especially the case for patients in the early stages of treatment for a psychotic disorder. These patients have generally had little,

if any, prior exposure to antipsychotic agents and EPSS can appear at surprisingly low medication doses. As well, up to 20% of patients first presenting with a psychotic disorder have abnormal EPSS prior to the initiation of antipsychotic medications. Baseline measures of EPSS, prior to initiating treatment, are thus essential. As well, patients with preexisting EPSS may be especially sensitive to further drug-induced side effects. The detection of drug-induced EPSS may also be important as a guide to determining an effective medication dose. The appearance of drug-induced EPSS suggests that the medication dose may be above that which will provide optimal treatment. Generally, the use of anticholinergic agents to control EPSS is not recommended in early psychosis. As will be discussed in more detail in a paper by Dr. Weiden in this symposium, the early experiences of patients and their families with medication treatment are strongly influenced by whether or not there are untoward side effects. Systematic evaluation for EPSS, coupled with the use of second-generation antipsychotic agents, makes it possible to provide effective treatment early in the course of psychotic disorders without problematic drug-induced EPSS.

No. 2B
MANAGING PSYCHOSIS IN ELDERLY PATIENTS

Dilip V. Jeste, M.D., *Department of Psychiatry, Veterans Affairs Medical Center, 3350 La Jolla Drive, San Diego, CA 92161-0001;* Jonathan P. Lacro, Pharm.D.; Sidney Zisook, M.D.

SUMMARY:

Psychosis in elderly patients is frequently secondary to dementias such as Alzheimer disease, medications such as dopaminergic drugs used in the treatment of Parkinson disease, or anticholinergic drugs that are either prescribed or over the counter. The risk of motor side effects of neuroleptics is considerably greater in older adults. We have found a high incidence of parkinsonsism in elderly psychotic patients treated with very low doses of typical neuroleptics (average 43 mg chlorpromazine equivalent daily). Older age, severity of dementia, and presence of extrapyramidal symptoms at baseline are risk factors for neuroleptic-induced parkinsonism. Patients with Lewy-body dementia are especially sensitive to developing this side effect. We have also noted a tendency for neuroleptic-induced parkinsonism to persist in elderly patients. Early development of parkinsonism is a risk factor for tardive dyskinesia. Additionally, treatment of parkinsonism with anticholinergic drugs in elderly patients is complicated by side effects of anticholinergics, including confusion and delirium. The newer atypical antipsychotics are significantly safer than the typical neuroleptics in terms of motor side effects. Nonetheless, they too have some adverse effects and need to be used in lower dosages than those given to younger adults.

No. 2C
ETHNICITY AS A RISK FACTOR FOR EPS WITH ANTIPSYCHOTICS

Henry A. Nasrallah, M.D., *Professor of Psychiatry and Neurology, University of Mississippi Medical Center, 1500 E. Woodrow Wilson Drive, Jackson, MS 39216*

SUMMARY:

Ethnicity is an important variable in psychopharmacology. There is a large and growing literature about ethnic differences in the pharmacokinetics of many psychotropic agents, which are associated with variations in clinical response or adverse side effects.

Several studies have reported a higher frequency of extrapyramidal side effects (EPS) secondary to neuroleptic (conventional antipsychotic) treatment in African-American and in Asian populations. There is also evidence that these two ethnic group as well as Hispanics may need a lower dose of antipsychotics than Caucasians to achieve clinical response. However, practitioners tend to use higher than necessary doses of antipsychotic medication in African-American patients, leading to a greater likelihood of acute EPS as well as tardive dyskinesia. Not surprisingly, the higher frequency of motor side effects is associated with poor compliance with medications, delays in seeking treatment, lower patient satisfaction, frequent rehospitalization, and a more chronic course of illness. The overall outcome of treatment is compromised by the higher risk of EPS and its sequelae.

The new-generation "atypical" antipsychotics are particularly helpful for treating psychosis in ethnic populations because of the lower frequency of EPS due to their neurochemical selectivity to non-striatal dopamine D2 receptors. Two of the novel antipsychotics, clozapine and quetiapine, do not differ from placebo in their EPS rates, even at high doses. The use of novel antipsychotics may improve outcomes in ethic patients at high risk of EPS such as African Americans, Asians, and Hispanics.

No. 2D
EPS AND TARDIVE DYSKINESIA: UNDERSTANDING THE RELATIONSHIP

Rajiv Tandon, M.D., *Professor of Psychiatry, and Director, Schizophrenia Program, University of Michigan Medical Center, 1500 E. Medical Center Drive, UH 9C-9150, Ann Arbor, MI 48103*

SUMMARY:

Extrapyramidal side effects (EPS) and the risk of tardive dyskinesia (TD) are two important adverse effects associated with conventional antipsychotic treatment. A variety of patient characteristics, illness characteristics, and treatment characteristics such as nature and duration of antipsychotic treatment, modify the risk of tardive dyskinesia. By definition, all atypical antipsychotics are associated with a lower risk of EPS than conventional antipsychotics. However, there are individual differences between different atypical antipsychotics with regard to this EPS advantage. This EPS advantage of atypical antipsychotics translates into several secondary benefits, including the possibility of a lower risk of TD. With respect to TD, basic pharmacological studies, including animal models, suggest that atypical antipsychotics will cause less TD than conventional neuroleptics. In fact, data suggest that atypical medications may have a possible ameliorative effect on TD movements. Prospective studies indicate that the risk of TD is less for the atypical antipsychotics than conventional agents. While this lower/negligible TD risk is clearly established for clozapine, emerging data with other atypical agents suggest this to be the case as well. Atypical antipsychotic agents are appropriately becoming the antipsychotic drugs of choice.

No. 2E
EPS AND NONCOMPLIANCE WITH ANTIPSYCHOTICS

Peter J. Weiden, M.D., *Professor of Psychiatry, SUNY Health Sciences, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203*

SUMMARY:

When older, "conventional" antipsychotics first appeared in the late 1950s, the extrapyramidal side effects (EPS) were considered to be "minor". By the 1980s, there was better recognition of the terrible burden imposed by EPS. The EPS burden occurs on many levels—direct morbidity as well as devastating indirect effects from stigma, erosion of the therapeutic alliance, and noncompliance.

This presentation will review how reducing the EPS burden may affect patient compliance. Data on the impact of EPS on patient compliance will be presented in the context of the Health Belief Model (HBM). The HBM assumes that patient compliance is based on a subjective balancing of the perceived benefits and perceived side effects of treatment. Findings from our research group show that:

(1) subjective distress from EPS is not the same as objective EPS,

(2) akinesia and akathisia are far and away the most distressing side effects,

(3) EPS alone is not a good predictor of compliance without taking into account other mediators of noncompliance,

(4) the most important compliance benefits from EPS-free medications come from indirect benefits such as reducing stigma and enhancing the therapeutic alliance.

The bottom line is that with the arrival of effective antipsychotic medications that have little or no EPS burden, it is no longer acceptable to have to deal with this terrible side effect.

REFERENCES:

1. Kopala L, Good KP, Fredrikson D, Whitehorn D, Lazier L, Honer WG: Risperidone in first-episode schizophrenia: improvement in symptoms and preexisting extrapyramidal signs. International Journal of Psychiatry in Clinical Practice 1998; 2:S19–S25.
2. Caligiuri MP, Lacro JP, Jeste DV: Incidence and predictors of drug-induced parkinsonism in older psychiatric patients treated with very low doses of neuroleptics. Journal of Clinical Psychopharmacology 1999; 19:322–328.
3. Lawson WB: Clinical issues in the pharmacotherapy of African Americans. Psychopharmacology Bulletin 1996; 32:275–81.
4. Frackiewirz EJ, Sramek JJ, Herrera JM, et al: Ethnicity and antipsychotic response. Annals of Pharmacotherapy 1997; 31:1360–1369.
5. Jibson MD, Tandon R: New atypical antipsychotic medications. Journal of Psychiatric Research 1998; 32:215–228.
6. Weiden PJ: Neuroleptic-induced parkinsonism DSM-IV Source Book: American Psychiatric Association Press pp. 505–532, 1994.
7. Weiden PJ, Mott T, Curcio N: Recognition and management of neuroleptic noncompliance in schizophrenia: In: Shriqui, C., and Nasrallah, H., eds. Contemporary Issues in the Treatment of Schizophrenia. Washington, DC: APA Press, pp 411–434, 1995.

Industry-Supported Symposium 3 **Thursday, October 26 6:30 a.m.-8:00 a.m.**

COMPARING THE COMPARATIVE TRIALS FOR CLINICAL SCHIZOPHRENIA PRACTICE

Supported by Janssen Pharmaceutica

Robert R. Conley, M.D., *Associate Professor, Department of Psychiatry, University of Maryland, and Maryland Psychiatric Research Center, Tulip Drive, P.O. Box 21247, Baltimore, MD 21228*

EDUCATIONAL OBJECTIVES:

Review the controlled studies comparing the atypical antipsychotics

List the similarities and differences between risperidone, olanzapine, and quetiapine

Evaluate the methodology of studies comparing atypical antipsychotics head-to-head

Identify strategies for translating trial data to clinical practice

SUMMARY:

With the advent of atypical antipsychotics, the options available for treating schizophrenia have grown rapidly. While clinical evidence has mounted supporting the use of atypicals as first-line agents, their comparative efficacies and safety profiles have only been examined in a select number of controlled trials. Four critical comparative trials have been conducted in recent years (Tran 1997; Conley 1999; Reinstein 1999; Ho 1999). A summary of these data will be presented, as well as a review of the many methodological considerations to be taken into account when comparing data across different clinical trials. The major similarities and differences between three of the atypical antipsychotics—risperidone, olanzapine, and quetiapine—will be examined. With this enhanced armamentarium comes multiple questions about implementation and the final section of this program will, therefore, address the translation of the clinical data into practical guidelines for real-world patients.

No. 3A
THE METHODOLOGICAL FLAWS AND ADVANTAGES OF CROSS COMPARISON

Nina R. Schooler, Ph.D., *Director of Psychiatry Research, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004*

SUMMARY:

Randomized clinical trials addressing similar questions are sometimes contradictory. Attempts to evaluate the overall database can be made by combining the results of several trials and thereby reconciling inconclusive results. Some of the elements necessary to justify combining and/or comparing the results of different trials include similarity among treatments, patient populations, and outcome variables. The recent comparative trials studying atypical antipsychotics in head-to-head paradigms have many common design features. These studies were randomized, focused on similar psychotic patient populations, and used similar outcome measures (such as the Positive and Negative Syndrome Rating Scale). This allows us to begin to draw some overall conclusions of the relative efficacy and tolerability of the atypical antipsychotic agents. A major drawback of this analytical technique is the potential for bias when negative results are not published and therefore not included in the comparison. Additionally, inter-comparisons may not be a substitute for trials with large sample sizes, or megatrials, which often obtain a high level of precision with narrow confidence intervals.

No. 3B
ATYPICAL ANTIPSYCHOTICS: COMPARATIVE TRIAL UPDATE

Robert R. Conley, M.D., *Associate Professor, Department of Psychiatry, University of Maryland, and Maryland Psychiatric Research Center, Tulip Drive, P.O. Box 21247, Baltimore, MD 21228*

SUMMARY:

The pace of new and innovative treatments emerging for the treatment of schizophrenia has increased greatly in the past few years. While atypical antipsychotics such as risperidone, olanzapine, quetiapine, and clozapine are effective in controlling psychotic symptoms, they vary in chemical structure, receptor binding affinity profiles, and pharmacokinetics, requiring in-depth comparisons of their efficacy and tolerability.

There is a limited database available regarding large controlled clinical trials with the atypical antipsychotics that mainly focuses on the two antipsychotics most often prescribed in the United States, risperidone and olanzapine. Comparative studies have also been performed with quetiapine and clozapine. Data on the efficacy of risperidone, olanzapine, and quetiapine from four randomized trials will be reviewed. The patient populations for these studies have centered on adults classified by DSM-IV or DSM-III-R criteria with schizophrenia or schizoaffective disorder. The standard parameter used to evaluate efficacy in these trials was the mean change in the Positive and Negative Syndrome Scale (PANSS), PANSS subscales, and Clinical Global Impression (CGI) scale. Data from these studies are beginning to provide converging evidence about the actual effects of these new drugs.

No. 3C
SIDE EFFECTS AND OTHER HASSLES

Samuel J. Keith, M.D., *Department of Psychiatry, University of New Mexico, 2400 Tucker, N.E., Albuquerque, NM 87131*

SUMMARY:

Progress in basic and clinical science has revolutionized our predictive power for disease outcome. However, the results of controlled clinical trials are inherently limited in their utility for a broader patient population.

While patients and doctors should seek evidence-based clinical information to improve clinical management, extrapolation of clinical data to clinical practice requires consideration of the applicability of the trial variables to the unique clinical and patient milieu.

Using four recent comparative atypical trials as a database, I will derive overall practice patterns for implementation in real-world psychiatric practice. The major limitations or considerations when using controlled clinical trials to determine clinical practice will be addressed.

No. 3D
ATYPICALS: WHERE DO WE STAND?

John P. Docherty, M.D., *Department of Psychiatry, The New York Hospital, Cornell University Medical College, 21 Bloomingdale Road, White Plains, NY 10605*

SUMMARY:

The two most often prescribed atypical antipsychotics in the United States are risperidone and olanzapine. Each is effective in controlling both positive and negative psychotic symptoms and both have been shown to have different pharmacokinetic and pharmacologic profiles, suggesting that these preclinical and clinical differences may translate into a more preferable efficacy and/or tolerability profile in one drug over the other.

An interpretation of the efficacy from three selected controlled clinical trials will be presented by subclass of the Positive and Negative Syndrome (PANS) rating scale and the length of treatment. Tolerability issues will be compared through a discussion of the major adverse events in each trial, including the presence of extrapyramidal symptoms (EPS) and dose relationships. Finally, assessment of the relative advantages and disadvantages based on adverse events such as weight gain, EPS, cognitive dysfunction, and prolactinemia, and their implications for patient compliance, will be given in summary.

No. 3E
EMERGING DATA: ATYPICAL ANTIPSYCHOTICS IN BIPOLAR DISORDER

Gary S. Sachs, M.D., *Director, Department of Psychiatry, Harvard Medical School/Massachusetts General Hospital, 50 Staniford Street, 5th Floor, Boston, MA 02114*

SUMMARY:

The utility of mood stabilizing anticonvulsants is well established for patients with bipolar disorder. However, many patients do not achieve full remission of their symptoms and may in fact benefit further from combination therapy. Atypical antipsychotics, including risperidone, olanzapine, quetiapine, and ziprasidone, are new potential candidates for adjunctive therapy in bipolar disease. These new agents possess unique pharmacologic properties that confer different thymoleptic profiles on each member. Additionally, unlike the conventional antipsychotics, they do not elicit many of the adverse effects of these traditional agents and have minimal drug interactions. Within the past year, a considerable amount of data has emerged examining the role of atypicals in treating bipolar patients. A review of these trials will be presented herein. Finally, I will review practical considerations when utilizing these agents in a polypharmacy regimen for real-world patients.

REFERENCES:

1. Conley RR, Mahmoud R and the Risperidone Study Group: Risperidone versus olanzapine in patients with schizophrenia and schizoaffective disorder. 1999; Unpublished data (RIS-112) on file, Janssen Pharmaceutica L.P.
2. Tran PV, et al: Double-blind comparison of olanzapine versus risperidone in the treatment of schizophrenia and other psychotic disorders. 1997; 17:407–418.
3. Ho, et al: A comparative effectiveness study of risperidone and olanzapine in the treatment of schizophrenia. J Clin Psychiatry 1999; 60:658–663.
4. Reinstein M, et al: Quetiapine and risperidone in outpatients with psychotic disorders: results of the QUEST trial. Poster presentation at the annual meeting of the American Psychiatric Association: May 16–20, 1999; Washington DC.
5. Cappelleri et al: Large trials vs meta-analysis of smaller trials: how do their results compare? JAMA 1996; 276(16):1332–8.
6. Gerbarg, Horwitz RI: Resolving conflicting clinical trials: guidelines for meta-analysis. J Clin Epidemiol 1988; 41(5):503–9.
7. Conley R, et al: Unpublished data (RIS-112) on file, Janssen Pharmaceutica L.P., 1999.
8. Ho B, et al: J Clin Psychiatry 1999; 60:658–663.
9. Tran P, et al: J Clin Psychopharmacol 1997; 17:407–418.
10. Reinstein M, et al: Quetiapine and risperidone in outpatients with psychotic disorders: results of the QUEST trial.
11. Poster at the annual meeting of the APA: May 16–20, 1999; Washington DC.
12. Bondolfi G, et al: Am J Psychiatry 1998; 155:499–504.
13. Conley R, Mahmoud R, and the Risperidone Study Group: Risperidone versus olanzapine in patients with schizophrenia and schizoaffective disorder. Unpublished data (RIS-112) on file, Janssen Pharmaceutica L.P., 1999.

14. Ho B, Miller D, et al: A comparative effectiveness study of risperidone and olanzapine in the treatment of schizophrenia. J Clin Psychiatry 1999; 60:658–663.
15. Tran P, Hamilton S, Kuntz A, Potvin J, et al: Double-blind comparison of olanzipine versus risperidone in the treatment of schizophrenia and other psychotic disorders. J Clin Psychopharmacol 1997; 17:407–418.
16. Tonkin AM: Issues in extrapolating from clinical trials to clinical practice and outcomes Aust N Z J Med 1998; 28(4):574–8.
17. Sachs GS: Treatment of refractory bipolar depression, in Psychiatric Clinics of North America, Edited by Amsterdam J, Rohan M. Philadelphia, Pa, WB Saunders, 1996.

Industry-Supported Symposium 4 **Thursday, October 26 12 noon-1:30 p.m.**

NEW RESEARCH FINDINGS AND CLINICAL APPROACHES TO THE TREATMENT OF CHRONIC DEPRESSION

Supported by Bristol-Myers Squibb

Robert E. Hales, M.D., *Professor and Chairman, Department of Psychiatry, University of California at Davis, 2230 Stockton Boulevard, Sacramento, CA 95817;* Stuart C. Yudofsky, M.D., *Chairman, Department of Psychiatry, Baylor College of Medicine, 1 Baylor Plaza, #115 D, Houston, TX 77030-3411*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) List new research findings on the biology and course of chronic depression. (2) Summarize the efficacy and benefits of combining psychotherapy with antidepressants in treating chronic depression.

SUMMARY:

The symposium will provide clinicians with both a theoretical update and practical strategies in treating chronic depression. Dr. David Dunner will provide a concise review of what we know and don't know about the biology and course of chronic depression. Dr. Martin Keller will highlight exciting research findings that document the enhanced efficacy of combining pharmacotherapy with psychotherapy to treat chronic depression.

No. 4A
CLINICAL AND BIOLOGICAL FACTORS IN CHRONIC DEPRESSION

David L. Dunner, M.D., *Professor of Psychiatry, University of Washington, Center for Anxiety and Depression, 4225 Roosevelt Way NE, #306, Seattle, WA 98105-6099*

SUMMARY:

The purpose of this paper will be to discuss the clinical and biological factors that may differentiate different forms of chronic depression. There are the following three major types of chronic depression: chronic major depressive disorder, dysthymic disorder, and so-called double depression (dysthymic disorder complicated by a major depressive episode). The clinical factors to be reviewed that may help in differentiating these conditions include age of onset, gender ratio, family history, suicide attempt history, prior treatment history, and comorbidity. Few biological factors have been studied in attempting to differentiate these populations, but the data available regarding sleep and dexamethasone suppression will be presented.

No. 4B
OPTIMAL TREATMENT FOR CHRONIC DEPRESSION: PSYCHOTHERAPY AND PHARMACOTHERAPY: ADDITIVE OR SYNERGISTIC

Martin B. Keller, M.D., *Mary E. Zucker Professor and Chairman, Department of Psychiatry and Human Behavior, Brown University and Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906*

SUMMARY:

This presentation will summarize a multicenter, multiphase clinical trial, involving 681 patients with moderate-to-severe chronic major depression. Patients were randomized to one of three treatment groups: a type of psychotherapy known as Cognitive Behavioral Analysis System of Psychotherapy (CBASP), the antidepressant nefazodone, or a combination of both CBASP and nefazodone Comb). The study consisted of four distinct phases: a 12-week acute treatment phase; a 16-week Continuation Phase for acute or crossover responders, and a 52-week maintenance phase. Patients who failed to respond to the acute monotherapy were crossed over to the opposite monotherapy for 12 additional weeks of acute treatment. Approximately 75% of patients in each treatment group completed the 12-week acute phase of the trial. The response rates for those who completed the acute phase were 85% for combination, 55% in for nefazodone and 52% in the CBASP arm. The results of the Continuation Phase demonstrated that continuation treatment significantly improved the response achieved with 12 weeks of acute treatment approximately doubling remission rates among satisfactory responders in each of the three treatment groups. Approximately 75% of remitters maintained remission and only 10% of re-

mitters experienced symptom re-emergence in each treatment group. Discontinuation rates due to adverse events in the Continuation Phase were less than 2% in each group. There was no significant weight gain among the three treatments. New data focusing on crossover and continuation treatment will be presented.

REFERENCES:

1. Pages KP, Dunner DL: Focus on Dysthymic Disorder in Chronic Depression, in The Psychiatric Clinics of North American: Annual of Drug Therapy, Edited by Dunner DL, Rosenbaum JF. Philadelphia, Pa, W.B. Saunders Co., pp 91–97, 1997.
2. Keller MB, Lavori PW, Muell TI, Edicott J, et al: Time to recovery, chronicity, and levels of psychopathology in major depression. A 5-year prospective follow-up of 431 subjects. Arch Gen Psychiatry 1992; 49(10):809–816.
3. Kupfer DJ: Long term treatment of depression. Journal of Clinical Psychiatry 1991; 52 Suppl:28–34.

Industry-Supported Symposium 5 — **Thursday, October 26 12 noon-1:30 PM**

OPTIMIZING WELLNESS IN SCHIZOPHRENIA FOR THE LONG TERM

Supported by Pfizer Inc.

Daniel E. Casey, M.D., *Chief, Psychiatric Research/ Psychopharmacology, 3710 S.W. US Veterans Affairs Hospital Road, Portland, OR 97201*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the enhanced long-term outcomes with atypical antipsychotics, such as improved relapse prevention, assess the propensity of different antipsychotic drugs to cause weight gain, as well as recognize and manage the medical comorbidities that occur in patients with schizophrenia

SUMMARY:

Since schizophrenia is an adult-onset, lifelong illness for most patients, long-term management strategies are critically important aspects of effective treatment. While atypical antipsychotics are more effective and better tolerated than the typical neuroleptics, these new agents have different side effects that must be considered in the benefit/risk profile for each agent. The goal of this symposium is to address several important issues that are associated with successful and healthy long-term outcomes in schizophrenia. Dr. Nina Schooler will review the data regarding long-term outcome and relapse prevention with both the typical and atypical antipsychotics. The evidence for enhanced efficacy in positive, negative, and affective symptoms as well as increased social functioning will be discussed. Dr. Peter Weiden will address the growing problem of moderate to marked weight gain with the atypical antipsychotics. He will describe how weight is assessed with the body mass index (BMI), discuss BMI differences in the general population and patients with schizophrenia, review the different weight gain profiles across the class of antipsychotics, and highlight the effect of excessive weight on quality of life and compliance. Dr. Daniel Casey will provide an overview of morbidity and mortality in schizophrenia, followed by new data about the increasing prevalence and consequences of obesity, hyperglycemia, and hyperlipidemia associated with atypical antipsychotics. Recommendations from monitoring and managing medical comorbidities will be presented. Overall, this symposium will address how the new atypical antipsychotic drugs enhance the opportunity for better long-term outcomes in mental and physical health.

No. 5A
LONG-TERM TREATMENT GOALS: CLINICAL AND SOCIAL OUTCOMES

Nina R. Schooler, Ph.D., *Director of Psychiatry Research, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004*

SUMMARY:

Long-term treatment goals for the management of patients with schizophrenia include preserving clinical gains achieved during acute care, preventing symptom exacerbation, furthering improvements in psychopathology, enhancing social and vocational functioning, and improving quality of life. Unfortunately, many of these goals have represented elusive targets. Critical to the improvement of long-term outcomes is the treatment of negative symptoms that characterize so many schizophrenic patients. The second-generation atypical antipsychotics promise to improve long-term outcome through several mechanisms, including negative symptom efficacy and improved relapse prevention. In order to better estimate the long-term effects of neuroleptic medication and psychosocial treatment, pertinent studies will be reviewed. While studies of long-term effects of second-generation antipsychotic medications are somewhat limited, data from a 12-month study comparing ziprasidone with placebo in clinically stabilized but hospitalized schizophrenic patients has provided the opportunity to estimate long-term effects on a multitude of factors. Among these factors are negative symptoms, symptom exacerbation, psychopathology, and side effects (Arató, 1997). The implications of the findings from this study for long-term community outcome with second-generation antipsychotic medications will be dis-

cussed in relation to the extensive body of data regarding the older medications.

No. 5B
ASSESSMENT AND MANAGEMENT OF OBESITY IN SCHIZOPHRENIA

Peter J. Weiden, M.D., *Professor of Psychiatry, SUNY Health Sciences, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203;* David B. Allison, Ph.D.

SUMMARY:

This presentation will cover new information on the evaluation and management of obesity among the mentally ill. Obesity is a major public health problem in the United States today. Even so, patients with severe mental illness are at greater risk for obesity than the general population. Because of a confluence of factors, it appears that the problem of obesity among the mentally ill will become even more of a problem in the years ahead. Unfortunately, up until now, better weight control has been noticeably absent with new pharmacologic treatments of psychosis. In fact, until ziprasidone is available, all new antipsychotics have a significant propensity to cause weight gain beyond that seen from most conventional antipsychotics.

Topics to be covered will include the following:

(1) The epidemiology of obesity in among non-mentally ill and mentally ill populations,

(2) Evaluation of obesity among psychiatric patients, including obtaining and calculating baseline and follow-up BMI measures,

(3) Review of the data on weight gain from commonly used antipsychotic medications

(4) Discussion of pharmacologic and non-pharmacologic management approaches for prevention and treatment of obesity.

No. 5C
ENHANCING PHYSICAL HEALTH IN SCHIZOPHRENIA

Daniel E. Casey, M.D., *Chief, Psychiatric Research/ Psychopharmacology, 3710 S.W. US Veterans Affairs Hospital Road, Portland, OR 97201*

SUMMARY:

Schizophrenia is an adult-onset, lifelong, potentially debilitating illness for most patients that requires a long-term management perspective. The new atypical antipsychotic drugs have enhanced efficacy across a wide range of symptoms. Additionally, they are much better tolerated, particularly with the near elimination of extrapyramidal syndromes. However, the different side effects that occur for each of the new atypical antipsychotics brings renewed emphasis toward assessing the benefit/ risk profile for each agent in order to achieve better outcomes in physical health. It has been well demonstrated for many decades that patients with schizophrenia have higher prevalence rates of common medical comorbidities compared with the general population. Those with schizophrenia also die at higher rates from natural causes. This is due, in part, to less medical attention for comorbid medical problems that are associated with the increasingly high rates of obesity, excessive cigarette smoking, and unhealthy lifestyles. Management options should utilize both medical and nonmedical approaches. Medical interventions include obtaining baseline weight, height, and vital signs, as well as fasting glucose and lipid profiles, followed by periodic retesting. Referral to dietary counseling and smoking cessation programs is also potentially helpful. The atypical antipsychotics bring new challenges to improve the physical health of our patients along with the new gains that have been achieved in mental health.

REFERENCES:

1. Arató M, O'Connor R, Bradbury JE, Meltzer H: Ziprasidone efficacy in the prevention of relapse and in the long-term treatment of negative symptoms of chronic schizophrenia. Eur Neuropsychopharmacol 1997; 7(suppl 12):S214.
2. Allison D, Fontaine KR, Heo M, et al: The distribution of body mass index among individuals with and without schizophrenia. Journal of Clinical Psychiatry 1999; 60(4):215–220.
3. Casey DE: The relationship of pharmacology to side effects. J Clin Psychiatry 1997; 58(suppl 10): 55–62.
4. Harris EC, Barraclough B: Excess mortality of mental disorder. Br J Psychiatry 1998; 173:11–53.

Industry-Supported Symposium 6 — **Thursday, October 26 6:00 p.m.-9:00 p.m.**

DEEPER THAN DEPRESSION: EXAMINING UNDERLYING CONDITIONS AND LIFE-SPAN ISSUES TO OPTIMIZE TREATMENT

Supported by Pfizer Inc.

Martin B. Keller, M.D., *Mary E. Zucker Professor and Chairman, Department of Psychiatry and Human Behavior, Brown University and Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants should be able to recognize and effectively treat depression with an underlying anxiety disorder. Understand

optimal treatment duration of depression with comorbid anxiety, premenstrual dysphoric disorder, postpartum depression, and depression in the elderly. Analyze treatment considerations for women and elderly patients with depression.

SUMMARY:

Depression is a devastating disorder that is associated with high rates of impairment and comorbidity with other disorders. Treatment options are readily available and can greatly improve functioning, however, suboptimal treatment is still an issue. Suboptimal treatment may result from incorrect diagnoses, incomplete diagnoses, or inadequate treatment duration. Clinicians must be able to identify underlying conditions, life-span issues, and proper treatment duration to ensure effective treatment. This symposium will begin with an overview of the underlying implications of depression including chronicity of illness, economic impact in the workplace, impact on quality of life, impact of effective treatment, and impact of treatment duration. This discussion will be followed by a presentation on depression with underlying anxiety disorders. This presentation will discuss prevalence data, recognition and diagnosis of comorbid depression and anxiety, clinical data on treatment, and optimal treatment duration. The next presentation will focus on female-life span issues in depressive illness, such as PMDD and postpartum depression. This presentation will discuss prevalence data, recognition and diagnosis of PMDD or postpartum depression, treatment considerations such as risk of pregnancy and breast milk concentrations, clinical data on treatment, and optimal treatment duration. The symposium will conclude with a presentation on depression in the elderly. This presentation will discuss the prevalence and presentation of depression in the elderly and treatment considerations such as dosing, toleration, and the effect of treatment on cognitive function.

No. 6A
DEPRESSION WITH UNDERLYING ANXIETY DISORDERS

Mark H. Rapaport, M.D., *Associate Professor of Psychiatry, Department of Psychiatry, University of California, San Diego, 8950 Villa La Jolla Drive, #2243, La Jolla, CA 92037-2315*

SUMMARY:

The management of depression is often complicated with comorbid medical and psychiatric illness. Incomplete diagnoses or inadequate treatment can severely limit a patient's improvement. However, with careful diagnosis and straightforward treatment, one can relieve suffering and restore functioning. This presentation will examine recent research into the coexistence of depression with panic disorder, posttraumatic stress disorder (PTSD), social anxiety disorder, obsessive-compulsive disorder, and generalized anxiety disorder. We will discuss the prevalence and recognition of depression with these anxiety disorders. Current data on treatment considerations will be reviewed. Finally, optimal treatment approaches and duration of treatment will be discussed.

No. 6B
FEMALE LIFE-SPAN ISSUES IN DEPRESSIVE ILLNESS

Susan G. Kornstein, M.D., *Department of Psychiatry, Medical College of Virginia, 700 W. Grace Street, Suite 303, Richmond, VA 23220*

SUMMARY:

Women show a greater prevalence rate of depressive disorders than men, especially during the childbearing years. In addition, gender differences in both presentation and treatment response have been demonstrated. Depressive symptoms in women commonly occur in association with reproductive events, such as premenstrually, during pregnancy and the postpartum period, and during the perimenopausal years. While the exact etiology of premenstrual dysphoric disorder remains elusive, effective treatments are available, including antidepressant medications and hormonal therapies. Available data suggest that many antidepressants may be used with minimal risk in pregnant or breastfeeding mothers. The risks of untreated illness or relapse should be strongly considered in the decision regarding whether to treat in such cases. Although the onset of menopause is not associated with an increased risk of major depression, hormonal fluctuations and changing life roles may contribute to minor depressive symptoms during the perimenopausal period, as well as an increased likelihood of recurrence among women with previous depressive episodes. This talk will focus on special considerations in the evaluation and management of depression in women across the life span.

No. 6C
DEPRESSION IN THE ELDERLY

J. Craig Nelson, M.D., *Professor, Department of Psychiatry, Yale University, 20 York Street, EP10-835, New Haven, CT 06504*

SUMMARY:

Older individuals are the most rapidly growing segment of the population. Diagnosing depression in elderly patients is particularly challenging, as older individuals

may not complain of depression or recognize that they are experiencing depressive symptoms. The diagnosis and treatment of depression in the elderly are oftentimes complicated by comorbid medical conditions, cognitive disturbances, polypharmacy, and significant adverse life events. This presentation will address the prevalence and recognition of depressive disorders in the elderly. Treatment considerations including dosing, toleration, and the effect of treatment on cognitive function will be reviewed. Data on treatment outcomes, as well as optimal treatment duration, will also be discussed.

REFERENCES:

1. Ormel J. et al: Outcome of depression and anxiety in primary care. Arch Gen Psychiatry 1993; 50:759–766.
2. Magee WJ. et al: Agotaphobia, simple phobia, and social phobia in the National Comorbidity Survey. Arch Gen Psychiatry 1996; 53:159–168.
3. Kornstein SG, Wojcik B: Depression in women, in Depression American College of Physicians Key Diseases Series. Edited by Levenson JLL, In press.
4. Kornstein SG: Gender differences in depression: implications for treatment. Journal of Clinical Psychiatry 1997; 58(S15):12–18.
5. Treatment of major depression in the elderly, in Geriatric Psychopharmacology, Edited by Nelson JC. Marcel Dekker: New York, pp 61–97, 1996.

Industry-Supported Symposium 7 — **Friday, October 27 6:30 p.m.-8:00 a.m.**

WHY DO ANXIOUS PEOPLE BECOME DEPRESSED?

Supported by Wyeth-Ayerst Laboratories

Philip T. Ninan, M.D., *Department of Psychiatry, Emory University, 1841 Clifton Road, NE, Room 401, Atlanta, GA 30329*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate a new understanding of the potential etioathogenesis of anxiety and depressive disorders, leading to enhanced clinical skills in managing patients with complex co-morbidities.

SUMMARY:

Treatment and clinical research in anxiety and depressive disorders are constricted by the conceptual limitations of our current nomenclature. Reliability of diagnostic criteria, though necessary, should not be confused with validity. Descriptive diagnoses encourage pigeonhole categories, but comorbidities are the rule in clinical practice, particularly with major depression and the anxiety disorders. The epidemiologic literature uses the term comorbidity as simply meaning co-occurrence of symptoms while general medicine defines it as the presence of two diseases with separate pathophysiologies. Psychiatric diagnoses are syndromal clustering of symptoms, and lack pathophysiologic specificity. Additionally, severity of illness in depressive and anxiety disorders is measured largely based on symptoms, but symptomatic severity is a limited proxy for true illness severity and dysfunction. Exciting and explosive advances in the neurosciences allow the examination of the functional anatomy and developmental pathophysiology leading to a new understanding of anxiety and depressive disorders. Such a "conceptual scaffold" can enhance our clinical observations, open novel treatment approaches, and target our interventions to specific dimensions of these illnesses.

Dr. Ned Kalin will explore the functional anatomy of emotions like anxiety and sadness derived from preclinical non-human primate research as well as clinical populations. Dr. Philip Ninan will present advances in the treatment of the complicated comorbid anxiety and depressive disorders with a focus on clinical strategies to manage challenging and complex patients seen by psychiatrists. The challenge today is to wisely choose from available treatment options to achieve remission of symptoms and functional recovery. Clinicians will learn to creatively use multimodal treatments optimally, while awaiting the next generation of treatment advances.

No. 7A
NEURAL CIRCUITS UNDERLYING ANXIETY AND DEPRESSIVE DISORDERS

Ned H. Kalin, M.D., *Department of Psychiatry, University of Wisconsin Medical School, 6001 Research Park Boulevard, Madison, WI 53719*

SUMMARY:

Recent neuroscientific advances provide insights into the neural circuits underlying the regulation of normal emotion as well as into mechanisms underlying anxiety and depression. Evidence demonstrates that the amygdala is important in responding to cued fears and is overactive in patients with depression and anxiety. The hippocampus is also involved with fearful responses, which are triggered by broad based contextual factors. The bed nucleus of the stria terminalis may mediate sustained anxiety responses as those associated with generalized anxiety disorder. Studies in humans and monkeys demonstrate that prefrontal cortex is lateralized in relation to emotion. Activation of left prefrontal regions is associated with the expression of positive approach-like emotions and right prefrontal activation is

associated with negative emotions like anxiety and sadness. Additionally, studies demonstrate that benzodiazepines and antidepressants affect the balance of activity between left and right prefrontal regions, and altered prefrontal cortical function occurs in patients with depression. Studies in primates suggest that excessive right prefrontal activity mediates anxiety/fearful temperament. Dorsolateral prefrontal cortex is interconnected with the hippocampus, whereas orbitofrontal regions are linked to the amygdala. In general, prefrontal regions are thought to be important in regulating emotional responses. This may be very pertinent to anxiety and depression, as these disorders can be characterized as problems of emotion regulation.

No. 7B
MANAGEMENT OF COMPLEX ANXIETY AND DEPRESSION

Philip T. Ninan, M.D., *Department of Psychiatry, Emory University, 1841 Clifton Road, NE, Room 401, Atlanta, GA 30329*

SUMMARY:

The National Co-morbidity Survey reported that 58% of individuals with a lifetime episode of major depression also met criteria for an anxiety disorder. The anxiety disorder developed first in 68% of individuals, with major depression developing, on average, 11 years later. So why do anxious people become depressed, and what are the implications of suffering from both conditions?

Clinical trials indicate an advantage for serotonin reuptake inhibitors (SRIs) over norepinephrine reuptake inhitors (NRIs) in the treatment of several anxiety disorders, including obsessive compulsive disorder, social phobia, PTSD, and panic disorder. In GAD, a series of studies have documented efficacy of the extended release version of veniafaxine. In major depression, particularly at the severe end of the spectrum marked by melancholia and the need for hospitalization, there is evidence that NRIs have superior efficacy over SRIs. Medications that powerfully inhibit both serotonin and norephrine reuptake (SNRIs) like venlafaxine and clomipramine, have the advantage of superior efficacy and greater likelihood of achieving remission, than a medication with a single mechanism of action. Clinical trials data can also inform clinicians and guide them in the choice of augmentation and combination strategies in partial and nonresponding patients. These issues will be examined using complex clinical case histories to examine optimal treatment options to best achieve rapid and complete response.

REFERENCES:

1. Davidson RJ, Irwin: The functional neuroanatomy of emotion and affective style. Trends in Cognitive Sciences 1999; 3:11–21.
2. Ninan PT: The functional anatomy, neurochemistry, and pharmacology of anxiety. J Clin Psychiatry 1999; 60 [Suppl 22]:12–17.

Industry-Supported Symposium 8 — **Friday, October 27 12 noon-1:30 p.m.**

MANAGING SCHIZOPHRENIA FROM THE EMERGENCY ROOM TO THE COMMUNITY

Supported by Janssen Pharmaceutica

Prakash S. Masand, M.D., *Director Psychiatric Consultation Services, SUNY Health Sciences Center, 750 E. Adams Street, Syracuse, NY 13210*

EDUCATIONAL OBJECTIVES:

Identify and acutely manage the psychotic patient in an emergency room setting

Evaluate risperidone, olanzapine, and quetiapine in terms of efficacy and safety profiles and contrast these agents to conventional antipsychotics

Manage adverse effects caused by atypical antipsychotics in a broad spectrum of patients

SUMMARY:

Despite a growing body of literature, data, and new pharmacologic options available for the treatment of schizophrenia, fundamental questions regarding clinical management persist. Many schizophrenic patients come to the attention of clinicians through the emergency room, an environment that offers special challenges for care. The use of chemical versus physical restraints in acute agitated psychosis will be considered as well as appropriate initial management for schizophrenic patients in general. As new data continue to emerge regarding the atypical antipsychotics, we have new opportunities to contrast these agents with their conventional counterparts and assess their true value in the psychotropic armamentarium. We will review the current base of clinical knowledge available for these agents and present algorithms to enhance efficacy and manage side effects when they arise.

No. 8A
EMERGENCY CARE OF THE AGITATED PSYCHOTIC PATIENT

Michael H. Allen, M.D., *Assistant Professor of Psychiatry, University of Colorado, Denver Health Medical Center, 777 Bannock Street, Denver, CO 80204*

SUMMARY:

The care of the agitated, acutely psychotic patient can be conceptualized as occurring in two phases: a brief period of initial management of behavioral disturbances, followed by a much longer period of definitive treatment of the underlying condition. Historically, both initial management and definitive treatment were accomplished with conventional neuroleptics, first intramuscularly and then orally. Several rapid tranquilization strategies evolved to include benzodiazepines and/or lower doses of neuroleptics including droperidol. While the wider practice environment has changed substantially with newer medications, shorter lengths of stay, and increased consumer participation, rapid tranquilization has remained static for a decade. In light of these changes, it is a good time to reexamine the evidence base for the current practice of rapid tranquilization and place it into the larger context of long-term outcome. Goals of the nonspecific management phase are limited but include distinguishing "functional" from "organic" conditions. Adverse events should be minimized during this phase and a rapid transition to voluntary treatment accomplished. For the definitive treatment of the agitated patient with schizophrenia, medications that specifically target aggressivity may reduce restraint and seclusion and resulting patient and staff injuries during the current episode. Greater efficacy for other target symptoms and reduced side-effect burden may produce better adherence and reduced recidivism in the future.

No. 8B
TEASING OUT THE DIFFERENCES: ATYPICAL VERSUS CONVENTIONALS FOR SCHIZOPHRENIA

Prakash S. Masand, M.D., *Director Psychiatric Consultation Services, SUNY Health Sciences Center, 750 E. Adams Street, Syracuse, 13210*

SUMMARY:

Recent advances in pharmacotherapy have revolutionized the treatment of schizophrenia. The novel antipsychotics, which represent first-line treatment in schizophrenic patients, offer several advantages over the conventional antipsychotics. These include improvement in negative and cognitive symptoms and a better tolerability and side-effect profile. Several studies have compared novel antipsychotics with each other in terms of efficacy in schizophrenia. There appear to be efficacy differences amongst the novel antipsychotics in the treatment of this population. This talk will focus on the efficacy of novel antipsychotics relative to conventional antipsychotics as well as a comparison of the efficacy of novel antipsychotics with each other. Issues related to special treatment populations, particularly first-episode patients, treatment-resistant schizophrenics, and elderly patients with psychosis will be discussed. Algorithms for managing patients who are partially responsive to monotherapy will also be a focus of the talk.

No. 8C
SIDE EFFECTS OF ANTIPSYCHOTIC MEDICATIONS: MAKING THEM MANAGEABLE

Zafar A. Sharif, M.D., *Assistant Professor, Clinical Psychiatry, Columbia University and Creedmoor Psychiatric Center, 80-45 Winchester Boulevard, Bldg 40, Queens Village, NY 11427*

SUMMARY:

Within the last decade, four atypical antipsychotics have been approved for use in the United States. The pharmacologic profiles of these drugs are not the same; thus, adverse effects differ markedly across the class depending upon differential neuroreceptor binding affinities. Therefore, patients can present with a broad range of side effects including weight gain, prolactinemia, sedation, and extrapyramidal symptoms. Appropriate management of these symptoms, with special consideration for patient variables such as age, comorbid conditions, and drug-drug interactions, will be summarized. Additionally, side effects will be examined in the context of short-term versus long-term treatment. Finally, impact of adverse effects on patient compliance will be addressed.

REFERENCES:

1. Ereshefsky L: J Clin Psychiatry 1999; 60(suppl. 10):20–30.
2. Stahl S: J Clin Psychiatry 1999; 60(suppl. 10):31–41.
3. Buckley PF: J Clin Psychiatry 1999; 60(suppl. 10):52–60.
4. Foster S, Kessel J, Berman ME, Simpson GM: Efficacy of lorazepam and haloperidol for rapid tranquilization in a psychiatric emergency room setting. Int Clin Psychopharmacology 1997; 12:175–179.
5. Allen MH: Emergency care of the agitated patient: J Clin Psychiatry, in press.
6. Battaglia J, Moss S, Rush J, et al: Haloperidol, lorazepam, or both for psychotic agitation? A multicenter, prospective, double-blind, emergency department study. Am J Emerg Med 1997; 15:335–340.
7. Ho, et al: A comparative effectiveness study of risperidone and olanzapine in the treatment of schizophrenia. J Clin Psychiatry 1999; 60:658–663.
8. Masand PS: Using newer antipsychotic agents in primary care. Prim Psychiatry. 1997; 4:64–68.
9. Ereshefsky L: J Clin Psychiatry 1999; 60(suppl. 10):20–30.

Industry-Supported Symposium 9 **Friday, October 27 12 noon-1:30 p.m.**

ADVANCES IN THE TREATMENT OF GERIATRIC DEPRESSION

Supported by Organon Inc.

Bruce G. Pollock, M.D., Ph.D., *Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811 Ohara Street, E1228, Pittsburgh, PA 15213-2593*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the factors that make the diagnosis and treatment of depression different in late life.

SUMMARY:

When left untreated, geriatric depression has a poor outcome with a high risk of mortality due to comorbid medical illness and suicide. Conversely, successful antidepressant treatment is one of the most effective ways to reduce disability, prevent morbidity, and improve quality of life in the elderly patient. This symposium will discuss the results of several recent studies that have advanced the treatment of geriatric depression. Five presentations will focus on the pharmacology of antidepressants pertinent to older patients (Dr. Pollock), treating older depressed patients with vascular illness (Dr. Roose), treating depression in the oldest-old with depression (including nursing home residents) (Dr. Salzman), treating older inpatients who have severe melancholic depression (Dr. Mulsant), and the current role of electroconvulsive therapy in the treatment of geriatric depression (Dr. Sackeim).

No. 9A
PHARMACOLOGY OF ANTIDEPRESSANTS PERTINENT TO OLDER PATIENTS

Bruce G. Pollock, M.D., Ph.D., *Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811 Ohara Street, E1228, Pittsburgh, PA 15213-2593*

SUMMARY:

Patients older than age 65 represent 12% of the U.S. population, yet they receive from 25% to 35% of all prescription drugs and disproportionately suffer from drug interactions and adverse effects of medications. Over the last decade, physicians in the U.S. who treat older psychiatric patients have gained access to eight new antidepressants. Age-associated physical comorbidity, cognitive impairment, and pharmacokinetic or pharmacodynamic changes prevent the "simple" extrapolation to the elderly of data acquired from younger patients. Hence, it is unfortunate that there is such a dearth of information regarding the use of these medications in older patients and in particular on their relative effectiveness in frail older patients when compared with older psychotropic medications. It is also important to appreciate that the side-effect profile of newer medications in the old may differ from younger, healthier patients typically included in regulatory clinical trials. The purpose of this lecture is to summarize features and study data for these new agents relevant to their use in the old. Particular attention will be given to age-associated concerns with antidepressant use, such as effects on cognition, balance, inappropriate antidiuretic hormone secretion, anticholinergic burden, and drug-drug interactions.

No. 9B
TREATMENT-RESISTANT DEPRESSION IN LATE-LIFE

Benoit H. Mulsant, M.D., *Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, E1226, Pittsburgh, PA 15213-2593;* Bruce G. Pollock, M.D., Ph.D.

SUMMARY:

Depression is one of the most prevalent psychiatric disorders in late life. It is associated with increased morbidity, disability, and mortality from comorbid physical illness and from suicide. The successful treatment of late-life depression reduces disability, prevents morbidity, and improves quality of life in older patients. More than one-third of older patients presenting with depression do not respond to their initial treatment. Published data on treatment-resistant depression in older patients are sparse. However, late-life depression truly unresponsive to adequate treatment is rare. Available data and clinical experience suggest that most older depressed patients labeled as "treatment-resistant" or even "treatment-refractory" have been misdiagnosed or have not received adequate antidepressant treatment. Comorbid physical or unidentified psychiatric conditions often contribute to treatment resistance. Somatic and cognitive symptoms are frequently associated with late-life depression. They make it difficult to assess antidepressant response accurately in this age group and lead to inadequate pharmacologic trials. In older patients, as in younger patients, the judicious selection of an antidepressant, given at an appropriate dose for an appropriate duration, is essential to ensure optimal therapeutic response. This presentation will review the major variables involved in treatment-resistant depression in the elderly and discuss a systematic approach to these patients.

No. 9C
TREATING DEPRESSION IN THE CANCER PATIENT

Diane S. Thompson, M.D., *Assistant Professor, Department of Psychiatry, Western Psychiatric Institute and Clinic, 300 Halket Street, Pittsburgh, PA 15213*

SUMMARY:

Depressive disorders occur in more than half of all oncology patients. Several factors may contribute to depressive symptoms; these include, chemotherapy, radiation, issues regarding mortality, body image, and hormonal changes. Side effects of chemotherapy may also cause depression. Nausea, insomnia, and weight loss can adversely affect mood and can significantly compromise the oncology patient's health and overall quality of life.

The use of antidepressant medication alleviates symptoms of depression in the cancer patient. The newer agents that influence serotonin or serotonin/norepinephrine offer few serious side effects and several positive effects that make them particularly desirable in the oncology population. Side effects such as weight gain, appetite stimulation, and lack of nausea will benefit the patient who is not able to eat due to chemotherapy-induced anorexia. Conversely some patients will gain weight on chemotherapy and need the reassurance that an antidepressant will not cause further weight gain. New studies show that some antidepressants may help with secondary side effects such as hot flashes and sleep disturbances. The use of an antidepressant that targets these specific problems will allow for fewer medications overall. Choosing the appropriate medication based on effectiveness, advantageous side effects, and drug interactions will be addressed.

REFERENCES:

1. Solai LK, Mulsant BH, Pollock BG: Pharmacologic treatment of geriatric depression. Psychiatric Clinics of North America: Annual of Drug Therapy. Edited by Dunner DL, Rosenbaum RF. 1999 Philadelphia, WB Saunders, 1999, pp. 73–92.
2. Pollock BG: Geriatric psychiatry: psychopharmacology: general principles, in Kaplan & Sadock's Comprehensive Textbook of Psychiatry/VII. Edited by Sadock BJ, Sadock VA. Baltimore, Williams & Wilkins, 2000, pp. 3086–3090.
3. Mulsant BH, Pollock BG: Treatment-resistant depression in late life. Journal of Geriatric Psychiatry and Neurology 1998; 11:186–193.
4. Tew JD, Mulsant BH, Haskett RF, et al: Acute efficacy of ECT in the treatment of major depression in the old-old. American Journal of Psychiatry 1998; 156:1865–1870.
5. Thompson D, Shear K: Psychiatric disorders and gynecological oncology: a review of the literature. Gen Hosp Psychiatry 1998; 20:241–247.
6. Osoba D, Zee B, Warr D, et al: Quality of life studies in chemotherapy-induced emesis. Oncology 1996; 53:92–95.

Industry-Supported Symposium 10 — **Friday, October 27 6:00 p.m.-9:00 p.m.**

ADVANCES IN THE UNDERSTANDING OF ANTIDEPRESSANT TREATMENT OPTIONS: AN INTERACTIVE CASE PRESENTATION

Supported by Organon Inc.

J. Craig Nelson, M.D., *Professor, Department of Psychiatry, Yale University, 20 York Street, EP10-835, New Haven, CT 06504*

EDUCATIONAL OBJECTIVES:

To review current understanding of the mechanism of action of antidepressants, discuss the rationale behind selecting antidepressants for patients with different presenting signs and symptoms, and evaluate the impact adverse effects may have on selecting antidepressants for different patient characteristics (eg, existing weight problems, sexually active, premenopausal, comorbid conditions.

SUMMARY:

Advances in our understanding of the mechanism of antidepressant drugs have led to recent therapeutic improvements. Newer agents have a more selective action on neurotransmission while possessing markedly reduced binding capacities at receptor sites not linked to their antidepressive actions. This development has improved the tolerability of antidepressants, both in therapeutic use and in overdose. Despite these advances, selecting the appropriate medication for an individual patient has become more—not less—complex. The faculty for this symposium will address the basic elements in clinical practice that are important for optimizing treatments for patients with depression. Elliott Richelson will begin the program with an interactive explanation of the neurobiology of depression, putting into perspective the effects of antidepressants on serotonin, norepinephrine, dopamine, and other neurotransmitters. J. Craig Nelson will address the selection of antidepressants based on antidepressant profiles and patient characteristics. Case vignettes will be presented to enhance the discussion of real-world treatment dilemmas. While the focus of Dr. Nelson's presentation will be on efficacy, the third presenter, Anita Clayton, will approach treatment decisions from the vantage point of adverse effects and tolerability. Her cases will highlight the need to consider patient characteristics (i.e. body mass, relevance of intact sexual function, hormonal status, and

presence of other medical or psychiatric conditions) in making therapeutic choices. Although definitive studies have not established differences between agents, patterns are developing that may aid clinicians in selecting agents that are best tailored to the needs of individual patients. For example, patients who present with low energy and motivational deficits may respond better to agents that selectively increase noradrenergic actions, whereas patients whose predominant presenting signs include sadness and irritability may be more likely to respond to an agent with serotonergic actions. Patients with more severe forms of depression may need combinations of noradrenergic and serotonergic agents. Audience participation in the discussions will be encouraged.

No. 10A
CURRENT UNDERSTANDING OF THE MOLECULAR MECHANISMS OF ANTIDEPRESSANT ACTION

Elliott Richelson, M.D., *Department of Psychiatry, Mayo Clinic at Jacksonville, 4500 San Pablo Road, South, Jacksonville, FL 32224-1865*

SUMMARY:

How do antidepressant medications bring about their therapeutic outcome? Why does the process take so long? To understand how antidepressants work, it is necessary to understand how they affect different neurotransmitter systems. We know that antidepressants have identifiable and immediate interactions with one or more neurotransmitter receptors, transporters for neurotransmitters, or enzymes involved in their degradation. These immediate effects may relate to certain adverse effects and drug interactions. In addition, we know antidepressants that bind to one or more specific brain receptor sites without blocking unwanted sites such as histamine and acetylcholine appear to be better tolerated. But following chronic treatment, the evidence from experimental and clinical studies suggests that all antidepressants produce qualitatively similar adaptive changes in serotonergic, noradrenergic, and dopaminergic transmission and that such adaptive changes parallel the onset of the therapeutic response. This presentation will attempt to shed light on our current understanding of the molecular basis for antidepressant action (both therapeutic and adverse) and will address differences and apparent similarities among the classes of antidepressants. Choosing an antidepressant that minimizes adverse effects and drug interactions may enhance compliance and, ultimately, therapeutic outcome.

No. 10B
RATIONAL SELECTION OF ANTIDEPRESSANTS FOR DIFFERENT PATIENT PROFILES

J. Craig Nelson, M.D., *Professor, Department of Psychiatry, Yale University, 20 York Street, EP10-835, New Haven, CT 06504*

SUMMARY:

Both norepinephrine and serotonin mediate the response to antidepressants. Reasonable questions about their role in depression therapy include 1) whether the efficacy of serotonergic and noradrenergic antidepressants is similar, and 2) whether there are differences in their effectiveness depending on the patient's presenting signs and symptoms. A recent review of double-blind, randomized studies comparing antidepressants relatively selective for serotonin and norepinephrine showed no significant difference between classes of compounds in the overall rates of response. With respect to predictors of response to these agents, no clear symptoms were markers for the use of serotonergic vs. noradrenergic antidepressants. With the introduction of other selective agents (e.g., citalopram and reboxetine), this latter question may be more completely addressed. Some subtypes of depression do appear to have predictive value, namely severe or melancholic depression. There is also limited evidence of differences in symptoms responding to selective serotonin reuptake inhibitors (SSRIs) and norepinephrine reuptake inhibitors (NRIs). This presentation will explore the rationale behind selecting appropriate antidepressants for patients who exhibit a variety of signs and symptoms. Case vignettes of actual patients will be introduced to highlight these differences. Audience participation will be encouraged.

No. 10C
APPROACHES TO THE ENHANCEMENT OF PATIENT COMPLIANCE WITH ANTIDEPRESSANT THERAPY

Anita L.H. Clayton, M.D., *Associate Professor of Psychiatry, University of Virginia, 2955 Ivy Road, Charlottesville, VA 22903*

SUMMARY:

Given that all current antidepressants have relatively similar efficacy for uncomplicated depression, the choice of an agent is strongly influenced by its specific profile for adverse effects and tolerability. Clinicians consider a number of issues as they make treatment recommendations, including the specific characteristics of therapeutic agents (i.e., its risk of treatment-emergent adverse effects, potential for drug interactions), the clini-

cal profile of the individual involved (i.e., general health, gender, age, lifestyle, cognitive status), and the anticipated duration of treatment (six-12 months vs. indefinite). Based on individual patient characteristics (i.e., body mass, sexual function, comorbid illnesses), certain antidepressants have advantages over others. Gender, hormonal or reproductive status, and cognitive function may influence response and tolerability to specific antidepressants. In addition, the absence of full remission of symptoms or the presence of long-term side effects may have significant impact on a patient's quality of life and resulting medication compliance. These issues and the respective differences among antidepressants will be discussed. To enhance a discussion of practical approaches to individualizing and optimizing antidepressant therapy, a number of patient vignettes will be included, and audience participation will be encouraged.

REFERENCES:

1. Richelson E: Basic neuropharmacology of antidepressants relevant to the pharmacotherapy of depression. Clin Cornerstone 1999; 4:17–30.
2. Richelson E: Synaptic effects of antidepressants. J Clin Psychopharmacol 1996; 16(suppl 2):1S–7S; discussion 7S-9S.
3. Nelson J: A review of the efficacy of serotonergic and noradrenergic reuptake inhibitors for treatment of major depression. Biol Psychiatry 1999; 49:1301–1308.
4. Dewan MJ, Anand VS: Evaluating the tolerability of the newer antidepressants. J Nerv Ment Dis 1999; 187:96–101.

Industry-Supported Symposium 11 **Saturday, October 28 6:30 a.m.-8:00 a.m.**

ANXIETY DISORDERS: RESEARCH AND PRACTICE

Supported by SmithKline Beecham Pharmaceuticals

Mark H. Pollack, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, Boston, MA 02114*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss the presentation and treatment of anxiety in childhood; explore new treatment options for panic disorder, social phobia, and post-traumatic stress disorder; and examine the impact of anxiety disorders and their treatment on patient's quality of life.

SUMMARY:

Anxiety disorders are among the most common psychiatric conditions and are associated with significant distress and impairment in affected individuals. For many, anxiety difficulties begin early in childhood and manifest variably over time through adulthood.

This symposium will begin with a presentation on the presentation of anxiety in childhood, including attention to its early manifestations and relationship to later difficulties, as well as discussion of a number of treatment considerations. Following will be presentations on three prominent anxiety disorders—panic disorder, post-traumatic stress disorder and social phobia—with particular attention to the course and complications of the disorders, consideration of critical patient characteristics, including gender and comorbidity, and review of cutting edge therapeutic approaches. The impact of anxiety disorders on quality of life will be explored in the next presentation, which will by followed by a discussion to review and expand on key points addressed in the presentations and serve as a stimulus for participation by members of the audience.

No. 11A
PTSD: INITIAL TREATMENT STRATEGIES AND BEYOND

Mark H. Pollack, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, Boston, MA 02114*

SUMMARY:

The treatment of panic disorder has been the focus of increasing attention over the last decade. A number of pharmacologic and cognitive-behavioral interventions have demonstrated efficacy for this condition; however, though most treated patients clearly improve with treatment, many remain at least somewhat symptomatic. Thus, there is continued interest in the search for new and effective agents and treatment strategies for patients with panic disorder. Recently, the selective serotonin reuptake inhibitors (SSRIs) have emerged as first-line agents for the treatment of panic.

In this presentation, we will review the pharmacologic options for the treatment of panic disorder, discuss factors that may contribute to partial or nonresponse to treatment, and discuss options for the management of treatment-refractory patients.

No. 11B
SOCIAL ANXIETY DISORDER: COURSE, COMPLICATIONS AND THERAPEUTICS

John H. Greist, M.D., *Healthcare Technology Systems, 7617 Mineral Point Road, Suite 300, Madison, WI 53717*

SUMMARY:

Some social anxiety is salubrious as it stimulates practice, which produces better performance and greater rewards. Beyond some threshold, social anxiety interferes with performance and becomes a handicap. Social anxiety covers a spectrum from normal to performance and generalized social phobias and ends in avoidant personality disorder. Bimodal onset in early childhood or around puberty is common and late onset rare. Prevalence is remarkably high, and recent studies have confirmed rates of clinically significant social phobia approaching 10%. Once begun, social phobia runs a chronic course, often with complicating comorbidities and substantial costs for sufferers and our communities.

Effective treatment is possible with MAOIs, benzodiazepines, SSRIs, and, for the performance type, beta blockers. For generalized social phobia, SSRIs are emerging as the treatment of choice because of their effectiveness, tolerability, and safety. Cognitive-behavior therapy is also effective although it is more difficult to design convenient exposure sessions for social phobia than for other anxiety disorders.

Common, chronic, fascinating, sometimes disabling, and imminently treatable, social phobia is emerging as another psychiatric disorder where careful diagnosis and straightforward treatment can relieve suffering and restore functioning.

No. 11C
UNDERSTANDING QUALITY OF LIFE IN ANXIETY DISORDERS

Mark H. Rapaport, M.D., *Associate Professor of Psychiatry, Department of Psychiatry, University of California, San Diego, 8950 Villa La Jolla Drive, #2243, La Jolla, CA 92037-2315*

SUMMARY:

This paper investigates the cost and adverse impact of anxiety disorder on quality of life and health care utilization. Particular emphasis will be placed on the impact of panic disorder on quality of life and health care utilization. We will review data from both epidemiological and clinical studies of patients with panic disorder. We will then review the treatment trials suggesting that effective treatment is associated with decreased health care utilization and increased quality of life. However, the majority of this presentation focuses on new data demonstrating the interaction between true treatment response and improvement in quality of life. These data clearly demonstrate that the remediation of symptoms with pharmacotherapy leads to enhancement in quality of life that is distinctly different from observed in placebo responders. This finding has important implications not only for the researcher, but in particular for clinicians in their interaction with health care systems. These data suggest that true beneficial treatment response is clearly linked to quality-of-life improvement.

REFERENCES:

1. March JS, Leonard HI: Obsessive compulsive disorder in children and adolescents: a review of the past 10 years. J Am Acad Child Adolesc Psychiatry 1996; 35:1265–1273.
2. Brady KT: Post-traumatic stress disorder and comorbidity: recognizing the many faces of PTSD. J Clin Psychiatry 1997; 58:12–15.
3. Greist JH: The diagnosis of social phobia. J Clin Psychiatry 1995; 56:5–12.

Industry-Supported Symposium 12 — **Saturday, October 28 12 noon-1:30 p.m.**

EFFECTIVE TREATMENT FOR BIPOLAR DISORDER: INDIVIDUALIZING STRATEGIES

Supported by Glaxo SmithKline

Charles L. Bowden, M.D., *Professor of Psychiatry and Pharmacology, University of Texas Health Science Center, San Antonio, 7703 Floyd Curl Drive, San Antonio, TX 78284-7792*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize factors that impact course of bipolar illness, demonstrate awareness of individualizing strategies, define factors that contribute to recurrence and morbidity, and list the potential risks and benefits of the newer agents, including AEDs.

SUMMARY:

An estimated 3 million persons in the U.S. are affected by bipolar disorder (BD). Approximately half of these people experience psychosocial and work performance problems that interfere significantly with their ability to lead a functional life. The range of presentation and course of illness in BD is wide and diverse. As understanding of bipolar disorder has grown through the last decade, so has the recognition that many patients do not respond to standard pharmacologic treatment strategies. These patients present a challenge to psychiatrists who must search for nontraditional agents to treat patients with refractory disease. This symposium will address recognition of bipolar subtypes, the current understanding of individualizing treatment, and the need for awareness of potential adverse reactions to traditional and newer pharmacologic agents.

No. 12A
THE COURSE OF BIPOLAR ILLNESS AND CURRENT THERAPY

Charles L. Bowden, M.D., *Professor of Psychiatry and Pharmacology, University of Texas Health Science Center, San Antonio, 7703 Floyd Curl Drive, San Antonio, TX 78284-7792*

SUMMARY:

There are many factors that impact the course of bipolar illness. Included are age at onset, psychiatric comorbidity, frequency of episodes, cycle pattern, rapid cycling, mixed symptoms, and precipitants of episodes such as substance abuse, use of antidepressants, and lithium discontinuation. Additive factors contributing to course of illness for patients with bipolar disorders will be identified. The diversity and range of presentation and course of illness will be discussed. Treatment with lithium, formerly the agent of choice, has more recently been recognized as inadequate, particularly if the subtype is other than bipolar I. Novel treatment strategies are needed. Case studies representing a variety of bipolar subtypes and treatment outcomes will be presented.

All too often, monotherapy is ineffective. Dose escalation is generally attempted initially, but adverse effects frequently occur, leading to patient noncompliance. When dose escalation is not effective, the use of a new drug with a different mechanism of action may allow a lower dose, with more efficacy and less resulting toxicity. Additionally, the importance of tailoring combination therapy to the individual patient will be discussed.

No. 12B
EXPANDING THERAPIES FOR THE 21ST CENTURY: EXPLORING RISKS AND BENEFITS

Stephen M. Strakowski, M.D., *Department of Psychiatry, University of Cincinnati College of Medicine, 231 Bethesda Avenue, ML0559, Cincinnati, OH 45267*

SUMMARY:

Until recently, the rate at which patients switch from bipolar depression to the manic or hypomanic phase of the disorder during antidepressant treatment was poorly defined. Long-term outcomes are often poor in bipolar patients despite treatment; more effective treatments are needed to reduce recurrences and morbidity. Patients with bipolar disorder (BD) who have rapid-cycling features are often treatment refractory. Clear and conclusive evidence regarding effective treatments for this group is not available. Recently, a number of new agents have become available to treat bipolar disorder; however, many patients may not respond fully to them even when used in combination. New mood stabilizers are needed that possess efficacy for all phases of bipolar disorder. A discussion of new agents and future directions for individualizing strategies for effective treatment will be presented.

Antiepileptic drugs (AEDs) are used in the treatment of BD and are considered standard treatment by many physicians even though only valproate has FDA indication. The potential benefit of any agent must always be weighed against possible risk. One of the more troubling adverse effects seen with the aromatic AEDs is the antiepileptic-drug hypersensitivity syndrome (AHS), a rare but serious reaction that is defined by fever, skin rash, and internal organ involvement. A discussion of the incidence, significance, and diagnosis of rash will be presented.

REFERENCES:

1. Bowden CL, Swann AC, Calabrese JR, et al: Maintenance clinical trials in bipolar disorder; design implications of the divalproex-lithium-placebo study. Psychopharmacol Bull 1997; 33:693–9.
2. Bowden CL: Role of newer medications for bipolar disorder. J Clin Psychopharmacol. 1996; 16(2 Suppl 1):48S-55S.
3. Swann AC, Petty F, Bowden CL, et al: Mania: gender, transmitter function, and response to treatment. Psychiatry Res 1999; 88:55–61.
4. Calabrese JR, Bowden CL, McElroy SL, et al: Spectrum of activity of lamotrigine in treatment-refractory bipolar disorder. Am J Psychiatry 1999; 156:1019–23.
5. Keck PE, Welge JA, Strakowski SM, et al: Placebo effect in randomized, controlled maintenance studies of patients with bipolar disorder. Biol Psychiatry 2000; 47:756–61.
6. Strakowski SM, DelBello MP: The co-occurrence of bipolar and substance use disorders. Clin Psychol Rev 2000; 20:191–206.
7. Keck PH, Welge JA, Stakowski S, et al: Placebo effect in randomized, controlled maintenance studies of acute bipolar mania and depression. Biol Psychiatry 2000; 47:748–55.

Industry-Supported Symposium 13 — **Saturday, October 28 12 noon-1:30 p.m.**

ALZHEIMER'S DISEASE PREDICTORS AND INTERVENTIONS: EVALUATING THE OPTIONS

Supported by Easai Inc., Pfizer Inc.

Gary W. Small, M.D., *Professor of Psychiatry and Biobehavioral Sciences, and Director, Center for Aging,*

UCLA, Neuropsychiatric Institute, 760 Westwood Plaza, Los Angeles, CA 90024-8300

EDUCATIONAL OBJECTIVES:

This symposium will inform participants on differentiating dementia from normal aging strategies for preventing cognitive decline, and future research directions.

SUMMARY:

Alzheimer's disease (AD) begins with a very gradual decline of memory abilities that initially resembles the mild forgetfulness that most people experience by the time they reach their fifties. Mounting neuropathological, neuropsychological, and neuroimaging data suggest that subtle memory changes preceding AD onset by many years could reflect an initial, potentially treatable preclinical disease stage. This symposium will review such evidence, describe approaches to prevention of cognitive decline, and future treatment research. The proposed program would begin with a 10-minute introduction by the Chair and then 20-minute presentation by each participant.

No. 13A
THE BORDER ZONE BETWEEN AGING AND DEMENTIA

Gary W. Small, M.D., *Professor of Psychiatry and Biobehavioral Sciences, and Director, Center for Aging, UCLA, Neuropsychiatric Institute, 760 Westwood Plaza, Los Angeles, CA 90024-8300*

SUMMARY:

The Age Revolution has led to an epidemic of dementia: an estimated 8% of people age 65 or older and as many as 47% in the age group over age 84 suffer from Alzheimer's disease (AD) and other progressive dementias. Although most elderly persons do not develop cognitive impairment severe enough to warrant a dementia diagnosis, a high proportion complain of age-related memory changes and experience concern that their mild forgetfulness will progress to disabling cognitive impairment. Mounting evidence from neuropathological studies of nondemented older adults indicates that the neuropathological hallmarks of AD—neuritic plaques and neurofibrillary tangles—accumulate years before the clinician can diagnose the disease. Functional neuroimaging using positron emission tomography (PET) shows an Alzheimer-like pattern of parietal and temporal hypometabolism, particularly in people with an AD genetic risk (APOE-4), decades prior to the age at risk for dementia. A new PET technology that allows *in vivo* imaging of amyloid plaques and tangles demonstrates significant correlations between objective memory measures and cerebral amyloid burden in both preclinical and clinical dementia states. The neuropathological, neuropsychological, genetic, and neuroimaging database argues for a continuum of cognitive decline that comprises the "border zone" between normal aging and dementia.

No. 13B
PREVENTING COGNITIVE DECLINE IN THE ELDERLY

Howard Fillit, M.D., *Executive Director, Institute for the Study of Aging, 767 Firth Avenue, New York, NY 10153*

SUMMARY:

As senile dementia of the Alzheimer's type (SDAT) was recognized as a common disease of old age, but not an inevitable accompaniment of aging, so too, we now recognize that Alzheimer's disease and other forms of dementia in old age may be preventable. Much of the data on methods to prevent cognitive decline and dementia has come from epidemiologic studies. These data from longitudinal, population-based, epidemiologic studies have identified several possible modifiable risk factors for cognitive decline and dementia, including dietary factors (e.g., as folic acid, vitamins [particularly the antioxidants vitamin E and vitamin C] and cholesterol); lifestyle factors (e.g., smoking, alcohol, physical and mental exercise); hormone deficiencies (particularly estrogen in women and possibly testosterone in men); medical comorbidities (e.g., hypertension, cardiovascular risks, and diabetes); and psychosocial factors (e.g., social isolation, occupational complexity, the intelligence of one's spouse, stress, and education). Genetic factors such as apolipoprotein E genotype, of course, significantly impact these modifiable risk factors. Further research in the prevention of cognitive decline and dementia is needed to definitively demonstrate the impact of controlling potential risk factors is needed. Nevertheless, current data support the notion that prevention of cognitive decline and dementia can be considered an important clinically relevant component of the practice of preventive gerontology.

No. 13C
THE FUTURE OF ALZHEIMER'S DISEASE TREATMENTS: FROM TRIALS TO TRIUMPHS

Pierre N. Tariot, M.D., *Department of Psychiatry, University of Rochester Medical Center, 435 East Henrietta Road, Rochester, NY 14620-4629*

SUMMARY:

Dementia may indeed be the next century's pandemic. Today it is recognizable, diagnosable, treatable, but not recognized or treated often enough. Through medical research, important advances have been made in the early recognition, detection and treatment of dementia, specifically Alzheimer's disease. Over the past several years, diverse clinical trials have validated long-held clinical beliefs in the benefits of numerous therapeutic interventions to stave off the type of progressive cognitive decline to which physicians had been historically resigned. While we know more from experience than controlled clinical trials that environmental and behavioral techniques can help, there is much more information about FDA-approved drugs, as well as those under review for approval. Clinical trials are not only designed to verify the impact of a particular drug on a disease state, they provide clinicians with the opportunity to validate, through their own experiences, important treatment algorithms that they might otherwise not consider. There are currently a number of clinical studies that indicate important ways to delay the onset of AD dementia, or at the very least, slow the progression of cognitive decline.

REFERENCES:

1. Small GW. American Journal of Medicine 1998; 104:32S–38S.
2. Small GW, La Rue A, Komo S, et al: Predictors of cognitive change in middle-aged and older adults with memory loss. American Journal of Psychiatry 1995; 152:1757–1764.
3. Van Duijn CM, Stijnen T, Hofman A, for the EURODEM Risk Factors Research Group: Risk factors for Alzheimer's disease: overview of the EURODEM collaborative re-analysis of case-control studies. Int J Epidemiol 1991; 20(suppl 2):S48–57.
4. Tariot PN, Loy R, Schneider LS: The pharmacological wager: prospects for delaying the onset or modifying the progression of Alzheimer's disease. European Journal of Neurology (in press).
5. Schneider LS, Tariot PN: Drugs for Alzheimer's disease. In Psychopharmacology of Cognitive and Psychiatric Disorders in the Elderly. Edited by Whastley D, Smith D. Chapman & Hall Medical, New York, 1998; pp. 92–115.

Industry-Supported Symposium 14 **Saturday, October 28 6:00 p.m.-9:00 p.m.**

CLINICAL FRONTIERS IN THE SLEEP/ PSYCHIATRY INTERFACE

Supported by Wyeth-Ayerst Laboratories

Karl Doghramji, M.D., *Department of Psychiatry, Thomas Jefferson University School of Medicine, 1015 Walnut Street, Suite 319, Philadelphia, PA 19107-5005*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) identify the differential diagnosis of insomnia and hypersomnolence and devise strategies for diagnosis and intervention; (2) recognize characteristic polysomnographic aberrations in depression, PTSD, and pain syndromes and their management; (3) recognize that sleep and wakefulness are not mutually exclusive states, as evidenced by the parasomnias, and identify diagnostic features of these disorders.

SUMMARY:

Sleep-related complaints such as insomnia and daytime hypersomnolence abound in the practice of psychiatry. Certain conditions, such as depression and chronic pain, feature such sleep-related symptoms, the alleviation of which has posed formidable challenges to patients and psychiatrists for decades. These challenges are magnified in the elderly. Nevertheless, sleep research has now begun to yield data with important implications regarding the understanding and management of these clinical entities.

This symposium will explore the pathophysiologic links between sleep biology and these psychiatric conditions. Our understanding of the mechanisms governing sleep and wakefulness will be reviewed. Subjective and polysomnographic findings in depression and aging will then be reviewed, and their implications will be clarified regarding diagnosis, future vulnerability, pathophysiology, and management. The scope of the topic will be expanded to include other psychiatric, medical, and primary sleep disorders that may account for sleep disruption. Finally, modalities of management for these disorders and their sleep-related symptoms will be presented, relying on data gathered from formal trials and clinical experience.

No. 14A
INSOMNIA AND HYPERSOMNOLENCE: OLD PROBLEMS WITH NEWER TREATMENTS

Karl Doghramji, M.D., *Department of Psychiatry, Thomas Jefferson University School of Medicine, 1015 Walnut Street, Suite 319, Philadelphia, PA 19107-5005*

SUMMARY:

Sleep-related complaints abound in the practice of psychiatry; 70% of depressives, 90% of psychotic patients, and 80% of C/L patients complain of disturbed sleep. Disturbed sleep is also highly prevalent in the general population; nearly half of all Americans above the age of 18 complain of insomnia during the course of a year, and a striking 12% of the general population suffer from chronic insomnia. Studies also reveal that

insomnia is associated with an increased risk of having psychosocial and occupational difficulties, cognitive impairments, accidents, and may even contribute to mortality. Hypersomnolence afflicts 10%–20% of the population and has been known to contribute to numerous catastrophes such as the explosion of the space shuttle Challenger and the grounding of the oil tanker Exxon Valdez. This presentation will review central mechanisms governing sleep and daytime alertness. It will also review the prevalence and impact of sleeplessness and daytime hypersomnolence and will stress the potentially important, yet poorly recognized, role of excessive daytime somnolence in the practice of psychiatry. The evaluation of these two symptoms will also be discussed, emphasizing the formulation of a differential diagnosis based on polysomnographic and office-based techniques. Options for management will be presented, including pharmacological agents, behavioral techniques, phototherapy, and psychotherapy, emphasizing the value of a multimodal approach.

No. 14B
EMERGING LINKS BETWEEN DEPRESSION AND SLEEP

J. Christian Gillin, M.D., *Department of Psychiatry, University of California at San Diego, VA Medical Center, 3350 La Jolla Village Drive, San Diego, CA 92161-0002*

SUMMARY:

This presentation will explore the complex and potentially mutually reinforcing relationship that may exist between depression and sleep. Subjective and polysomnographic alterations in depression, both in the acute phase and following remission, will be reviewed, and their implications will be explored regarding diagnosis, vulnerability to relapse, and the pathophysiology of depression itself. The role of serotonin in depression, the sleep of depressives, and the sleep-related aspects of antidepressant therapy will be reviewed. The effects of antidepressants and other therapeutic agents on polysomnographic patterns of depressives will be reviewed, and the implications of these findings will be discussed regarding the selection of pharmacologic agents.

No. 14C
CHRONIC PAIN, SLEEP AND AROUSAL: NEUROBIOLOGICAL MECHANISMS AND IMPLICATIONS REGARDING INTERVENTION

Mitchell J.M. Cohen, M.D., *Department of Psychiatry, Thomas Jefferson University School of Medicine, 841 Chestnut Street, Suite 1001, Philadelphia, PA 19107*

SUMMARY:

Sleep abnormalities are commonly encountered in patients with chronic pain. Pain is fundamentally activating through spinoreticular pathways and the paleospinothalamic component of the spinothalamic tract. Comorbid anxiety and depression, medication use, and altered daily activity levels contribute to a multifactorial pathogenesis of these sleep abnormalities. Spinal pain, myofascial pain, headache, and pelvic pain are among pain conditions in which sleep problems have been specifically studied. Sleep disorder is one criterion for the diagnosis of fibromyalgia, and some reports suggest specific electroencephalographic findings in this condition. Some population data suggest pain is the most common cause for a secondary sleep disturbance. Various data demonstrate associations between depressive symptoms and sleep disturbance in pain patients. In the clinical course of chronic pain, some data suggest that sleep disturbance and depression become self-sustaining in the central nervous system and independent of the specific peripheral pain generator. This presentation reviews these neurobiological issues, exploring central linkages between pain, sleep, and affective disturbances. Data on sleep disturbances in chronic pain conditions and associations with depression are summarized. Chronic pain is costly in terms of individual suffering, medical utilization, and productivity losses. This presentation concludes by outlining pharmacologic and behavioral treatment strategies that can mitigate these costs.

No. 14D
SLEEP IN THE ELDERLY: BIOLOGICAL MECHANISMS AND STRATEGIES FOR MANAGEMENT

Alejandro D. Chediak, M.D., *Department of Sleep Disorders, University of Miami at Mount Sinai, 4300 Alton Road, Miami Beach, FL 33140*

SUMMARY:

Surveys inquiring about sleep in geriatric subjects report increased nocturnal awakenings, more frequent use of hypnotics, and greater number of somatic discomforts such as nocturia, headache, gastrointestinal illness, and cardiovascular symptoms occurring during sleep. Polysomnographically defined sleep in normal aging reveals decreased sleep efficiency, increased non-REM stage 1 sleep, and reductions in non-REM stage 3–4 sleep. Elderly subjects may have a shift of REM sleep earlier in the night, with less REM occurring later in the night, suggesting age-related alterations of circadian sleep timing. In addition, advancing age is accompanied by increasing prevalence of specific sleep-fragmenting disorders such as obstructive sleep apnea, central sleep apnea, and periodic limb movement disorder. Finally,

the net amount of sleep obtained does not change with aging, and the need for sleep is equally strong in elderly and aged individuals. The combined effects of specific sleep, medical, and psychiatric disorders with age-related alterations of sleep help explain the relatively high prevalence of sleep complaints in the elderly. This portion of the symposium will review normal and disturbed sleep in elderly subjects with emphasis on management strategies based on the understanding and correction of the pathophysiologic mechanisms promoting specific sleep complaints.

REFERENCES:

1. Doghramji K: Sleep Disorder: a selective update. Hospital and Community Psychiatry 1989; 40:29–40.
2. Gillin JC, Ancoli-Israel S, Erman M: Sleep and sleep-wake disorders, in Psychiatry 2. Edited by Tasman A, Kay J. Lieberman JA. Philadelphia, W.B. Saunders Company, 1996, pp. 1217–1248.
3. Moffitt PF, Kalucy EC, Baum FE, Cooke RD: Sleep difficulties, pain, and other correlates. Journal of Internal Medicine 1991; 230:245–249.
4. Bliwise OL: Sleep in normal aging and dementia. Sleep 1993; 16:40–81.
5. Foley D, et al: Incidence and remission of insomnia among elderly adults: an epidemiologic study of 6,800 persons over three years. Sleep 1999; 22(supplement 2):S366–S373.

INNOVATIVE PROGRAMS: SESSION 1 SERVICES AND SYSTEMS

Innovative Program 1 Wednesday, October 25 10:00 a.m.-11:30 a.m.

USING EPIDEMIOLOGICAL METHODOLOGY TO SUCCESSFULLY MANAGE BEHAVIORAL HEALTH CARE

Bryce McLavlin, M.D., *Community Behavioral Health, 714 Market Street, 5th Floor, Philadelphia, PA 19107*; Marcella Maguire, Ph.D., *Behavioral Health Liaison, Philadelphia Behavioral Health System, 1101 Market Street, Suite 800, Philadelphia, PA 19107*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize individuals who are underserved or inappropriately served in the Philadelphia Behavioral Health System.

SUMMARY:

The presenters are officials from the Philadelphia Behavioral Health System who are involved in using epidemiological methodology to satisfy requirements of the state-driven Medicaid Managed Care program, known in Pennsylvania as Health Choices. The project uses data collected by the managed care organization, Community Behavioral Health, to identify individuals who are underserved or inappropriately served by the Philadelphia Behavioral Health System. Examples of under- or inappropriately served individuals include consumers of emergency services (emergency rooms or inpatient psychiatric acute units) who are not linked to ongoing community care or individuals who are homeless with substance abuse issues who are unable to access treatment and therefore present at emergency rooms on a regular basis.

A disease management strategy is used to drive a continuous quality improvement mechanism. Data are collected by the managed care organization on all members of the managed care plan. Clinical profiles are developed of underserved or inappropriately served individuals and a factor analysis is used to determine clusters of clinical and social profiles of individuals. A care management strategy is developed for certain high-risk individuals. As clusters of individuals become identified, effective programmatic components can be identified from the clinical treatment literature. Existing services can be enhanced or new services developed to serve a population that previously had been unknown to systems planners. In this process, increased access to quality care and better use of scarce system resources can be realized.

REFERENCES:

1. Dincin J, Wasmer D, Witheridge T, Sobeck L, Cook J, Razzano L: Impact of assertive community treatment on the use of state hospital inpatient bed days. Hospital and Community Psychiatry 1993; 44:833–838.
2. Chandler D, Meisel J, McGowen M, Mintz J, Madison K: Client outcomes in two model capitated integrated service agencies. Psychiatric Services 1996; 47:175–180.

Innovative Program 2 Wednesday, October 25 10:00 a.m.-11:30 a.m.

CONSUMER PROGRESS NOTES: OUTCOMES

Katherine G. Levine, M.S.W., *Program Director, Community Mental Health Services, Visiting Nurse Service of New York, 1250 Broadway, New York, NY 10001*; Augusto Torres, M.S.W., *Program Coordinator, Community Mental Health Services, Visiting Nurse Service of New York, 1250 Broadway, New York, NY 10001*; David C. Lindy, M.D.; Nicolás Dávila-Katz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) describe a consumer progress note, (2) describe specific outcomes related to the use of a consumer progress note.

SUMMARY:

The Visiting Nurse Service of New York operates as Mobile Community Support Service in the Mott Haven section of the South Bronx. The program's mission is to prevent the psychiatric hospitalization of youth through provision of family friendly and consumer collaborative mental health services. This service has piloted the use of a consumer progress note. The service provider and the consumer collaborate on completing a brief description of what was done during the session; the consumer also completes a checklist designed to measure risk factors and consumer satisfaction. This program will first describe the consumer progress note. Outcome data will then be presented. This will include hospitalization rate, reduction of measurable risk factors, length of service, consumer satisfaction with outcome, and staff satisfaction with outcome. Outcome data will be derived from comparing 30 cases in which the progress note was used with 30 comparable cases in which a routine progress note was used.

REFERENCES:

1. Miller SD, Duncan BL, Hubble MA: Escape from Babel. New York, Norton, 1997.

2. LeVois M, et al: Artifact in client satisfaction assessment. Evaluation and Program Planning 1981; 4:139–150.

Innovative Program 3 Wednesday, October 25 10:00 a.m.-11:30 a.m.

EMOTIONAL WELL-BEING IN THE U.S. AIR FORCE: A MODEL FOR A COMMUNITY MENTAL HEALTH PROMOTION PROGRAM

Steven E. Pflanz, M.D., *Chief, Mental Health Services, F.E. Warren Air Force Base, U.S. Air Force, 408 West First Avenue, Cheyenne, WY 82001*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand one community's approach toward the primary prevention of mental illness and the importance of implementing mental health outreach programs.

SUMMARY:

It has become increasingly clear that the medical establishment will need to dedicate a much greater share of its resources toward the prevention of illness and shift its focus away from the treatment of existing illnesses. Given the widespread prevalence of and tremendous costs associated with mental illness, the reduction of mental illness and stress is clearly critical to any effort aimed at fostering population health. The existing research clearly supports this reality. One-third to one-half of the U.S. population suffers from a mental illness during their lifetime. In addition to the terrible personal toll exacted by emotional distress, individuals suffering from psychiatric illness exhibit decreased work productivity, increased workforce turnover, increased absenteeism, and higher medical costs. Efforts to reduce the incidence of psychiatric illness will likely lower the costs associated with mental illness and will enhance the emotional well-being of our communities.

Our mental health service has implemented a comprehensive mental health promotion campaign for our community. The cornerstone of this effort is a mental health education program, titled "Emotional Well-Being in the USAF." This program offers the following basic health education on five mental health topics to enhance the emotional health of USAF personnel: stress management, suicide prevention, emotional response to trauma, alcohol/drug abuse prevention, and violence awareness education. This is the first community outreach program we are aware of that offers this broad mental health education to an entire population.

REFERENCES:

1. Pflanz SE: Psychiatric illness and the workplace: perspectives for occupational medicine in the military. Military Medicine 1999; 164:401–6.
2. Sauter SL, Murphy LR, Hurrell JJ: Prevention of work-related disorders. Am Psych 1990; 45: 1146–58.

INNOVATIVE PROGRAMS: SESSION 2 SUBSTANCE ABUSE AND AGING

Innovative Program 4 Thursday, October 26 8:00 a.m.-9:30 a.m.

TREATMENT IS AVAILABLE: SUBSTANCE ABUSE TREATMENT FOR PEOPLE WITH PHYSICAL DISABILITIES

Mario Cruz, M.D., *Clinical Assistant Professor and Associate Head of Clinical Services, Department of Psychiatry, University of Arizona, 1501 North Campbell Avenue, Tucson, AZ 85724*; Laura Benchik, M.A., *Director, Network Services, COPE Behavioral Services, 101 South Stone Avenue, Tucson, AZ 85701*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate understanding of barriers to substance abuse treatment for people with physical disabilities and elements of a program that addresses these barriers.

SUMMARY:

According to recent estimates, 25% to 30% of people with severe physical disabilities also have substance abuse disorders. Unfortunately, barriers to substance abuse treatment for this population seriously attenuate the number who seek and receive treatment. The barriers range from societal views inhibiting referral of people with disabilities to substance abuse treatment (Perez & Pilsecker, 1994) to programmatic elements that make participation in treatment difficult (Tyas & Rush, 1993). In Tucson, Arizona, individuals with physical disabilities and substance abuse disorders were noted to be underrepresented in substance abuse treatment programs, and a plan to address this problem was developed by COPE Behavioral Services, Inc. In 1999, COPE began a program in partnership with five local agencies to provide substance abuse treatment services for individuals with physical disabilities. The project is funded by the U.S. Center for Substance Abuse Treatment (CSAT), and was designed to improve the existing system of care, increase access to treatment, and provide care that specifically addresses the needs of people with physical disabilities and their families. Innovative services including acu-

puncture, detoxification, group psychotherapy, and aftercare are included in the COPE program. Specific information on how the community partnership was developed, elements of the tailored treatment program, and outcome data for the program will be described.

REFERENCES:

1. Perez M, Pilsecker C: Group psychotherapy with spinal cord injured substance abusers. Paraplegia 1994; 32:188–192.
2. Tyas S, Rush B: The treatment of disabled persons with alcohol and drug problems: results of a survey of addiction services. Journal of Studies of Alcohol, 54:275–282.

Innovative Program 5 Thursday, October 26 8:00 a.m.-9:30 a.m.

INTEGRATING A TRADITIONAL SUBSTANCE ABUSE PROGRAM WITH ONE THAT SERVES THE SEVERE AND PERSISTENT MENTALLY ILL

Nina R. McGowan, M.D., *Associate Medical Director, Project Renewal, Inc., New Providence Women's Shelter, 225 East 45th Street, New York, NY 10017*; Laura K. Metallo, C.S.W., *Clinical Director, Project Renewal, Inc., 225 East 45th Street, New York, NY 10017*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1) Understand key clinical issues in the treatment of patients with co-existing severe and persistent mental illness and substance disorders; and 2) Understand the advantages and disadvantages of integrating a program for patients with severe and persistent mental illness and substance disorders with a program for ''pure'' substance abusers.

SUMMARY:

New Providence Women's Shelter provides transitional shelter and clinical treatment in NYC for 130 single, homeless adult females in three categories: severely and persistently mentally ill with and without substance abuse disorders, and those with ''pure'' substance disorders. Treatment is provided in the context of two programs operating within the same shelter: the Transitional Living Community (TLC) for those with psychotic disorders, and the Modified Therapeutic Community (MTC) for the ''pure'' substance abusing population. An attempt was made to integrate these two programs. As the programs evolved, the desirable degree of integration became a significant programmatic question.

The presentation will explore clinical and programmatic issues arising in integrating these programs. Concepts for discussion include the advantages and challenges of integrating the SPMI population with the nonmentally ill population, abstinence vs. harm-reduction treatment models with the SPMI population, clinical characteristics of the TLC approach, patient and staff responses to modifications to the MTC approach.

The proposed presentation will be of interest to clinicians working with these populations, as well as those developing programs in this area. The presenters will highlight the importance of balancing the need for individualized treatment with the goal of effective community development among patients and staff.

REFERENCES:

1. Bellack AS, Diclemente CC: Treating substance abuse among patients with schizophrenia. Psychiatric Services 1999; 50:75–80.
2. Blankertz LE, Cnaan RA: Serving the dually diagnosed homeless: program development and interventions. The Journal of Mental Health Administration 1993; 20:100–112.

Innovative Program 6 Thursday, October 26 8:00 a.m.-9:30 a.m.

NORMALIZING THE CHALLENGES OF AGING

Leila B. Laitman, M.D., *Team Psychiatrist, Community Mental Health Services, Visiting Nurse Service, 1601 Bronxdale Avenue, Bronx, NY 10462*; Rebecca Morales, C.S.W., *Social Worker, Community Mental Health Services, Visiting Nurse Service, 1601 Bronxdale Avenue, Bronx, NY 10462*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize that elderly clients can be influenced to accept mental health follow up, (2) understand methods that can be used to overcome resistance in elderly clients.

SUMMARY:

A central task for older adults is to adopt effective strategies for dealing with loss and to be able to change goals based on either physical or psychosocial limitations. Goals of treatment involve trying to prevent or treat a psychiatric disorder while enhancing competence, self-esteem, and a sense of well being. While social support through a referral into the mental health system can be very helpful, many older people refuse this option due to stigma. The challenges of aging need to be ''normalized'' to get them to accept ongoing help. This presentation describes an innovative program designed to increase the likelihood that elderly clients would accept referral for outpatient treatment. It was developed by

the geriatric outreach team of the Visiting Nurse Service of New York. Full-time staff participated in a 12-session workshop focused on interviewing and counseling techniques intended to overcome patient and family resistance to ongoing mental health follow up. Per-diem staff did not participate in the training. New cases were rated by the intake clinician as to the likelihood of acceptance of mental health referrals, and actual disposition was recorded at discharge and then compared with the initial perception. This was done before and after staff completed the training, and the success of the trained group was also compared with the untrained per diems. The study suggests clinicians who participated in the training were able to increase the rate of patients' acceptance of referrals and develop an awareness that even if contact was brief, helping the elderly deal with the usual problems of aging was not a hopeless endeavor.

REFERENCES:

1. Perlin LI, Skaff MM: Stressors and adaptation in late life, in Emerging Issues in Mental Health and Aging, Edited by Gatz M, American Psychological Association, Washington, D.C. 1995, pp. 97–123.
2. Speer DC: Mental Health Outcome Evaluation. Academic Press, New York, 1998.

INNOVATIVE PROGRAMS: SESSION 3 STRATEGIES IN PSYCHOTHERAPY

Innovative Program 7 **Thursday, October 26**
10:00 a.m.-11:30 a.m.

CULTURAL CONTEXT OF THE DOCTOR/ PATIENT RELATIONSHIP IN PSYCHOTHERAPY

Albert C. Gaw, M.D., *Medical Director, Mental Health Rehabilitation Facility and for Long-Term Care for the Community Mental Health Services, City and County of San Francisco, 887 Potrero Avenue, San Francisco, CA 94110*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the impact of culture on processes and structure of the doctor/patient relationship in psychotherapy.

SUMMARY:

Increasingly, psychotherapists are being called upon to treat patients of diverse ethnic backgrounds. Such cross-cultural encounters not only require therapists to bridge linguistic and cultural gaps between them and their patients, but also force therapists to confront their basic assumptions about psychotherapy. For examples, (1) What are the deeply held values, beliefs, and concepts that drive therapeutic procedures? (2) Should the optimal outcome of therapy be the emancipation and liberation from the social context from which the patient has suffered conflicts or should the outcome be aimed toward a harmonious integration with the patient's social setting? (3) Is Western-style psychotherapy, as is currently constructed and practiced, applicable to all cultures? (4) How does the changing macro-social context of the health care environment impact the therapist/patient relationship? and (5) How should psychotherapy be viewed in the context of culture?

This presentation will examine various psychotherapeutic issues from the cultural context. Specifically, I shall address: (1) therapeutic features common to all forms of psychotherapies, (2) the cultural context of psychotherapy and its impact on the process and structure of the therapist/patient relationship, and (3) recent advances in conceptual understanding toward a biopsychocultural integration of psychotherapy and healing across cultures.

REFERENCES:

1. Kleinman A: Rethinking Psychiatry, New York, NY, The Free Press, 1988.
2. Pederson PB, Draguns JG, Lonner WJ, Trimble JE (eds): Counseling Across Cultures, Honolulu, Hawaii, The University Press of Hawaii, 1981.

Innovative Program 8 **Thursday, October 26**
10:00 a.m.-11:30 a.m.

INTEGRATING PSYCHOTROPICS AND PSYCHOTHERAPY FOR ADULTS WITH SEVERE DEVELOPMENTAL DISABILITIES

Peggy E. Chatham-Showalter, M.D., *Consultation Psychiatrist, Raker Center, Good Shepherd Rehabilitation Center, 3420 Walbert Avenue, Allentown, PA 18104*; Phyllis Perna, Psy.D., *Psychology Consultant, Raker Center, Good Shepherd Rehabilitation Center, 2045 Westgate Drive, Suite 300, Bethlehem, PA 18104*; Jayne Bayer, L.C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to list challenges in integrating psychotherapy with psychotropic medications for adults with severe cerebral palsy and other similar disabilities; describe psychotropic side effects of special concern; and identify highly germane therapeutic issues.

SUMMARY:

A long-term-care facility providing a community environment for adults (n = 120) with severe developmental disabilities has had a psychiatrist evaluate and direct treatment for residents prescribed psychotropics. After four years, the prevalence of diagnosed psychiatric disorder requiring medication has been 34.1%; among this cohort, average age was 43.2 ± 13 years, 73% with cerebral palsy, 12% spina bifida with hydrocephalus, 10% childhood TBI, 2.5% Fredreich's ataxia, and 2.5% childhood stroke. Psychiatric diagnosis has been distributed as follows: 52% mood disorder; 15% anxiety (generalized or panic) disorder; 9% obsessive compulsive disorder; 26% organic personality syndrome, with 7% psychotic features of any diagnosis; and 26% had two or more diagnoses. Interesting psychopharmacological and psychodynamic issues (individual and group process) continually present opportunities for effective and satisfying clinical work. Developmental issues of autonomy, intimacy, and productivity need to be addressed, and most patients participate in some form of psychotherapy: supportive psychotherapy with a master's level social worker, cognitive or behavioral psychotherapy with the psychiatrist, or more insight oriented work with a doctoral level psychologist. All therapists provide family sessions or therapy as indicated. The social worker also provides roommate or romantic couple's therapy. After overcoming logistical challenges, therapeutic work can proceed that integrates psychotropic medications and psychotherapy with existing occupational, physical, recreational, and speech therapies to improve overall function.

REFERENCES:

1. Kessler RC, McGonagle KA, Shanyang Z, et al: Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. Arch Gen Psych 1994; 51:8–19.
2. Kopecky HJ, Yudofsky SC: Agitation: conceptualization, measurement, and treatment. Bulletin of the Menninger Clinic 1999; 63 (Suppl A):A31–A52.

Innovative Program 9 **Thursday, October 26**
10:00 a.m.-11:30 a.m.

THE PRECIPITATING EVENT: A STRATEGY FOR INTENSIVE INPATIENT PSYCHOTHERAPY

John Hitchcock, M.D., *Clinical Associate Professor of Psychiatry, University of Pittsburgh, 128 North Craig Street, Suite 217, Pittsburgh, PA 15213-2758*; Viveca A. Meyer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to elicit the significant psychodynamic issues entailed in the event precipitating a psychiatric hospitalization and formulate an intensive psychotherapeutic plan for implementation during the hospital stay.

SUMMARY:

The specific psychological/emotional experiences surrounding the events precipitating a patient's admission to a psychiatric inpatient facility provide the focus for intensive inpatient psychotherapy, even in brief hospitalizations.

Whatever the patient's psychiatric history or diagnosis may be, the fact of hospitalization *at this time* reflects a disruption of the patient's usual adaptive/defensive patterns, which, if identified and explored, may enable the patient to recognize similar circumstances in the future and to respond more effectively.

The presenter will detail the type of initial evaluation, the development of the psychotherapeutic formulation and its implementation with several examples, and invite participants to offer examples from their experiences.

TARGET AUDIENCE:

Psychiatrists, nurses, psychologists and other mental health workers, as well as trainees in all these professions, who work in psychiatric emergency rooms or in psychiatric inpatient settings.

REFERENCES:

1. Kalis B, et al: Precipitating stress as a focus in psychotherapy. Archives of General Psychiatry 1961; 18:219–227.
2. Fauman J: Crisis intervention, in Comprehensive Psychiatry. Kaplan, Sadock, 6th edition. Williams and Wilkins, 1997.

INNOVATIVE PROGRAMS: SESSION 4 INNOVATION IN COMMUNITY TRAUMA SERVICES

Innovative Program 10 **Friday, October 27**
10:00 a.m.-11:30 a.m.

SHIFTING SYSTEMS TO RECOGNIZE AND DEAL WITH SECONDARY TRAUMA

Lynn Ohrenstein, D.S.W., *Senior Associate, Center for Trauma Program Innovation, Jewish Board of Family and Children's Services, 135 Central Park, West, New York, NY 10024*; Janet A. Geller, Ed.D., C.S.W., *Director, Family Violence Prevention Center, Jewish Board of Family and Children's Services, 65 West 95th Street, New York, NY 10025*; Libbe Madsen, C.S.W.

EDUCATIONAL OBJECTIVES:

The participant will be able to understand the importance of dealing with secondary trauma and the CRMT model.

SUMMARY:

An initiative is underway at the Jewish Board of Family and Children's Services, a large not-for-profit mental health and social service organization, to improve clinical services for families with traumatic stress disorders. One critical step in any system change is understanding clinicians' reactions. Successful work with trauma includes understanding its impact on clinicians as well as on clients. Hence a program was developed to help staff work together and not become overwhelmed.

The Clinical Risk Management Team was developed to help staff stay focused on appropriate tasks within a phase-treatment approach. This model structures case discussion, thus helping to counterbalance the overwhelming cognitive and affective impact of trauma. The model was piloted in several different programs within the agency, and tailored to facilitate its ongoing ownership and independent use within each setting.

The general principles of the model will be discussed, along with methods for modification and implementation in different systems. Discussion will be encouraged.

REFERENCES:

1. van der Kolk BA, McFarlane AC, Weisaeth L: Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society. New York, Guilford Press, 1996.
2. Bloom S: Creating Sanctuary: Toward an Evolution of Sane Societies. New York, Routledge, 1997.

Innovative Program 11 **Friday, October 27**
10:00 a.m.-11:30 a.m.

CREATING SANCTUARY IN AN ADOLESCENT RESIDENTIAL TREATMENT CENTER

Robert H. Abramovitz, M.D., *Chief Psychiatrist and Director, Center for Trauma Program Innovation, Jewish Board of Family and Children Services, 120 West 57th Street, New York, NY 10019-3320*; Sandra L. Bloom, M.D., *Executive Director, The Sanctuary, 13 Druim Moir Lane, Philadelphia, PA 19118*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand how and when to modify systems of care using the Sanctuary Model.

SUMMARY:

Residential treatment centers for adolescents serve large numbers of youngsters traumatized by either witnessing or being directly victimized by violence. These same youngsters also exhibit impulsive and aggressive behavior and often perpetrate both self and other directed violence. The task of maintaining a safe, stable milieu for such difficult, highly aroused adolescents is quite challenging.

A trauma-focused treatment program offers the best opportunity to meet this need. Our approach involves introducing such a program within a complex institution. It involves adapting the Sanctuary Program originally developed by Sandra Bloom, M.D., for an acute inpatient hospital unit for adults. It impacts on all levels of the organization simultaneously and involves intensive team building exercises with a diverse staff representing many disciplines. It aims to build a collaborative approach based on a set of shared assumptions. Training regarding a stage-oriented trauma treatment approach is occurring simultaneously. In addition, the staff and the youngsters themselves are being engaged in a collaborative process directed at creating a firm commitment to nonviolence within the institution. The presentation describes the process of system adaptation. The principles of the Sanctuary model will be used to engage the audience in discussion.

REFERENCES:

1. Bloom S: Creating Sanctuary: Toward the Evolution of Sane Societies. New York, Routledge, 1997.
2. Bloom S: Creating Sanctuary in the school. Journal for a Just and Caring Education 1995; 1:4 Corwin Press, Inc.

Innovative Program 12 **Friday, October 27**
10:00 a.m.-11:30 a.m.

SAFE FAMILIES: COMPREHENSIVE INTERVENTIONS IN DOMESTIC VIOLENCE SHELTERS

Marie B. Philip, *Director, Horizons, Jewish Board of Family and Children Services, P.O. Box 060280, Brooklyn, NY 11206*; Bettina Buschel, D.A., *Jewish Board of Family and Children Services, 39 West 87th Street, #2, New York, NY 10024*; Paula G. Panzer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be able to recognize the value of integrated models of care for survivors of family violence.

SUMMARY:

Women and children are profoundly affected by family violence. Many women also have histories of childhood abuse and neglect. Domestic violence shelters provide an opportunity for assessment and treatment of trauma consequences for families. However, shelters must balance competing goals, such as safety and stabilization of families, assistance with financial and legal issues, and rapid transition to safe housing despite unpredictable access. Therefore, services must occur in a flexible and contextually appropriate fashion.

Our innovation is a comprehensive model of care, which enhances the natural healing environment. Assessment of women is done through several modalities, including milieu observations, individual and group social work meetings, and psychiatric interviews. Evaluations are strengths focused, and potential stigma of a psychiatric meeting is minimized. Families are evaluated as a unit, and children are involved in ongoing art therapy groups. All work is coordinated. This enhanced model allows for addressing the consequences of both short-term and life-long trauma in a crisis shelter setting. Women are offered the opportunity for help without removing the primary focus for their presence—they are in shelter to escape interpersonal violence and find safe housing. We will present a summary of our model and stimulate discussion.

REFERENCES:

1. van der Kolk BA, McFarlane AC, Weisaeth L: Traumatic Stress: the Effects of Overwhelming Experience on Mind, Body and Society. New York, Guilford Press, 1996.
2. Bloom S: Creating Sanctuary: Toward an Evolution of Sane Societies. New York, Routledge, 1997.

INNOVATIVE PROGRAMS: SESSION 5 MOVING BEYOND OUR OFFICES

Innovative Program 13 Saturday, October 28 8:00 a.m.-9:30 a.m.

TEACHING BEHAVIORAL SCIENCES TO FAMILY DOCTORS

Jonathan S. Davine, M.D., *Assistant Professor of Psychiatry, McMaster University, East Region Mental Health Services, 2757 King Street, East, Hamilton, Ontario, Canada L8G 5E4*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe a longitudinal method of teaching behavioral sciences to family medicine residents and CME initiatives in a shared care family medicine/psychiatry program

SUMMARY:

In this presentation, we describe the approach to the teaching of behavioral sciences to family medicine residents at McMaster University in Hamilton, Ontario. Instead of a block placement in the psychiatric unit, teaching takes place on a weekly half-day, devoted to behavioral sciences, for the entire duration of the two-year residency. During this time, a psychiatric consultant is present on site in the family medicine unit. The training is problem based, usually within small groups, and utilizes examples from cases that residents are seeing in their practice.

In addition, we discuss a new program at McMaster, named the Hamilton-Wentworth HSO Mental Health Program, in which psychiatrists work directly with family doctors in the community. Psychiatrists go to the family doctor's office on a weekly or biweekly basis and work on site. This type of work affords many opportunities for educational activities with family doctors already established in the community. Different approaches to CME in this setting are discussed.

TARGET AUDIENCE:

Psychiatrists, family physicians and mental health specialists.

REFERENCES:

1. Kates N, et al: Psychiatry and family medicine: the McMaster approach. Can J Psychiatry Vol. 32, 1987.
2. Strain J, et al: The role of psychiatry in the training of primary care physicians. General Hospital Psychiatry 1986: vol 8.

Innovative Program 14 Saturday, October 28 8:00 a.m.-9:30 a.m.

INNER-CITY CHILDREN: TEACHING SURVIVAL SKILLS

Kenneth H. Gordon, Jr., M.D., *Clinical Professor, Department of Child Psychiatry, Jefferson Medical College, 1250 Upper Gulph Road, Radnor, PA 19087-2734*; Andrea Wilson-Harvey, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to apply what we know about human development to help inner-city teachers teach children how to develop survival skills, which should prevent student drop out and prevent teacher burn out.

SUMMARY:

The target audience is emotional support teachers and psychiatric consultants in schools.

Fifty to 70 percent of large-city children drop out of school before graduation. Many of them have multiple and severe ego defects. In the school district the authors studied, emotional support (ES) teachers had a burn out rate of 90% over three years. There was also a high incidence of absenteeism in ES classes. The objectives of the study were three: to determine if inner-city children can develop ego functions in ES classes, and if the ES teacher burn out rate and student absenteeism in ES classes can be reduced. ES teachers were provided with in-school child and adolescent psychiatric consultants. They also had monthly in-service training to learn about the development of ego functions. An ES student's progress was charted on a report card that was specially designed for this project. The results were positive: one-third of children in ES classes for two or more years were mainstreamed each year. The other two-thirds showed academic progress. The ES teacher burn out rate was zero, and the absenteeism rate in ES classes was almost zero.

REFERENCES:

1. Anderson E: The Code of the Street: Decency, Violence, and the Moral Life of the Inner City. New York, W.W. Norton & Co., 1999.
2. Comer J, Hill H: Social policy and the mental health of black children. J Am Acad of Child Psychiatry 1985; 24:175–181.

Innovative Program 15 Saturday, October 28 8:00 a.m.-9:30 a.m.

PSYCHOLOGICAL DISTRESS OF HOMEBOUND AIDS PATIENTS

Lawrence B. Jacobsberg, M.D., Ph.D., *Team Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York, 220 East 63rd Street, New York, NY 10021*; Thomas Laverack, C.S.W., *Program Coordinator, Community Mental Health Service, Visiting Nurse Service of New York, 2170 McDonald Avenue, Brooklyn, NY 11223*; Karen Decher, M.S.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the symptoms of psychological distress in AIDS/HIV patients and plan effective treatment strategies for the home care setting.

SUMMARY:

Patients with HIV/AIDS are often homebound as a result of their illness. The Visiting Nurse Service of New York supports HIV-Mental Health Consultation Teams, to provide consultation and liaison to the medical home care services of these patients.

Reason for referral varies, but includes acute stress of medical illness, as well as chronic psychosocial problems. Each necessitates different modifications to the patient's treatment plan. Managing the physical environment can address concrete issues, while manipulating the psychosocial environment with supportive individual or family psychotherapy is useful to address psychological issues such as secondary depression. Psychotropic medications are sometimes prescribed, but in the bulk of cases, the focus is on psychosocial interventions.

The psychological distress of referred patients was evaluated both at intake and following intervention for the approximately 100 patients seen over a one-year period. The Brief Symptom Inventory was administered to evaluate distress and psychopathology. Quality of life in several domains was evaluated by the treating clinician. The effects of intervention were assessed after accounting for the impacts of antiretroviral therapy, psychosocial support, and constitutional vulnerability.

By engaging a varied audience of caregivers, each of whom has unique clinical experiences, the presentation will expand the treatment repertoires of all participants.

REFERENCES:

1. Grassi L, Rigm R, Makoui S, et al: Illness behavior, emotional stress and psychosocial factors among asymptomatic HIV-infected patients. Psychother Psychosom 1999; 68: 31–8.
2. Judd FK, Cockram A, Mijch A, McKenzie D: Liaison psychiatry in an HIV/AIDS unit. Aust NZ J Psychiatry 1997; 31: 391–7.

INNOVATIVE PROGRAMS: SESSION 6 LEGAL AND FORENSIC ISSUES

Innovative Program 16 Saturday, October 28 10:00 a.m.-11:30 a.m.

PROJECT LINK: PREVENTING INCARCERATION OF ADULTS WITH SEVERE MENTAL ILLNESS

J. Steven Lamberti, M.D., *Associate Professor of Psychiatry, Strong Ties, University of Rochester, and Director of Project Link, 1650 Elmwood Avenue, Rochester, NY 14620*; Robert L. Weisman, D.O., *Assistant Professor of Psychiatry, University of Rochester, and Co-Director of Project Link, 1650 Elmwood Avenue, Rochester, NY 14620*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to identify risk factors for incarceration of persons with severe mental illness, recognize the importance of assertive outreach, cultural competence, and service integration in preventing jail and hospital recidivism, and describe the development and operation of Project Link.

SUMMARY:

Jails and prisons have become a final destination for persons with severe mental illness in America. Addiction, homelessness, and cultural barriers have contributed to the problem and have underscored the need for new service delivery approaches. This presentation will discuss Project Link, recipient of the American Psychiatric Association's 1999 Gold Achievement Award. Project Link is a university-led consortium of community agencies that spans health care, social service, and criminal justice systems. A board of director-level representative from each of the community agencies oversees the project. Project Link features a mobile treatment team with a forensic psychiatrist and culturally diverse case advocates, a dual-diagnosis residence, and integration with the criminal justice system. The goal of Project Link is to prevent jail and hospital recidivism among multicultural populations with severe mental illness through outreach and linkage with community services.

This presentation will discuss risk factors for incarceration among the severely mentally ill and the development and operation of Project Link. Results of a recent program evaluation of Project Link will also be discussed. This lecture will be of interest to all mental health professionals working with severely mentally ill persons, as well as mental health administrators and policy makers.

REFERENCES:

1. Lamberti JS, Weisman RL, Schwarzkopf SB, Mundondo-Ashton R: Prevention of jail and hospital recidivism among outpatients with schizophrenia. Schizophrenia Research 1999; 36: 344.
2. Torrey EF: Out Of The Shadows: Confronting America's Mental Illness Crisis. New York, NY, John Wiley and Sons, 1997.

Innovative Program 17 Saturday, October 28 10:00 a.m.-11:30 a.m.

ETHICAL DILEMMAS IN ASSERTIVE COMMUNITY TREATMENT

Jeffrey G. Stovall, M.D., *Assistant Professor of Psychiatry, University of Massachusetts and Medical Director, Outpatients Services, Community Healthlink, 72 Jacques Avenue, Worcester, MA 01610*; Eileen C. Reilly, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the unique ethical issues that arise in assertive community treatment and understand how staff address those dilemmas in the context of providing treatment.

SUMMARY:

Programs for Assertive Community Treatment (A.C.T) have become the standard of care for providing community-based services to individuals with severe and persistent mental illness. Envisioned to overcome fragmented systems of care, A.C.T. teams provide continuous, intensive, and persistent treatment aimed at providing seriously ill individuals with a higher quality of life.

While the clinical outcomes of A.C.T. programs are well studied and discussed, ethical issues unique to A.C.T. are less well reviewed. This presentation will use the accepted foundations of ethical treatment: nonmalfeasance, beneficence, justice, and respect for autonomy—to explore possible intrusions associated with A.C.T. In particular, the presenter will discuss issues of coercion and paternalism and use case examples to stimulate discussion among the participants. Finally, the presenter will discuss the emergence of A.C.T. in the context of limited resources for providing treatment for individuals with serious and persistent mental illness.

TARGET AUDIENCE:

Participants who work in community settings or who administer or regulate services in the community.

REFERENCES:

1. Dennis DL, Monaham J: Coercion and Aggression Community Treatment: A New Frontier in Mental Health Law. New York, Plenum Press, 1996.
2. Geller JL: Rights, wrongs, and the dillema of coerced community treatment. American Journal of Psychiatry 1986; 143:1259–1263.

Innovative Program 18 Saturday, October 28 10:00 a.m.-11:30 a.m.

ISSUES IN COMPETENCE ASSESSMENTS FOR DEFENDANTS WITH MENTAL RETARDATION

Michael A. Bluestone, Ph.D., *Department of Psychology, Southern Maryland Regional Office, Developmental Disabilities Administration, 312 Marshall Avenue, Laurel, MD 20707*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to perform competency assessments for defendants with mental retardation and demonstrate understanding of issues involved with this population.

SUMMARY:

Recently, professionals have been paying increasing attention to the issue of competency to stand trial for defendants with mental retardation and other developmental disabilities. While these individuals may understand the gist of the proceedings or bits and pieces, they may not have a rational and factual understanding of the nature and object of the proceedings and may not be able to assist in their own defense. Twelve defendants with a diagnosis of mental retardation were administered the CAST-MR (Competence Assessment for Standing Trial for Defendants with Mental Retardation) as part of a pretrial screening process. Seven of the defendants fell below the norms for competency and were found not competent to stand trial based on a comprehensive assessment. Four of the defendants scored above the norms and were found competent. One of the 12 defendants was restored to competence prior to standing trial using competency training (i.e., role playing). These findings further validate the use of the CAST-MR with defendants with mental retardation. The target audience for this innovative program is professionals involved in competency assessments of defendants with developmental disabilities. Basic legal concepts are required background.

REFERENCES:

1. Dove D: Competency to stand trial of criminal defendants diagnosed as mentally retarded—modern cases. Lawyers Cooperative Publishing Co., 1999, 3–69.
2. Ellis, Luckasson R: Mentally retarded criminal defendants. The George Washington Law Review 1985; 53: 414–493.

Lecture 1 **Wednesday, October 25**
8:00 a.m.–9:30 a.m.

AFTER ALL THESE YEARS: RISK FACTORS FROM THE TEXAS JAIL SUICIDE PROJECT

Michael R. Arambula, M.D., *Clinical Associate Professor and Director, Psychiatry and Law Section, University of Texas Health Science Center, San Antonio, 14800 U.S. 281 North, # 110, San Antonio, TX 78232*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to recognize suicide risk factors in the community setting, recognize suicide risk factors in the correctional setting, and recognize liability parameters in the correctional setting.

SUMMARY:

The incidence of completed suicides in jails has been historically higher than what occurs in the community. Over the years and as a consequence of deinstitutionalization, there has been an increasing population of mentally ill offenders in our jails and prisons—now recognized as the largest state hospitals in our communities. The corrections literature identifies suicide risk factors that have been stable through the 1970s and 1980s. However, and with the more recent criminalization of our mentally ill, we explored whether those suicide risk factors are as stable as before. We reviewed jail administrative records; demographic, psychiatric, and criminological variables for all suicide completers in Texas jails over the past eight years. We also compared our findings with a retrospective control group of nonsuicide completers. Our results will shed light on how social policy affects suicide risk factor assessment at the time of jail booking.

REFERENCES:

1. Hages L: Suicide prevention in correctional facilities: an overview, in Clinical Practice in Correctional Medicine. Edited by Puisis M. pp. 245–58, Mosby, 1998.
2. Cohen F: Suicide, in The Mentally Disordered Inmate and the Law, 14-1-32, Civic Research Institute pp. 14-1-32, 1998.

Lecture 2 **Wednesday, October 25**
10:00 a.m.–11:30 a.m.

PSYCHIATRISTS AND LEADERSHIP: LESSONS LEARNED

Carolyn B. Robinowitz, M.D., *Dean, Georgetown University School of Medicine, 7204 Helmsdale Road, Bethesda, MD 20817-4624*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture the participant should be able to identify skills, behaviors, and knowledge needed by women leaders to be successful in their tasks.

SUMMARY:

Abstract: This presentation will address the factors that influence performance in various leadership functions, based on students from the business and legal as well as medical and psychological literature. Included will be styles of leadership and relationships with male and female colleagues at all levels. Issues for women "at the top" as well as in more subordinate positions will be elaborated. Case-based examples both from the literature and from the presenter's experience both in leadership and as a therapist will provide illustrations. An analysis of successes and problems will lead to a statement of principles.

REFERENCES:

1. Women in Science: Meeting Career Challenges. Edited by Pattatucci A. Sage Publications, pp. 1–304, 1998.
2. Valian V: Why So Slow? The Advancement of Women. Cambridge, MIT Press, pp. 1–404, 1998.
3. Eisenhart M, Finkel E: Women's Science: Learning and Succeeding from the Margins. Chicago, University of Chicago Press, 1999.
4. Myerson D, Fletcher J: Harvard Business Review, Jan-Feb, 2000.

Lecture 3 **Wednesday, October 25**
1:30 p.m.–3:00 p.m.

APA'S ADVOCACY AGENDA: STRATEGY AND TACTICS

Steven M. Mirin, M.D., *Medical Director, American Psychiatric Association, 1400 K Street N.W., Washington, DC 20005*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, attendees will have a comprehensive understanding of the forces that currently impede patients' access to timely and appropriate mental health care and APA's strategic goals and the strategies and tactics the Association is using to achieve these goals.

SUMMARY:

The last two decades have seen enormous advances in our understanding of the pathogenesis of mental disorders, and there have been significant improvements in our ability to care for our patients. Yet as we begin the new millennium, access to quality care for patients with

mental disorders is still hampered by stigma, cost-containment pressures, and the inertia of policymakers in addressing this issue. Looking to the future, professional associations, advocacy groups, and others will need to focus and intensify their efforts to extend care to the millions of our citizens who need it. Doing so will require analysis and dissemination of data on the efficacy of specific treatments, the cost-effectiveness of quality care, and the cost-offsets associated with timely and appropriate treatment to key audiences including insurers, managed care organizations, employers, legislators, and the general public. This lecture will focus on these and other APA strategies and tactics in implementing this policy agenda.

REFERENCES:

1. Mechanic D, McAlpine DD: Mission unfulfilled: potholes on the road to mental health parity. Health Affairs, 1999; 18:7–19.
2. Frank RG, McGuire TG, Normand SLT, Goldman HH: The value of mental health care at the system level: the case of treating depression. Health Affairs, 1999; 18:71–86.

Lecture 4 **Thursday, October 26**
8:00 a.m.–9:30 a.m.

ACCESS TO CARE: A CHALLENGE TO PUBLIC SECTOR PSYCHIATRY

Pedro Ruiz, M.D., *Professor and Vice Chair for Clinical Affairs, University of Texas Health Science Center, 1300 Moursund Street, Houston, TX 77030-3406*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participants will better understand the problems facing psychiatric patients in the public sector with respect to their access to health/mental health care. Additionally, they will learn how to improve access to health/mental health care and will gain sensitivity vis-à-vis the barriers to quality health/mental health care that currently exist in our health care system.

SUMMARY:

Concerns about access to psychiatric and medical services in the public sector are not new. Actually, the Medicare and Medicaid programs were instituted in 1965 with the intention of improving access to health/mental health care among the poor and disadvantaged populations of the United States. Unfortunately, however, 35 years later the level of access to health/mental health services in this country is worse than in 1965. Currently, there are close to 50 million Americans who do not have health insurance coverage. In the 1980s some new initiatives, such as the expansion of the Medicaid program and the formation of state health insurance pools, were developed. These initiatives, however, were not able to resolve the uninsurance crisis that is currently facing this nation. Needless to say, the majority of persons affected by this lack of access to health/mental health care receive their health and mental health services in the public sector, and they are primarily composed of poor and disadvantaged persons, most of whom belong to the ethnic minority groups who reside in this country. In this lecture, the population affected will be described, the neglected health/mental health services areas will be identified, and new initiatives designed to resolve this serious health/mental health care problem will be advanced.

REFERENCES:

1. Ruiz P: Access to health care for uninsured hispanics: policy recommendations. Hospital and Community Psychiatry 1993; 44:958–962.
2. Ruiz P, Venegas-Samuels K, Alarcon RD: The economics of pain: mental health care costs among minorities. Psychiatric Clinics of North America 1995; 18:659–670.

Lecture 5 **Thursday, October 26**
8:00 a.m.–9:30 a.m.

USING THE SURGEON GENERAL'S REPORT ON MENTAL HEALTH

Howard H. Goldman, M.D., Ph.D., *Professor of Psychiatry, University of Maryland School of Medicine, 10600 Trotters Trail, Potomac, MD 20854-4241*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant will learn about the contents of the Surgeon General's report and will learn how to use its courses of action to affect policy.

SUMMARY:

The publication of the Surgeon General's Report on Mental Health in late 1999 created an opportunity for mental health advocacy. It is also expected to reduce the stigma associated with mental illness. The principal objective of the report is to inform the public of the body of scientific evidence revealing increased understanding of mental disorders and supporting the effectiveness of a range of treatments and supportive services. It also identifies limitations in our knowledge, our mental health and social welfare policies, and in access to mental health services. The report does not make policy recommendations, but Chapter 8 identifies eight "courses of action" to successfully implement the opportunities created by advances in the science of mental health. It is

expected that others will use the evidence in the report to recommend policy.

REFERENCES:

1. U.S. Dept of Health and Human Services: Mental Health: A Report of the Surgeon General Rockville MD, USDHHS, SAMHSA, CMHS, NIMH, 1999.
2. Corrigan PW, Penn DL: Lessons from social psychology on discrediting psychiatric stigma. American Psychologist 1998; 54:765–776.

Lecture 6 **Thursday, October 26**
10:00 a.m.–11:30 a.m.

SCHOOL SAFETY, DANGEROUS PLACES, MORALITY AND CULTURE: AN INTERNATIONAL PERSPECTIVE ON VIOLENCE IN SCHOOLS

Ron A. Astor, Ph.D., *Professor, School of Education and School of Social Work, University of Michigan, 1080 South University, Ann Arbor, MI 48105*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, participants will have an understanding of the major philosophical, programmatic, and conceptual issues underlying current intervention strategies surrounding school violence interventions.

SUMMARY:

In this lecture, I will discuss how social sciences have defined school violence—especially how and when a school is defined as having a school violence problem. I will explore how traditional "psychologically oriented" interventions have targeted students perceived to be "violent" and the very poor outcomes associated with such an approach. In contrast, large-scale research from multiple countries will be used to demonstrate how a broad school-based ecological approach had has produced dramatic results in the reduction of school violence. This lecture will also explore how students, teachers, and principals reason about violent acts, their role(s) regarding the prevention of violence, and their moral judgments regarding both allowing for violence and disallowing various forms of school violence. Cultural, gender, and age variations in reasoning and judgments about violence will be highlighted. Finally, a new mapping/interviewing procedure will be discussed as a method of including school context and generating setting-specific interventions.

Lecture 7 **Thursday, October 26**
10:00 a.m.–11:30 a.m.

IMMIGRATION AND MENTAL HEALTH: AN UPDATE

Javier I. Escobar, M.D., *Professor and Chair, Department of Psychiatry, University Medical and Dental of New Jersey, Robert Wood Johnson Medical School, 314 Sayre Drive, Princeton, NJ 08540-5872*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant will review research findings examining the relationship between immigration and psychopathology with a focus on Mexican-Americans, offer plausible explanations for the paradoxical findings, and outline practical implications of these data.

SUMMARY:

The mental health consequences of migration have been debated in American psychiatry since the end of the 19th century. Most studies emphasized the social, economic, political, and health-related disadvantages of recent immigrants, and touted "Americanization" as the key salubrious influence that would eventually dispel most of the immigrants' disadvantages. However, data emerging from new research on Mexican Americans have come to challenge the old idea that immigrants are necessarily disadvantaged.

In this presentation, I will summarize results of several recent studies focusing primarily on immigrants from Mexico showing that despite socioeconomic disadvantages, these immigrants have significantly lower prevalence rates for most psychiatric disorders examined. The advantages of immigrants appear also to extend to other health indexes such as physical functioning, mortality rates, pregnancy outcomes, heart disease, obesity and hypertension. Possible explanations for these advantages favoring Mexican immigrants will be outlined in the discussion.

REFERENCES:

1. Vega WA, Kolody B, Aguilar-Gaxiola S, et al: Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican-Americans in California. Archives of General Psychiatry 1998; 55:771–8.
2. Escobar JI.: Immigration and health: why are immigrants better off?. Archives of General Psychiatry 1998; 55:781–782.

Lecture 8 **Thursday, October 26**
1:30 p.m.–3:00 p.m.

RECOVERY FROM A PSYCHIATRIST'S POINT OF VIEW

Ronald J. Diamond, M.D., *Professor of Psychiatry, Mental Health Center of Dane County, 6001 Research Park Boulevard, Madison, WI 53719-1179*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, participants will have an understanding of some of the different ways the term "recovery" has been used, understand how the concept of recovery can be an effective focus for treatment for persons with serious psychiatric disability, and understand the role of mental health professionals in promoting, or at times interfering with, the recovery process.

SUMMARY:

Recovery is one of the current "buzz words" in psychiatry and psychiatric rehabilitation, but it is often unclear what it means. Recovery is not the same as cure. Cure may not always be possible, but everyone can aspire to having more to life than just illness. Recovery is a process, not a destination. We have learned that many people with a physical disability can have a life that includes work, friends, and most importantly, a sense of self-esteem. What can we do to promote this same sense of recovery among consumers with a psychiatric disability? How can medications be used to promote rather than interfere with recovery. Too often, psychiatrists and mental health professionals are perceived as getting in the way of recovery rather than helping. Consumer surveys have identified a number of factors that seem connected with a person's sense of recovery, including acceptance of illness, taking personal responsibility, learning coping mechanisms, and having support. The most important element supporting recovery is hope; hope that the person can have a real life; hope that things will really get better. This sense of hope is often fragile, and supporting hope may be one of the more important ways that clinicians can promote recovery.

REFERENCES:

1. Ellison M, Russinove Z: A National Survey of Professionals and Managers with Psychiatric Conditions: A Portrait of Achievements and Challenges: 1996–1999
2. Deegan P: Recovery as a journey of the heart. Psychiatric Rehabilitation Journal 1996; 19:91–97.

Lecture 9 **Thursday, October 26**
3:30 p.m.–5:00 p.m.

EVALUATION OF SEXUAL DYSFUNCTION BY PSYCHIATRISTS

Troy L. Thompson II, M.D., *Consultant, APA Institute Scientific Program Committee, and Professor of Psychiatry, Jefferson Medical College, 841 Chestnut Street, Suite 1001, Philadelphia, PA 19107-5005*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to better recognize, diagnose, and treat sexual dysfunction associated with psychiatric conditions and medications.

SUMMARY:

It would be beneficial for many patients if psychiatrists and other physicians conducted an assessment of sexual history and functioning as part of routine evaluations and at least periodically during follow up. Each of the four aspects or phases of sexual functioning (i.e., libido, excitement, orgasm, and resolution) should be assessed, including previous levels of functioning and previous problems and changes in both over time. Discussion of sexual functioning should include facilitating patients to ask questions, which will allow patient education as needed, including to dispel misinformation and myths, which are prevalent in these areas.

It is important to assess the four phases separately because psychiatric and other medical conditions and many medications typically affect the phases differently and a mixture of symptoms (e.g., depression associated with anxiety) may further alter the presentation. The types of sexual dysfunction often caused by common psychiatric disorders and medications will be discussed.

Assessment of sexual functioning may be avoided or minimized because the topic is so personal that a physician may feel some discomfort in directly asking the necessary questions. For example, questions may be asked in such a way and with nonverbal cues from physicians that make an affirmative reply awkward and clearly not what the physician wants to hear, such as, "You aren't having any sexual problems, are you?", as the physician breaks eye contact and looks away. Or a comment rather than a question is sometimes offered, such as: "I assume your sex life is OK". Such oblique approaches make it more difficult for most patients to initiate discussion of sexual concerns and questions they have with their physicians. Also, indirect approaches indicate to patients that their physician is not comfortable in discussing these matters, which may cause the patient to question the physician's competence in evaluating and treating such symptoms and increase the likelihood of non-adherence with further evaluation and treatment efforts.

Sexual functioning also is a sensitive indicator of incipient psychiatric and medical problems and of problems in intimate relationships. Educating patients of the importance of consulting the physician as soon as any negative changes begin in sexual functioning may lead to earlier diagnosis and appropriate intervention. A decrease in sexual functioning may be quite stressful to a partner and, thereby, catalyze further deterioration in the relationship. Also, improving sexual functioning may foster improvement in the relationship with the partner which can have positive psychological effects on both, including more interest in pursuing other treatment recommendations.

REFERENCES:

1. Levine SB: Sexuality in Mid-Life. New York, Plenum Press, 1988.
2. Rothchild AJ: Sexual side effects of antidepressants. J Clin Psychiatry 2000; 61 (suppl 11):28–36.

Lecture 10 **Thursday, October 26**
3:30 p.m.–5:00 p.m.

THE PSYCHIATRIST EXECUTIVE IN THE PUBLIC SECTOR: CLINICIAN ADMINISTRATOR, LEADER, FOLLOWER

A. Anthony Arce, M.D., *Chair, Department of Behavioral Medicine, and Hospital Director, Gerard Medical Center, North Philadelphia Health System, 1416 Academy Lane, Elkins Park, PA 19027-2515*

EDUCATIONAL OBJECTIVES:

At the conclusion ot this lecture the participant should: (1) be familiar with the challenges and stresses of professional transition; (2) identify internal and external boundaries that influence his/her role in the decision-making process; and (3) understand the importance of collaborative relationships to assure quality patient care and program survival.

SUMMARY:

In the wake of the transformation of health care from a "service industry" psychiatric administration today is dominated by professional managers with degrees in hospital, public, or business administration. "Patient care" has been replaced by the "bottom line." Nevertheless, psychiatrists and their professional organizations (APA, AAPA, AACAP) continue to advocate for the importance of a medical background as a critical element in ensuring quality patient care. Most psychiatrists begin as clinicians and gradually move into administrative positions without any formal training. This entails a gradual redefinition of their professional identity with its accompanying anxieties and doubts. The psychiatrist's professional training is an asset in this process, during which a great deal is learned and unlearned. This lecture explores the psychiatrist administrator as a "boundary manager" both internally within the organization and externally with the broader system. This endeavor is mediated through relationships across a complex hierarchical spectrum of diverse personalities. The role is in many ways a balancing act requiring a flexible integration of competing sub-roles as clinician, administrator, leader, and follower.

REFERENCES:

1. Shore MF: Administration and the Third Ear. New DirMent Health Serv 1991; 49:19–29.
2. Keill SL, Arce AA, Mallott DB: Strategies for organizational change, in Textbook for Administrative Psychiatry, edited by Talbott JA APPI, 1992; pp. 117–134.

Lecture 11 **Friday, October 27**
8:00 a.m.–9:30 a.m.

SAFETY, AFFECT REGULATION, GRIEF WORK AND EMANCIPATION: PROMOTING A CULTURE OF RECOVERY

Joseph Foderaro, L.S.W., *Program Director, Sanctuary at Hampton Hospital, 200 Apple Street, Suite 1, Quakertown, PA 18951-1645;* Ruth Ann Ryan, M.S.N., *Program Director, Sanctuary at Horsham Clinic, 200 Apple Street, Suite 1, Quakertown, PA 18951-1645*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, participants should be able to identify the four main elements of the SAGE model and to name one critical component of each of the four elements of SAGE.

SUMMARY:

Clinicians today are faced with the difficult task of managing an ever-escalating presentation of social and behavioral problems with a diminished access to resources allowing them to intervene.

The SAGE Model of Recovery has proven to be an accessible, effective, and efficient framework that can be applied by the client and clinician throughout the course of recovery from trauma. SAGE is an acronym for Safety, Affect Modulation, Grieving, and Emancipation. This model is used in both inpatient and outpatient settings to distill complex theoretical tenets into a practical roadmap that begins with the establishment of basic principles of safety and ends with the individual feeling the empowerment that comes with being emancipated from the tyranny of the past. SAGE does not discriminate between different types of violence. It emphasizes that

harm to self is the same as harm to others, and that the development of nonviolent coping skills empowers the individual towards the effective management of powerful affect. This nonviolent framework thus allows for a safer and healthier movement through issues related to the losses and grief associated with trauma. When violent outcomes are renounced by individuals or societies, healthier and more constructive experiments in conflict resolution are possible.

Clinicians today face the difficult task of managing an ever-escalating presentation of social and behavioral problems with diminished access to resources for intervention. The SAGE model of recovery has proven to be an accessible, effective, and efficient framework, which can be applied by the client and clinician throughout the course of recovery from trauma. This non-violent framework allows for safer and healthier movement through issues related to the lossed and grief associated with trauma.

REFERENCES:

1. Bloom SL: Creating Sanctuary: Towards the Evolution of Sane Societies. New York, Routledge, 1997.
2. Herman JL: Trauma and Recovery. New York, Basic Books, 1992.
3. Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society. Edited by Van der Kolk, BA, McFarlane AC, Weisaeth L. New York, Guilford, 1996.

Lecture 12 **Friday, October 27**
8:00 a.m.–9:30 a.m.

MANAGED CARE IN EUROPE: DIFFERENT ANIMAL, SAME FUR

John A. Talbott, M.D., *Liaison, APA Institute Scientific Program Committee, and Professor of Psychiatry, University of Maryland School of Medicine, 701 West Pratt Street, Room 354, Baltimore, MD 21201-1596*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should understand how managed care is conceptualized and implemented in several European countries.

SUMMARY:

The presentation will discuss the history of the administrative and fiscal development of health, particularly mental health, services in Europe versus the United States. It will then deal with the similarities and differences between "managed care" and "managing care" on both sides of the Atlantic. Finally, it will make some predictions as to future directions for managed and managing care in Europe.

REFERENCES:

1. Talbott JA: Rehabilitation and managed care: how American developments can change European mental health. La Rehabilitacio Psicosocial Integral 1995; 1:80–84.
2. Talbott JA: De La Deinstitutionalization Au "Managed Care": Etude de l'impact aux Etats-Unis des changements economiques sur le traitement des malades mentaux depuis 1950. L'Information Psychiatrique 1997; 8:806–812.

Lecture 13 **WITHDRAWN**

Lecture 14 **Friday, October 27**
10:00 a.m.–11:30 a.m.

PSYCHOTHERAPY IN THE ELECTRONIC WORLD: AN HISTORICAL PERSPECTIVE

Ian E. Alger, M.D., *Multimedia Consultant, APA Institute Scientific Program Committee, and Clinical Professor of Psychiatry, New York Presbyterian Hospital-Cornell Medical Center, 500 East 77th Street, New York, NY 10162-0025*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant will have an increased awareness of the complexity of elements involved in human communication and will understand the challenges in effectively transmitting these communication elements through electronic media. The attendee will also have an increased understanding of the role of empathy in human communication as well as an awareness of the role of nonverbal communication within an existential philosophic framework.

SUMMARY:

Since the 1960s electronic recordings of both sound and pictures have been used in a wide variety of therapeutic approaches, and the evolution of some of these technologies in the presenter's own professional experience will be demonstrated. With videorecordings, patients have the opportunity to follow Burns' admonition to "See themselves as others see them." Video playback has been used in group and marital as well as in individual communication, and in enhancing behavior modification approaches. With the introduction of virtual reality, even more novel therapeutic experiences have become possible, and special behavioral therapies are now used to treat phobias, post traumatic distress disorders, and to provide distraction through psychodramatic and virtually enhanced techniques designed, for example, to diminish the pain felt so severely by patients undergoing burn-wound treatment.

The future holds even more promise with the introduction of "distance learning and therapy" and with remote-controlled complex interactions, such as "distance-surgery" being developed through the Mars Project. Elements of this latter project will be demonstrated, as man prepares to travel to the planets while retaining a complex relationship with the world of our everyday experiences.

REFERENCES:

1. Alger I: Therapeutic use of video playback. Journal of Nervous and Mental Disease 1969; 148:430–436.
2. Alger I: Telemedicine: a personal journey, in Medicine Meets Virtual Reality. Edited by Hoffman HM, Stredney D, Weghorst SJ. IOS Press and Ohmsha, 1998.

Lecture 15 **Friday, October 27**
10:00 a.m.–11:30 a.m.

AMERICAN PSYCHIATRY AND PEOPLE OF COLOR: CHALLENGES FOR THE 21ST CENTURY

Altha J. Stewart, M.D., *Detroit-Wayne County Community Mental Health, 640 Temple, 8th Floor, Detroit, MI 48201*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to recognize the impact of racism on the practice of psychiatry in America, the complex dynamic of institutional racism and its influence on the practice of American psychiatry, and the consequences of psychiatry's continued lack of attention to the unique needs of black patients.

SUMMARY:

Psychiatry now treats a greater number of blacks than ever before. Racism has promoted two basic themes related to blacks—they are born with inferior minds and are abnormal because they are not like whites. The period between the abolishment of slavery and the start of the civil rights movement includes many examples of the use of psychological theories to support the unique system of institutionalized racism and discrimination found in the U.S. Behavior once defined as pathological must be viewed through filters with the real conditions facing the patient. Psychiatrists of color have long recognized that racism deprives black patients of the full range of treatment available due to stereotypical beliefs about their psychological preparedness. The role psychiatry continues to play in the dynamics of racism and its effect in both the black and white communities heads the list of problems to be examined in the 21st century.

REFERENCES:

1. Sabshin M, et al: Dimensions of institutional racism in psychiatry. American Journal of Psychiatry 1970; 127:787–793.
2. Jones B, Gray B: Black and white psychiatrists: therapy with blacks. Journal of National Medical Association 1985; 77:9–13.

Lecture 16 **Friday, October 27**
1:30 p.m.–3:00 p.m.

THE POLITICS OF PSYCHIATRY AND THE PSYCHIATRY OF POLITICS: REFLECTIONS ON A YEAR IN THE SENATE

David A. Pollack, M.D., *Associate Professor of Psychiatry, and Associate Director, Public Psychiatry Training Program, Oregon Health Sciences University, 3181 S.W. Sam Jackson Park Road, Portland, OR 97201*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant will be able to increase awareness of the political and policy issues associated with mental health and substance abuse needs and services, especially at the federal level; to identify some of the parallels between working in the legislative arena of Congress and doing community-based consultation; to encourage mental health professionals to consider active participation in health policy processes as an appropriate extension of their clinical and administrative missions.

SUMMARY:

Very few psychiatrists and mental health professionals have had the opportunity to participate in the inner workings of the legislative or even regulatory arenas, especially at the federal level, even though these entities have direct and significant impacts on such providers and their patients. Dr. Pollack will describe some of his experiences associated with being a Robert Wood Johnson Health Policy Fellow in 1999. These included exposure to the health policy community both within and outside the government, activities as a legislative aide in a senior Senate office, and opportunities to participate in the development of laws relating to mental health and substance abuse issues. The lecture will also identify how being a community psychiatrist can be used effectively in working in such an environment: consultation skills and psychological insights can be important Congressional resources.

REFERENCES:

1. Lewin ME Lipoff, E (Eds): Information Trading: How Information Influences the Health Policy Pro-

cess. National Academy Press, Washington, DC 1997.
2. Smith H: The Power Game: How Washington Works. Ballantine, New York, 1988.

Lecture 17 **Friday, October 27**
3:30 p.m.–5:00 p.m.

ADDICTION AND RESPONSIBILITY

Richard J. Bonnie, L.L.B., *John S. Battle Professor of Law, and Director, Institute of Law, Psychiatry, and Public Policy, University of Virginia, 580 Massie Road, Charlottesville, VA 22903-1789*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to explore ethical and legal concepts of responsibility in relation to addiction.

SUMMARY:

Taking as its starting point the now-axiomatic characterization of addiction as a "brain disease," this lecture explores the implications of recent developments in neuroscience for the concept of responsibility. The terrain will be divided into three parts: responsibility for becoming addicted; responsibility for behavior symptomatic of addiction; and responsibility for amelioration of addiction. In general, the lecture will defend the thesis that recent scientific developments have sharpened but not erased traditional understandings in the first two areas, while recent legal developments have exposed new and intriguing theories of responsibility for amelioration of addiction that may also have implications for other chronic relapsing disorders.

REFERENCES:

1. Leshner AI: Addiction is a brain disease, and it matters. Science 1997; 278:45–47.
2. Satel SL, Goodwin FK: Is Addiction a Brain Disease? Washington, D.C. Ethics and Public Policy Center, 1998.

Lecture 18 **Saturday, October 28**
8:00 a.m.–9:30 a.m.

WHAT CAUSES HOMOSEXUALITY AND WHY DO PATIENTS AND THERAPISTS WANT TO KNOW?

Jack Drescher, M.D., *Supervising Psychoanalyst, William Alanson White Institute, and Clinical Assistant Professor of Psychiatry, State University of New York, Brooklyn, New York, 420 West 23rd Street, Apt. #7-D, New York, NY 10011-2174*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, participants will not only have some familiarity with a wide range of theories that purport to explain the origins of homosexuality, they will also learn how these theories have a psychological impact on gay patients.

SUMMARY:

This lecture examines homosexuality's etiological theories from three perspectives. First it explains how theories make use of unidimensional, stereotypical constructs of homosexuality. Although many theories are often framed in the debate between "nature versus nurture," when the unproven assumptions and inarticulated beliefs of this dichotomy are brought into clearer focus, opposing arguments surprisingly line up on the same side.

The second perspective illustrates the unproven assumptions used in narratives of immaturity, pathology, and normal variants. These etiological narratives resemble creation stories. They also raise several questions: How does one's place in the developmental line relate to one's place in a hierarchy? Who decides which positions are better or worse? How do individuals or cultures decide which values go into making these decisions?

Finally, upon recognizing the forms that theories of immaturity, pathology, and normal variation can take, some of the moral lessons embedded in each of them become clearer.

REFERENCES:

1. Byne W, Parsons B: Human sexual orientation: the biologic theories reappraised. Arch Gen Psychiat 1993; 50:228–239.
2. Drescher J: Psychoanalytic Therapy and The Gay Man. Hillsdale, NJ, Analytic Press, 1998.

Lecture 19 **Saturday, October 28**
8:00 a.m.–9:30 a.m.

BIOLOGY OF PERSONALITY DISORDERS: THE MOLECULES OF CHARACTER

Kenneth R. Silk, M.D., *Associate Professor and Associate Chair, Department of Psychiatry, University of Michigan Health System, 3935 Waldenwood Drive, Ann Arbor, MI 48105*

EDUCATIONAL OBJECTIVES:

At the conclusion of the lecture, participants should have knowledge of (1) recent biological research in the arena of personality disorders, (2) how biological mechanisms are thought to underlie certain dimensions of behavior prevalent among patients with personality disor-

ders, and (3) how these biological understandings can inform decisions about specific pharmacologic agents in the treatment.

SUMMARY:

Over the last 10–15 years biological studies and theories with respect to the processes that underlie the development of personality disorders (nature) have emerged to challenge prior considerations of personality disorders as purely environmental (nurture) in origin. A review of these studies begins with defining dimensions of behavior and their relationship to neurotransmitters, travels through neuroimaging and structural brain chemistry, and ends with sophisticated studies at the molecular level of the gene. These advances are reviewed and placed in the context of overall treatment approaches, both psychopharmacologic as well as psychotherapeutic, to patients with personality disorders. We have only begun the process of isolation and consideration of certain biological mechanisms active in the development of personality disorders. Future understanding of the biological basis of personality disorders can lead to the development of more specific and effective treatments for this large group of patients whose current treatment remains fraught with frustrating limitations.

REFERENCES:

1. Siever LJ, Davis KL: A psychobiological perspective on the personality disorders. Am J Psychiatry 1991; 148:1647–1658.
2. Silk KR: Biology of Personality Disorders. Washington, DC, American Psychiatric Press, 1998.

Lecture 20 **Saturday, October 28**
10:00 a.m.–11:30 a.m.

A CONCISE GUIDE TO THE IDENTIFICATION OF WORKING THROUGH IN PSYCHODYNAMIC PSYCHOTHERAPY

J. Mark Thompson, M.D., *Assistant Clinical Professor of Psychiatry, UCLA, Neuropsychiatric Institute, and Assistant Director of Education, Los Angeles Psychoanalytic Institute, 11600 Wilshire Boulevard, Suite 500, Los Angeles, CA 90025-1733*

EDUCATIONAL OBJECTIVE:

At the conclusion of this lecture, participants should be able to understand the elements of the working-through process and how this subject can be taught.

SUMMARY:

The identification of the working-through process is often seen as abstract and difficult to understand by beginning therapists. By breaking the elements of a working-through process into small, observable elements, which can be related to not just as psychotherapy process but also to life experience, the identification of the small steps of a working-through process, on a session-by-session basis becomes possible for the beginning therapist. Some of the elements include the identification of "new" emotions, recollection of memories, continuity with the past, mourning processes (including mourning of the past, loss secondary to pathology, loss of previous sense of self), transference evolution, existential crisis, perception of others, and true self false self-paradigm.

REFERENCES:

1. Ernst K: The recovery of childhood memories in psychoanalysis. Psychoanal. St Child, 1956; 11:54–88.
2. Winnicott DW: Ego distortion in terms of true and false self, in The Maturational Processes and the Facilitating Environment. International Universities Press, Inc., New York, pp. 140–152, 1965.

Lecture 21 **Saturday, October 28**
10:00 a.m.–11:30 a.m.

EYES WIDE SHUT: ADVOCACY ADVENTURES

National Allieance for the Mentally Ill

Laurie M. Flynn, *Executive Director, National Alliance for the Mentally Ill, Colonial Place Three, 2107 Wilson Boulevard, Suite 300, Arlington, VA 22201-3042*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should have a greater knowledge of grass roots advocacy; in particular, policy development, policy implementation and the ongoing positioning of the organization and its mission. They will have knowledge of NAMI's advocacy stance and tactics, which have at times been controversial, yet have met with strong success.

SUMMARY:

A career in grass roots advocacy teaches many lessons. Policy development is only the beginning. The real test of effectiveness is policy implementation and the ongoing positioning of the organization and its mission. In over 15 years as executive director of NAMI, I have found that many of the old rules don't work very well. Conventional wisdom inside the beltway stresses the importance of working within coalitions and seeing victory as an incremental process. That may indeed be effective for some organizations, but it has not been my core strategy as a NAMI leader. Whether the issue was

returning NIMH to NIH, legislating parity coverage for severe mental illness, or strengthening protections for human subjects in research, NAMI has led boldly. Often our stance and our tactics have been controversial, yet our advocacy has meet with strong success. I will share the philosophical and political underpinnings of NAMI's policy and strategy and describe the role of the board of directors and membership. In looking at several case examples, I will attempt to illustrate how and why NAMI's issues have risen to prominence. Our tactics and targets combine to set an agenda for policymakers that consistently assigns priority to people with severe mental illnesses and their caregiving families. I will conclude with a candid appraisal of the relationship between NAMI and organized psychiatry and a preview of issues on the horizon.

REFERENCES:

1. Leafley HP, Johnson DL: Famailies as Allies in Treatment of the Mentally Ill, New Directions for Mental Health Professionals. Washington, D.C., American Psychiatric Press, Inc., 1990.
2. Burland, J: NAMI Family to Family Education Program, 1997.

Lecture 22 **Saturday, October 28**
1:30 p.m.–3:00 p.m.

PSYCHIATRY AND PUBLIC HEALTH IN AMERICA: A TIME FOR REVOLUTION

National Mental Health Association

Michael M. Faenza, M.S.S.W., *Consultant, APA Institute Scientific Program Committee, and President and Chief Executive Officer, National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314-2971*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to give participants an overview of policy and service system changes in community mental health services in the United States during the last 30 years, to offer participants a critical analysis of the gains and failures of current approaches to articulating the role of mental health services and priority issues to the American public and policy makers, to offer participants an alternative perspective on increasing economic and political support for improvements in access and quality of behavioral health services, and to offer participants ideas about the leadership role of organized psychiatry in promoting increases success in making "community mental health" central to all public health issues and endeavors in the United States.

SUMMARY:

In 2000, more than 30 years after deinstitutionalization and the development of community mental health centers, access to quality medical and rehabilitation services for people with major mental illness is the exception, not the rule. Modern psychiatry, and the other economic, political and moral interests that care about mental health services in America, face a continuation of a now decades-old conundrum. Stigma surrounding people with mental illnesses and their families, discrimination in health insurance and employment, and underfunded and often fragmented public mental health structures and services loom large on the mental landscape in the United States.

It would obviously be poor social policy and even immoral for public mental health policy makers, administrators, and professional practitioners to steer away from serving people most immediately in need of services. However, what is called for is a new balance in mental health advocacy and national dialogue that is inclusive of a much wider array of public interests represented within populations and professional activities of psychiatry and other mental health endeavors. There needs to be a more pervasive effort to focus public attention and public policy on the prevention, ttreatment, and rehabilitation needs of a much broader group of Americans. Without this, we will not be able to create the moral, economic, and political imperative necessary to make behavioral health central to all public health endeavors in the nited States.

REFERENCES:

1. Surgeon General's Report on Mental Health.
2. Public Mental Health Leaders in Transition: A Report on National Summit for Chairs of Departments of Psychiatry. State Mental Health Program Directors and Consumer Advocates Producerd by: National Mental Health Association; National Association of State Mental Health Program Directors; and American Association of Chairmen of Departments of Psychiatry.

Lecture 23 **Saturday, October 28**
1:30 p.m.–3:00 p.m.

SEXUAL TRAUMA IN WOMEN: CLINICAL TREATMENT ISSUES

Marian I. Butterfield, M.D., M.P.H., *Director, Women's Mental Health Program, Durham VA Medical Center, and Assistant Clinical Professor of Psychiatry and Behavioral Medicine, Duke University Medical Center, 508 Fulton Street, Durham, NC 27705-3875*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to recognize the prevalence and clinical presentation of a history of sexual trauma; to review the psychiatric diagnostic and treatment issues that arise in working with women who have survived sexual trauma; and to understand a treatment framework, including pharmacotherapy and psychotherapy, for women who have survived sexual trauma.

SUMMARY:

Sexual trauma in women is disturbingly common. Sexual trauma can happen at any time across the lifecycle, and impact on mental and physical health. Women with a history of victimization commonly present to psychiatrists and other mental health professionals for help. Because of the adverse mental and physical health effects of sexual trauma, clinicians working with women must have an understanding of how sexual trauma can impact on a women's clinical presentation, coping skills, mental disorder symptoms, and the clinical strategies needed to treat her. This lecture will present an assessment and treatment framework that includes both pharmacotherapy and psychotherapy for clinicians working with women who have survived sexual trauma. Pharmacotherapy for the treatment of posttraumatic stress disorder related to sexual victimization will be discussed. Individual and group therapy models of treatment will be reviewed. Common clinical pitfalls that arise in working in the area of sexual trauma treatment will also be discussed.

REFERENCES:

1. Butterfield MI, Panzer PG, Forneris CA: Victimization of women and its impact on assessment and treatment in the psychiatric emergency setting. Psychiatr Clin N Am 1999; 22:875–896.
2. Butterfield MI: Sexual trauma in women: mental health role in responding to the challenges. Fed Pract Suppl 1998; 15:10–15.

Lecture 24 **Saturday, October 28**
3:30 p.m.–5:00 p.m.

INTROSPECTION, ANXIETY AND THE MIND-BODY PROBLEM, OR WHY PSYCHIATRY NEEDS PSYCHOTHERAPY?

Elio J. Frattaroli, M.D., *Assistant Clinical Professor of Psychiatry, University of Pennsylvania, 168 Gramercy Road, Bala Cynwyd, PA 19004-2905*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture the participant should be able to understand how philosophical assumptions influence psychiatric theory and practice; for instance, the assumption that anxiety and depression are neurochemical disorders rather than fundamental human experiences, genetic defects rather than genetic adaptations; to understand how scientific research has been misinterpreted as having proven what are really the unprovable philosophical assumptions on which the research was originally based; and to understand that the root meaning of the term psychiatry is "healing the soul" and that in limiting ourselves to medicating the brain psychiatrists are failing in their primary mission.

SUMMARY:

Over the last quarter century there has been a dramatic erosion of psychotherapeutic training and practice in psychiatry, caused largely by a change in our philosophical beliefs. Psychopharmacology has replaced psychotherapy because brain has replaced soul—i.e., chemical imbalance has replaced inner conflict—as the philosophical basis for psychiatric explanation. We no longer consider it important to trouble ourselves with the inner lives of our patients—the nuances of thought, feeling, impulse, and imagery in their minds and souls. We consider these private experiences that are of such deep concern to our patients to be largely irrelevant to their symptoms and personality problems, which we believe are caused directly by chemical imbalances in the brain. This dehumanizing materialist philosophy reflects a crisis not only in psychiatry, but in the culture as a whole. We are all too eager for quick fixes and facile explanations that allow us to evade the fundamental anxiety of the human condition. If psychiatry is to survive and fulfill its proper mission of healing the soul, then we need to re-evaluate our philosophical assumptions and reclaim as our primary focus the inner lives of ourselves and our patients.

REFERENCES:

1. Styron W: Darkness Visible: A Memoir of Madness. New York, Random House, 1990.
2. Stoller R: Psychiatry's mind-brain dialectic, or the Mona Lisa has no eyebrows. American Journal of Psychiatry 1984; 141:554–558.

Lecture 25 **Saturday, October 28**
3:30 p.m.–5:00 p.m.

YOUTH VIOLENCE: PREVENTION AND COMMUNITY ACTION

Paul J. Fink, M.D., *Professor of Psychiatry, Temple University School of Medicine, and Past President, American Psychiatric Association, One Belmont Avenue, Suite 523, Bala Cynwyd, PA 19004-1608*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, the participant should be able to teach the methods for prevention of youth violence and to show how to implement them; to give a clear understanding of the extent of youth violence in society; and to explain the need for communication, cooperation, and collaboration among agencies in order to effect true intervention and prevention methods.

SUMMARY:

This lecture on youth violence will try to demonstrate that it is possible to get communities to pull together and implement successful methods of prevention and intervention of youth violence using the Philadelphia Interdisciplinary Youth Fatality Review Team (PI-YFRT) and the Middle School Summit Project efforts to demonstrate some of the key markers in young children that lead to extensive youth violence, murdering, or being murdered. Following the motivation to identify at-risk children early, the paper will outline the special needs of children who ultimately end up being difficult adolescents who use violence as their only mechanism for dealing with life stressors. Topics such as truancy control, suspensions, bullying, dealing quickly with witnesses of violence, and using the existing resources to address the needs of troubled children will be emphasized. Finally, the approach of parenting education as the single most important primary prevention tool for youth violence will be explicated.

REFERENCES:

1. Miedzian M: Boys Will Be Boys. New York, Doubleday, 1991.
2. Straus MA: Beating The Devil Out Of Them. New York, Lexington Books, 1994.
3. McCall N: Makes Me Wanna Holler. New York, Random House, 1995.

Lecture 26 **Sunday, October 29**
10:00 a.m.–11:30 a.m.

HERBACEUTICALS IN PSYCHIATRY

Sally Guthrie, Pharm.D., *Associate Professor of Pharmacy, and Department of Psychiatry, University of Michigan Medical School, 428 Church Street, Ann Arbor, MI 48109-1065*

EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture the participant should be able to learn which herbal therapies are being used by Americans for the treatment of depression, anxiety, memory problems, or weight loss; to evaluate the evidence for efficacy of herbal treatments of depression, anxiety, memory problems, or weight loss; and to understand the extent of available information regarding drug-herbal interactions and the side effects of herbal therapies used to treat psychiatric disorders.

SUMMARY:

This presentation will explore some of the reasons why herbal remedies have become so popular in the United States. The differences in the designation of a drug versus a nutritional supplement will be discussed. Additionally, some of the more toxic herbals will be listed, as well as some useful herbals that have been used as over-the-counter products in this country for many years. The presentation will then proceed to a more in-depth discussion of some of the most popular herbal remedies for psychiatric disorders including St. John's wort, gingko biloba, valerian root, kava kava, and herbal weight-loss products. The evidence regarding efficacy, side effects, and drug interactions will also be presented.

REFERENCES:

1. Ernst E: Second thoughts about the safety of St. John's wort. Lancet 1999; 354:2014–6.
2. Miller LG: Herbal medicinals. Arch Intern Med 1998; 158:2200–11.

Medical Update 1 **Wednesday, October 25**
1:30 p.m.-3:00 p.m.

MEDICAL MANAGEMENT OF SEXUAL DYSFUNCTION IN THE ELDERLY

Bradley W. Fenton, M.D., *Clinical Associate Professor of Medicine, Jefferson Medical College, 833 Chestnut Street, East, Suite 702, Philadelphia, PA 19107*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) update psychiatrists in the current clinical evaluation and management of sexual dysfunction in the aging male; 2) specifically outline the role of sildenafil (Viagra) and other medications and therapies in the management of sexual dysfunction; and 3) discuss the association between erectile dysfunction and depression.

SUMMARY:

Not too many years ago most erectile dysfunction was attributed to psychologic causes: performance anxiety and depression. Today, in the aging male the vast majority of causes for this common problem are known to be organic in nature. Depression and erectile dysfunction are frequently associated although it may be difficult to untangle cause and effect. This discussion will review the causes of sexual dysfunction in aging men, outline an appropriate evaluation and discuss the therapy including the role of sildenafil (Viagra) in the diagnosis and management of erectile dysfunction. We will also discuss the interactions between depression, other mood disorders, erectile dysfunction, and adverse drug reactions of psychotropic medications.

REFERENCES:

1. Sexual Dysfunction. Postgraduate Medicine Special Report May 2000. 1–39.
2. Lue TF. Erectile Dysfunction. N Eng J Med 2000: 342(24); 1802–1813.

Medical Update 2 **Thursday, October 26**
1:30 p.m.-3:00 p.m.

ACUPUNCTURE IN PAIN MANAGEMENT

Judith R. Peterson, M.D., *Clinical Assistant Professor of Rehabilitation Medicine, Jefferson Medical College, 1015 Chestnut Street, Suite 307, Philadelphia, PA 19107*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) review the history and philosophy of acupuncture; 2) review the neurophysiological basis of acupuncture analgesia; and 3) present an evidenced based review of acupuncture effect in various clinical scenarios.

SUMMARY:

Acupuncture is one of medicine's most ancient therapeutic techniques. Acupuncture involves the insertion of needles along pathways termed "meridians" to correct theorized imbalances in energy flow. The restoration of flow of "Qi" or life energy restores health and optimum functionality in traditional Chinese philosophy. The popularity of acupuncture as a therapeutic technique is exploding in the United States. The inclusion of acupuncture as a topic for a recent NIH Consensus Conference highlights the interest and concerns of both physicians and patients concerning the appropriate inclusion of alternative therapies into conventional allopathic medical care. This talk will review the history of acupuncture and its underlying philosophies. The complex neurophysiologic basis of acupuncture effect will be discussed. An evidence based review of the effect of acupuncture for various pain syndromes such as knee osteoarthrits and headache will be presented. It is hoped that this presentation will enable physicians to appropriately refer patients who may benefit from acupuncture treatment.

REFERENCES:

1. Acupuncture Energetics: A Clinical Approach for Physicians. Helms JM, 1990, Medical Acupuncture Publishers, Berkeley, CA.
2. Acupuncture: A Comprehensive Test. 1990, Eastand Press, Inc., Seattle, WA.

Medical Update 3 **Friday, October 27**
1:30 p.m.-3:00 p.m.

ADVANCES IN THE TREATMENT OF OBESITY

Thomas A. Wadden, Ph.D., *Director, Weight and Eating Disorders Program, University of Pennsylvania Health System, 3600 Market Street, Suite 734, Philadelphia, PA 19104*

Educational objectives, a summary and references were not provided for this session. Therefore, only category 2 credit will be given for attending this session.

Medical Update 4 **Saturday, October 28**
1:30 p.m.-3:00 p.m.

PSYCHIATRIC MANIFESTATIONS OF RHEUMATOLOGIC DISORDERS

Warren A. Katz, M.D., *Clinical Professor of Medicine, University of Pennsylvania School of Medicine, and*

Chief of Rheumatology, Presbyterian Medical Center, 39th and Filbert Streets, Suite 102, Philadelphia, PA 19104

Educational objectives, a summary and references were not provided for this session. Therefore, only category 2 credit will be given for attending this session.

Multimedia Session 1 Wednesday, October 25 1:30 p.m.-3:00 p.m.

VIDEO WORKSHOP: ENDNOTES: A MODEL FOR PALLIATIVE CARE

B. Perry Ottenberg, M.D., *Clinical Professor of Psychiatry, University of Pennsylvania, 210 West Washington Square, Suite 501, Philadelphia, PA 19106*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate the healing power of the multiple nuance clinical use of music in therapy in a palliative care setting, demonstrating the unique and sensitively directed healing talents of a music therapist.

SUMMARY:

If all of us would know that our last days would be spent surrounded by caring people in a humane environment, such as the one at the Royal Victoria Hospital, then dying would be less terrifying. The hospice here has been under the leadership of Balour Mount, M.D. The entire staff, from housekeepers to volunteers to nurses, doctors, and therapists are engaged in the complex task of meeting the emotional as well as physical needs of their patients. The staff creates a sense of normalcy and even vibrancy, which emanates from the ward as pleasures from the outside world are brought in. The warm atmosphere allows family and friends to interact naturally with their loved ones. Filmed over one month, *Endnotes* captures the unique philosophy of a world-renowned model for compassionate care.

REFERENCES:

1. Cassem NH: The dying patient, in Massachusetts General Hospital Handbook of General Hospital Psychiatry, 3rd edition. Edited by Cassem NH. St. Louis, MO, Mosby-Yearbook, 1991, pp 343–371.
2. Rando TA: Creating therapeutic rituals in the psychotherapy of the bereaved. Psychotherapy: Theory, Research and Practice, 1984.

Multimedia Session 2 Wednesday, October 25 3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: ON WINGS OF SONG

B. Perry Ottenberg, M.D., *Clinical Professor of Psychiatry, University of Pennsylvania, 210 West Washington Square, Suite 501, Philadelphia, PA 19106*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better appreciate how music therapy can enhance the relationship among caretakers, patients, and families.

SUMMARY:

Deborah Salmon has worked as a music therapist with the terminally ill since 1984. Featuring her work in the Palliative Care Unit of the Royal Victorian Hospital, *On Wings of Song* shows how a skilled music therapist may help a diverse group of patients find spiritual and emotional nourishment during their last days. By calling upon the knowledge of a wide range of musical instruments and styles, a music therapist is able to forge a strong emotional connection with patients. This poignant and inspiring film captures moments of humor, celebration and joy made possible through music.

REFERENCES:

1. Fruman CE: Effectiveness of music therapy procedures: Documentation of research and clinical practice (2nd ed.). National Association for Music Therapy, Silver Spring, MD, 1996.
2. Taylor DB: Biomedical foundations of music as therapy. MMB Music, St. Louis, MO, 1997.

Multimedia Session 3 Wednesday, October 25 3:30 p.m.-5:00 p.m.

COMPUTER WORKSHOP: CONTINUOUS MONITORING OF SYMPTOMS, MEDICATIONS AND SOCIAL DIMENSIONS

Elliot D. Luby, M.D., *Professor of Psychiatry, Wayne State University Medical School, 4467 Stoney River Drive, Bloomfield Hills, MI 48301-3655*; Jack Ferguson, Ph.D., *Professor of Sociology, University of Windsor, Ontario, Canada N9B 3P4*; Tamara Ferguson, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to become familiarized with a simple computerized monitoring system for Axes I, II and III.

SUMMARY:

This easy-to-use program is designed to monitor patient progress by contrasting symptom level over time. Practitioners can record, in narrative, the mental status examination, diagnosis, physiological tests, and medications. Symptoms correspond to Axes I, II and III of *DSM-IV* (Axis II is documented partially); they are recorded as "not at all," "occasionally," and "very often," so that at the subsequent session, any change may be identified. Changes in diagnosis, tests and medication are recorded in narrative. Entries may be made first on paper and then keyboarded by clerical staff, or entered directly

into the computer. At each following session, current symptoms are recorded and any change from the previous session is noted on the screen, and written to a printable file, as "better," "same," or "worse." The data from each session are appended to the original file in readable form. The program runs under Windows 95, 98 or NT and is contained on a self-installing diskette.

REFERENCES:

1. Trzepacz PT, Baker RW: The psychiatric mental status examination. New York, Oxford University Press, 1993.
2. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th edition. Washington, DC, American Psychiatric Press, 1994.

Multimedia Session 4 Thursday, October 26 8:00 a.m.-9:30 a.m.

VIDEO WORKSHOP: MY FRIEND PAUL

Jonathan Berman, *Producer, Five Points Pictures, Inc., 396 Third Avenue, 2nd Floor, New York, NY 10016*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better appreciate how a diagnosis of manic depression impacts the friendship of two men who have known each other from childhood. One of these men, the film maker, provides a dramatic documentary of the evolution of his friend's life.

SUMMARY:

As children, Jonathan and his friend Paul made movies in which they played gangsters. As adults, Jonathan became a film maker and Paul became a bank robber. This film began when Jonathan got a call from Paul, who was then serving ten years in prison. During that time, Paul had been diagnosed as manic depressive, but Jonathan assumed he was just putting on a good act. Released to a halfway house, Paul almost immediately jumped parole, stopped taking his psychiatric medication and headed for New York and his old friend Jonathan. Feeling that he was the only one Paul could count on for help, and enjoying hanging out with his friend again, Jonathan nonetheless was more than a little bit freaked out by the reality of dealing with Paul's mental illness. This intimate and endearing documentary tragicomedy raises issues about mental illness, criminality, creativity, and maybe most important, the meanings of responsibility and friendship.

REFERENCES:

1. Bech P: Acute therapy of depression. Compr Psychiatry 1993; 54 (suppl 8):18–27.
2. Bemporad JR: Psychodynamic models of depression and mania, in Depression and Mania. Edited by Georgotas A, Cancro R. New York, Elsevier, 1988, pp 167–180.

Multimedia Session 5 Thursday, October 26 10:00 a.m.-11:30 a.m.

VIDEO WORKSHOP: A BRIEF THERAPY ON VIDEOTAPE

Milton Viederman, M.D., *Professor of Clinical Psychiatry, Weill Medical College, Cornell University, and Training and Supervising Psychoanalyst, Columbia Psychoanalytic Center; 525 East 68th Street, New York, NY 10021-4873*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate the psychological engagement of physically ill patients and their families, and examine the issue of grief and change in the context of a patient's life crisis.

SUMMARY:

This video consists of two independent parts, which illustrate different phenomena. The first part, which lasts about 90 minutes, is a three-session psychotherapy that is edited and cut into segments to illustrate various themes and concepts that are discussed at the end of each segment as the therapy evolves. It is complete in its own right. This part begins with a discussion of the nature of therapeutic engagement. Part two of this tape lasts thirty minutes and is separate but related. It examines the issue of grief and change in the context of a patient's life crisis. What unites these separate presentations is the fact that they are illustrated by the same patient and that the second is to be viewed, at least in part, as the outcome of the first.

REFERENCES:

1. Viederman M: The psychodynamic life narrative: A psychotherapeutic intervention useful in crisis situations. Psychiatry 1983; 46:236–246.
2. Viederman M: Presence and enactment as a vehicle of psychotherapeutic change. The Journal of Psychotherapy Practice and Research 1999; 8:274–283.

Multimedia Session 6 Thursday, October 26 2:00 p.m.-5:00 p.m.

VIDEO WORKSHOP: ANALYZE THIS

Helen J. Rosen, Ph.D., *Faculty, Philadelphia Association for Psychoanalysis, P.O. Box 384, Wenonah, NJ 08090*; Ruth S. Garfield, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have an increased ability to utilize principles of psychodynamic psychotherapy with atypical patients and an overall better understanding of the usefulness of psychodynamic treatment in contemporary psychiatry.

SUMMARY:

The contemporary psychodynamic psychiatrist functions in a world that is very different from the world of most of his/her teachers and mentors. It is a common and universal lament among us that "things have changed." The advent of managed care and changes in societal expectations and interests have all contributed to an atmosphere in which the present-day psychodynamic psychotherapist feels he is working in a hostile environment. For Ben Sobol, the psychiatrist in *Analyze This,* this is even more true. His work with an anxiety-ridden member of the Mafia threatens not only his sense of professional identity and ability, but also threatens his life! Within a highly entertaining, humorous portrayal of a psychodynamic psychotherapist attempting to help a member of the Mafia who has lost his "nerve," the movie raises a number of realistic questions about the practice of psychodynamic psychotherapy in contemporary times. Some of the issues raised in the movie are universal problems that therapists encounter in their work today, while others pertain more specifically to work with "atypical" patients. There are no background requirements for this session. It is open to any interested participants. The session will begin with a viewing of the film, which stars Billy Crystal and Robert DeNiro (directed by Harold Ramis). Following the movie, there will be a presentation of brief papers that develop some of the issues raised in the movie and their relevance for psychodynamic psychotherapists today. A discussion period will conclude this session.

REFERENCES:

1. Binder J, et al: Countertransference in time-limited dynamic psychotherapy: further extending the range of treatable patients. Conte Psychoanal 1983; 19:608–622.
2. De Jonghe F, et.: Psychoanalytic supportive psychotherapy. J Amer Psychoanal Assn 1994; 42:421–446.

Multimedia Session 7 **Friday, October 27**
8:00 a.m.-9:30 a.m.

VIDEO WORKSHOP: GOOD MEDICINE

Richard C. Lippincott, M.D., *Assistant Secretary, Office of Mental Health, Louisiana Department of Health and Hospitals, P.O. Box 4049, Bin #12, Baton Rouge, LA 70821*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better understand and appreciate the healing rituals and beliefs of Native Americans.

SUMMARY:

This truly educational and beautiful film deals with an understanding of Native American healing. It was produced and directed by Christopher R. Goul, of WQED in Pittsburgh, and Dr. Lippincott was consultant to the project because of his work in understanding Native American healing.

REFERENCES:

1. Thompson JW, Walker RD, Silk-Walker P: Mental illness in American Indians and Alaska Natives, in Culture, Ethnicity and Mental Illness. Edited by Gaw AC. Washington, DC, American Psychiatric Press, pp 189–243, 1993.
2. Attneave C: American Indians and Alaska Native Families: Emigrants in their Own Homeland in Ethnicity and Family Therapy. Edited by McGoldreck M. Guilford Press, 1982.

Multimedia Session 8 **Friday, October 27**
8:00 a.m.-9:30 a.m.

COMPUTER WORKSHOP: NETWORKED OFFICE INFORMATION INTEGRATION

Carmen M. Sugai, M.D., *P.O. Box 82380, Baton Rouge, LA 70884*; Edward Sugai

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the benefits of working in a collaborative, networked office and recognize the various technological advantages in doing clinic functions.

SUMMARY:

An office of networked machines utilizing a centralized computer database for client records provides an opportunity for more efficient management and communication. This presentation will provide an overview for small group operations or solo practitioners to see how a networked office can enhance recordkeeping and communications. This will be more than just a presentation on patient databases. Rather, it will focus on how the networked office can provide to the practitioner avenues of efficient communications. Basic computer operations knowledge is assumed. Familiarity with managed care operations knowledge is assumed. Familiarity with managed care operations, collaborative communications and outpatient recordkeeping are also assumed. The opportu-

nity exists to enhance operations, not just "computerizing the current methods." The networked office information system provides the foundation on which to build this platform. The presentation will focus on the small group or department organization and will demonstrate both internal and external communications.

REFERENCES:

1. McCormack J.: Wooing physicians to adopt electronic records. Health Data, October 1999.
2. Haverson D: Sharing access, protecting privacy. Imaging & Document, 8:12, December 1999.

Multimedia Session 9 — Friday, October 27 10:00 a.m.-11:30 a.m.

VIDEO WORKSHOP: THERE WAS A CHILD

Michael D. Miller, M.D., M.P.H., *Instructor, Department of Psychiatry, Thomas Jefferson Medical College, 1525 Locust Street, Philadelphia, PA 19102*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to develop a greater awareness and sensitivity to the unique ways that each family copes with the loss of a newborn.

SUMMARY:

This documentary captures the deeply emotional transactions of three families as they experience the tragic loss of a newborn and strive to find some resolution to their grief and disappointment.

REFERENCES:

1. Wheeler SR and Limbo RK: Blueprint for a perinatal bereavement support group. Pediatric Nursing 1990; 16(4):341–44.
2. Potvin L, Lasker J, and Loedter L: Measuring grief: a short version of the perinatal grief scale. Journal of Psychopathology and Behavioral Assessment 1989; 11(1):29–45.

Multimedia Session 10 — Friday, October 27 10:00 a.m.-11:30 a.m.

COMPUTER WORKSHOP: INTERNET-ENABLED FAMILY HOSPITAL VISITS

Swatee Surve, *Project Leader, Imaging Research and Advanced Development, Eastman Kodak Company, Research Lab, Building 65, Rochester, NY 14650-1829*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate how Internet-Enabled Family Hospital Visits can facilitate the management of family members who are potentially or actively involved in the hospitalization experience of an ill family member.

SUMMARY:

This session consists of a demonstration of the research and development of a new two-way, high-band telecommunications system between hospitalized patients and their families.

REFERENCES:

1. Angood PB: Internet-based telemedicine: a practical tool? Medicine Meets Virtual Reality, page 383, IOS Press, Washington, DC, 1998.

Multimedia Session 11 — Friday, October 27 1:30 p.m.-3:00 p.m.

VIDEO WORKSHOP: CLOZAPINE AND GROUP PSYCHOTHERAPY

Leo H. Berman, M.D., *Department of Psychiatry, Greater Bridgeport Community Mental Health Center, 19 Otter Trail, Westport, CT 06880–4920*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the beneficial effects of the combined use of the novel antipsychotic medication clozapine and group psychotherapy with a group of chronic schizophrenic patients.

SUMMARY:

The patient had been isolated, delusional and dysfunctional and had spent long periods in the hospital. With clorazil, there had been considerable improvement in the schizophrenic symptomatology, but that is not sufficient to help the patient toward the goals of socialization and adequate functioning. An active therapeutic program emphasizing interaction completes the process by which the patients can now be humanized.

REFERENCES:

1. Carpenter WT, Conley A, et al: Patient and resource management: another view of clozapine treatment of schizophrenia. Amer J Psychiat 1995; 152:827–832. 1995.
2. Lieberman J, Safferman A, et. al: Clinical effects of clozapine in chronic schizophrenia; response to treatment and predictors of outcome. Amer J Psychiat 1994; 152:1744–1782.

3. Meltzer H: The mechanism of action of novel antipsychotic drugs. Schizophrenia Bulletin 1996; 17:262–283.

Multimedia Session 12 Friday, October 27 3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: SURVIVING DEATH: STORIES OF GRIEF

Paul J. Fink, M.D., *Professor of Psychiatry, Temple University School of Medicine, and Past President, American Psychiatric Association, One Belmont Avenue, Suite 523, Bala Cynwyd, PA 19004-1608*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better understand the different dimensions of grieving as experienced by persons who have survived the death of a family member.

SUMMARY:

When a loved one dies, the process of making the loss real can be a lonely and confusing experience. *Surviving Death: Stories of Grief* is about people negotiating a new relationship with life after losing a loved one. Seven people including parents, children, siblings, partners and friends reveal how they have been affected by the death of someone close to them.

REFERENCES:

1. Falken MH: Moderating grief of widowed people in talk groups. Death Studies 1990; 14:171–76.
2. Rosenblatt P, Elde C: Shared reminiscence about a deceased parent. Family Relations 1990; 39:2016–10.

Multimedia Session 13 Saturday, October 28 8:00 a.m.-9:30 a.m.

VIDEO WORKSHOP: NO FEARS, NO TEARS: 13 YEARS LATER

Ruth P. Zager, M.D., *Section of Child Consultation, Jefferson Medical College, 841 Chestnut Street, Philadelphia, PA 19107*; Gail A. Edelsohn, M.D., *Director, Child and Adolescent Psychiatry, Jefferson Medical College, 841 Chestnut Street, Philadelphia, PA 19107*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the value of utilizing the subjective experience of children when thinking about treatment plans and pain management.

SUMMARY:

Thirteen years ago a documentary was made of eight children undergoing painful cancer treatment. Now, 13 years later, they dramatically recollect their painful childhood experience, and the consequences of the way they were able to help themselves.

REFERENCES:

1. Masek BJ, Spirito A, Fentress DW: Behavioral treatment of symptoms of childhood illness. Clin Psychol Rev 1984; 4:561–570.
2. Varni JW, Jay SM, Masek BJ, et. al: Cognitive-behavioral assessment and management of pediatric pain, in Handbook of Psychological Treatment Approaches. Edited by Holvman AD, Turk ED. New York, Pergamon, pp 168–192, 1986.

Multimedia Session 14 Saturday, October 28 8:30 a.m.-11:30 a.m.

VIDEO WORKSHOP: WIZARD'S WAY: NEW WAYS IN CHILD AND ADOLESCENT THERAPY

Dennis B. Alters, M.D., *Author, Wizard's Way, Dennis B. Alters, Inc., 2125 El Camino Real, Suite 104, Oceanside, CA 92054-6260*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand how to use this innovative model; 2) integrate cognitive, behavioral and dynamic child therapy; 3) establish a multitiered continuity from outpatient, inpatient, home and school; and 4) transform *DSM-IV* symptoms into child imagery, metaphor and ritual.

SUMMARY:

Wizard's Way®, an outpatient and total hospital behavior management program, eliminates the level system and has reduced seclusion and restraint by 50%. It emphasizes a multimodal approach organizing cognitive, behavioral, dynamic, art, psychodrama and music into a model that appeals to children and adults. Wizard's Way®, treats high- and low-risk children through preoperational and operational formats.

REFERENCES:

1. Trad PV: Use of developmental principles to decipher the narrative of preschool children. Journal of American Academy of Child Adolescent Psychiatry 1992; 31:4:581–592.
2. Hoagwood K, Jensen PS, Burns BJ: Outcomes of mental health care for children and adolescents: a comprehensive model. Journal of the American

Academy of Child Adolescent Psychiatry 1996; 35:1055–1063.

Multimedia Session 15 Saturday, October 28 10:00 a.m.-11:30 a.m.

VIDEO WORKSHOP: VIRTUAL REALITY THERAPY DEMONSTRATION: PART I

Ian E. Alger, M.D., *Multimedia Consultant, APA Institute Scientific Program Committee, and Clinical Professor of Psychiatry, New York Presbyterian Hospital-Cornell Medical Center, 500 East 77th Street, New York, NY 10162-0025*; Larry F. Hodges, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand new advances in applications of virtual reality therapy in PTSD by virtual reality immersion.

SUMMARY:

Dr. Larry Hodges, a leading researcher in the field of virtual reality therapy, will show current advances in the application of this modality in PTSD with Vietnam War veterans, now participating in VA-sponsored research. In addition, applications of virtual reality in the treatment of various phobias, especially fear of flying, will be demonstrated.

REFERENCES:

1. Rothman BO, Hodges LF, Kooper R, et. al: Effectiveness of virtual reality graded exposure in treatment of acrophobia. American Journal of Psychiatry 1995; 152:626–628.
2. Medicine Meets Virtual Reality, IOS Press, Burke, VA, USA, 1999.

Multimedia Session 16 Saturday, October 28 1:30 p.m.-3:00 p.m.

VIDEO WORKSHOP: THE PORTRAYAL OF PSYCHIATRY IN RECENT AMERICAN FILMS

Steven E. Pflanz, M.D., *Chief, Mental Health Services, F.E. Warren Air Force Base, U.S. Air Force, 408 West First Avenue, Cheyenne, WY 82001*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to critically examine contemporary films with mental health clinicians and understand how the images portrayed in these films influence the public perception of psychiatry and mental illness.

SUMMARY:

The American film industry has long had a fascination with psychiatry. The history of film is replete with vivid images of psychiatrists and their patients. Perhaps unlike any other force in America, major motion pictures have the power to enduringly influence the public perception of mental illness, its treatments and the profession of psychiatry. In particular, the far reaching appeal of films with success at the box office gives them a unique opportunity to shape the attitudes of everyday Americans. Oftentimes, mental health professionals pay more attention to films that achieve critical acclaim for their artistic merits. The value of these films is undeniable. However, to understand the forces shaping the public perception of our profession, it is necessary to examine the images of mental illness and the mentally ill in commercially successful films. In this workshop, the facilitator will discuss briefly the portrayal of psychiatry in contemporary films during the 1990s, focusing on *The Prince of Tides, Basic Instinct, As Good as It Gets, Good Will Hunting* and *Analyze This.* Each of these films achieved both critical acclaim and box office success and was viewed by many Americans. To generate discussion, short film clips from these movies will be viewed. The majority of the session will be devoted to audience discussion of these and other films and how we understand contemporary film to influence the image of psychiatry in America.

REFERENCES:

1. Gabbard GO, Gabbard K: Psychiatry and Cinema, 2nd Edit, Washington, DC, American Psychiatric Press, Inc., 1999.
2. Hesley JW, Hesley JG: Rent Two Films and Let's Talk in the Morning: Using Popular Films in Psychotherapy. New York, John Wiley & Sons, Inc., 1998.

Multimedia Session 17 Saturday, October 28 1:30 p.m.-3:00 p.m.

VIDEO WORKSHOP: VIRTUAL REALITY THERAPY DEMONSTRATION: PART II

Ian E. Alger, M.D., *Multimedia Consultant, APA Institute Scientific Program Committee, and Clinical Professor of Psychiatry, New York Presbyterian Hospital-Cornell Medical Center, 500 East 77th Street, New York, NY 10162-0025*; Suzanne Weghorst, M.S., M.A.; Hunter Hoffman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to show new advances in applications of virtual reality therapy in PTSD and stress and pain

reduction in burn patients mitigated by virtual reality immersion.

SUMMARY:

Coming from the Human Interface Technology Laboratory (HIT Lab) in Seattle, Washington, out of which flows a continuing stream of new ideas and applications in virtual reality, Suzanne Weghorst, Ph.D., a research scientist from the same HIT Lab, will demonstrate "The Use of Immersive Virtual Reality to Reduce Burn Pain During Wound Care and Physical Therapy."

REFERENCES:

1. Hoffman HG, Prothero J, Wells M, Groen J: Virtual chess: the role of meaning in the sensation of presence. International Journal of Human-Computer Interaction, in press.
2. Medicine Meets Virtual Reality, IOS Press, Burke, VA, USA, 1999.

Multimedia Session 18 Saturday, October 28 3:30 p.m.-5:00 p.m.

VIDEO CASE STUDY WORKSHOP: A PATIENT WITH DID

Leah J. Dickstein, M.D., *Associate Dean and Chair of Academic Affairs, and Director, Division of Attitudinal and Behavioral Medicine, Department of Psychiatry and Behavioral Science, University of Louisville, 500 South Preston Street, #214, Louisville, KY 40292*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize how a patient with dissociative identity disorder (DID) changes from one alternate to another and how this impacts on the original.

SUMMARY:

This multimedia presentation is a videotape consisting of two sessions of a young woman with DID, diagnosed in 1977. The videos were made in 1980 of the alternates and in 1981 of the original viewing the alter personalities. The presenter will first present the patient's psychiatric history, the video, then show slides of the patient's artwork demonstrating traumatic experiences, and alters will be shown. Finally, there will be adequate time for questions.

REFERENCES:

1. Kluft R: Multiple personality disorder: a contemporary perspective. Harvard Mental Health Letter, 10(4): 5–7, October 1993.
2. Schreiber F: Sybil, Chicago, Regnery Press, 1973.

TARGET AUDIENCE:

Mental health professionals who have never spoken with or have known how to recognize a patient with DID or those who don't believe such a diagnosis exists.

Multimedia Session 19 Saturday, October 28 3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: FIRST BREAK

Gregg E. Gorton, M.D., *Associate Director of Adult Outpatient Services, Jefferson Medical College, 841 Chestnut Street, Philadelphia, PA 19107-5005*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better appreciate the lived experience from the perspective of those who are suffering mental illness for the first time.

SUMMARY:

In this program, three young adults and their families courageously come forward and illuminate with compelling candor their personal experiences during the first episode of mental illness.

REFERENCES:

1. Lamb HR: Some reflections on treating schizophrenics. Arch Gen Psychiatry 1986; 43:1007–1011.
2. Lamb HR: Lessons learned from deinstitutionalization in the United States. Br J Psychiatry 1993; 162:587–592.

POSTER SESSION I

Posters 1-23

Poster 1 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

THE FIRST TWO YEARS OF CHIPPS ASSERTIVE COMMUNITY TREATMENT'S SUCCESS IN PENNSYLVANIA

M. Fuat Ulus, M.D., *Assertive Community Treatment Programs, Visiting Nurses Association, and Northwestern Human Services Resources, 406 Rockhill Circle, Bethlehem, PA 18017–1702*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the program's treatment and management principles, as applied to the chronically mentally ill.

SUMMARY:

The presenter is a full-time psychiatrist employed by three different ACT program teams, whose finances are funded by the separate organizations. The team psychiatrist is neither a consultant nor a team leader, but rather a very active team member whose expertise is utilized in problem-solving processes. His responsibilities include visiting with more than 75% of his patients in the community through house calls; maintaining liasion between them and their primary physicians; and meeting with the teams weekly to discuss administrative, clinical, ethical, and legal matters pertaining to the services. He is an advisor to the Care Management Agency, which oversees the operations. The teams consist of highly-skilled case managers, social workers, psychologists, nurses, and D&A counselors.

The consumers are seen from twice a day to once a week, depending upon their current needs. Presently, 125+ patients are in the program. Less than 10% returned to long-term institutional services within two years. Furthermore, less than 10% have been in need of crisis centers' referrals and/or short-term psychiatric unit hospital care for psychiatric acuities while receiving services in the community. Therefore, more than 80% of the population has successfully been maintained and served by the program in the community at any given time.

REFERENCES:

1. Burns BJ: Links between research findings and the future of assertive community treatment: a commentary. American Journal of Orthopsychiatry 1998; 68:261–264.
2. Dincin J, Wasmer D: Witheridge TF, et al: The impact of assertive community treatment on the use of stare hospital inpatient bed-days. Hospital and Community Psychiatry 1993; 44:833–838.

Poster 2 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

ENGAGING TREATMENT IN A NONTRADITIONAL SETTING

Melissa J. Sharlat, B.S., *Social Recreational Coordinator, John Hopkins Bayview Medical Center, 2400 Broening Highway, Suite 180, Baltimore, MD 21224;* Susan J. McCormick, B.A., *Department of Psychiatry, Johns Hopkins Bayview Medical Center, 2400 Broening Highway, Suite 180, Baltimore, MD 21224;* Gerard Gallucci, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify techniques to engage resistant patients in treatment. In addition, it will highlight alternative methods used in forming the unique relationships between patient and clinician within this capitated setting.

SUMMARY:

Creative Alternatives is a capitated mental health program that was designed to provide case management and psychiatric services for patients with severe and persistent mental illness. The capitated funding mechanism has challenged staff to develop alternative treatment approaches for this patient population. Consequently, staff and members have formed new alliances in the process, allowing this patient group to successfully remain in the community.

These relationships have, in part, been fostered by the flexible method of capitated funding, and contrast with the patient/staff relationships found in most traditional mental health programs. Strong values, and a "member driven" approach provide the cornerstone to forming meaningful bonds specific to each patient and clinician in the program. Staff are directly involved in housing, recreational, employment, financial, substance abuse, and other treatment issues. As a result, patients are empowered to make their own decisions in a supportive environment.

REFERENCES:

1. Shepard W: Creative alternatives in mental health. Caring Magazine, July 16–22, 1995.
2. Shepard W: Intensive case management keeps psychiatric patients in the community. Case Management Advisor 1997; 8:56–58.

Poster 3 **Thursday, October 26 3:30 p.m.-5:00 p.m.**

INPATIENT PSYCHOSOCIAL REHABILITATION PROGRAM AND IMPROVED COMMUNITY TENURE

Joselito B. Morales, M.D., *Staff Psychiatrist, Eastern State Hospital, 100 Carnoustie Court, Yorktown, VA 23693;* Karen M. Marsh-Williams, O.T., *Rehabilitation Director, Eastern State Hospital, 107 Wilderness Lane, Williamsburg, VA 23188*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate the effectiveness of an inpatient psychosocial rehabilitation program on improving patient's ability to function in the community setting.

SUMMARY:

Objective: To determine the effects of an inpatient psychosocial rehabilitation program on the patient's successful adaptation into the community.

Method: An inpatient psychosocial rehabilitation was implemented at the nation's first state psychiatric hospital's 190-bed, long-term unit. The essential elements of the program were intensive training, full staff support and commitment, and involvement of all clinical disciplines in running groups aimed at improving the patient's adaptation into the community. We compared the 60-day readmission rate and length of stay in the community two years before (1995) and two years after (1999) the program was fully implemented.

Results: The 60-day readmission rate dropped from 68 in 1995 to 14 in 1999, representing an almost five-fold decrease. The length of stay in the community increased from 264 in 1995 to 661 in 1999, representing an almost three-fold increase.

Conclusion: The psychosocial rehabilitation program that was implemented at this Virginia state psychiatric hospital represents a strong commitment to improving patients' successful adaptation into the community. It is apparent from the result that one of the goals of the program has succeeded. It has been adapted in other settings and has made a significant and positive impact in the lives of the patients.

REFERENCES:

1. Smith RC: Implementing psychosocial rehabilitation with long-term patients in a public psychiatric hospital. Psychiatric Services 1998; 49:593–595.
2. Kopelowicz A, Wallace CJ, Zarate R: Teaching psychiatric inpatients to re-enter the community: a brief method of improving the continuity of care. Psychiatric Services 1998; 49:1313–1316.

Poster 4 **Thursday, October 26 3:30 p.m.-5:00 p.m.**

INPATIENT PSYCHOSOCIAL REHABILITATION PROGRAM AND DECREASED PATIENT VIOLENCE

Joselito B. Morales, M.D., *Staff Psychiatrist, Eastern State Hospital, 100 Carnoustie Court, Yorktown, VA 23693;* Karen M. Marsh-Williams, O.T., *Rehabilitation Director, Eastern State Hospital, 107 Wilderness Lane, Williamsburg, VA 23188*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate the effectiveness of an inpatient psychosocial rehabilitation program on decreasing patient's violence/aggression without increasing use of chemical restraint.

SUMMARY:

Objective: To determine the effect of an inpatient psychosocial rehabilitation program on the patient's seclusion/restraint rate.

Method: The inpatient psychosocial rehabilitation program that was implemented at the nation's first state psychiatric hospital's 190-bed, long-term unit is based on intensive training, full staff support and commitment, and involvement of all the clinical disciplines in running groups. Groups aimed at improving the maladaptive interpersonal interaction as well as improving medication understanding and compliance were run. The rate of seclusion/restraint was compared two years before (1995) and two years after (1999) the program was implemented. In addition, staff injury related to patient aggression and use of extra (prn/stat) medications was also compared.

Results: The seclusion/restraint rate was 922 in 1995 as compared with 207 in 1999. This represents a four-fold decrease. Staff injury related to aggressive patients dropped from 301 to 121. The use of prn medications also dropped from 1277 to 331.

Conclusion: Clearly, the psychosocial rehabilitation program implemented in this Virginia state hospital has contributed to a significant decrease in the patient's display of violent/aggressive behavior. This was achieved without increase in the use of chemical restraint. This is a highly replicable program and is adaptable to other clinical settings.

REFERENCES:

1. Bopp JH, Ribble DJ, Cassidy JJ, Markoff RA: Reengineering the state hospital to promote rehabilitation and recovery. Psychiatric Services 1996; 47:697–701.

2. Smith RC: Implementing psychosocial rehabilitation with long term patients in a public psychiatric hospital. Psychiatric Services 1998; 49:593–595.

Poster 5 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

WHO GETS COURT ORDERED PSYCHOTROPIC MEDICATIONS IN SOUTHERN ILLINOIS?

Jagannathan Srinivasaraghavan, M.D., *Professor of Psychiatry, Southern Illinois University School of Medicine, and Medical Director, Choate Mental Health and Development Center, 1000 North Main Street, Anna, IL 62906;* Shobha Dayal, M.D., *Instructor in Anatomy, Southern Illinois State University, Lindegren Hall, Suite 110, Carbondale, IL 62906;* Nancy Watkins, B.S.; Sarah Andrew, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize Illinois statute regarding court-ordered psychotropic medications and characteristics of patients who were granted their petitions against those whose petitions were denied or withdrawn.

SUMMARY:

Background: Choate Mental Health Center, serving southern 28 counties of Illinois with nearly 600,000 population, had 221 patients refusing psychotropic medications during the period 1991–1998 who were considered for court-ordered medications under Illinois statute.

Objective: Compare patient characteristics of cases that were granted (42%), denied (7%), or dismissed (51%).

Sample: All of the cases filed from Choate Mental Health Center in Circuit Court of Union County from 1991–1998.

Method: Collection of all demographic data such as age, gender, race, living arrangement, length of stay, and diagnosis from hospital medical records.

Results: Almost 95% of cases were studied; nearly 80% had schizophrenia or schizoaffective disorder; 39% had an Axis II diagnosis; 65% had an Axis III diagnosis; whites constituted 78%; more than half the patients lived alone; females constituted 52%; approximately 72% of patients were between ages of 35 and 69; three-fourths of the patients had no alcohol or substance abuse diagnosis listed.

Conclusions: Characteristics of patients whose petitions were granted include homelessness, living alone or in a residential setting ($p = 0.028$), absence of alcohol and substance abuse diagnosis ($p = 0.002$), and female gender ($p = 0.004$). Younger age ($p = 0.030$) and shorter length of stay ($p = 0.004$) were associated with denial or dismissal of petitions.

REFERENCES:

1. Illinois Mental Health & Developmental Disabilities Code, Section 2-107.1 (1992 Revised).
2. Srinivasaraghavan J, Watkins N: Court-Ordered Psychotropic Medication in Southern Illinois: Eight Years Data. The 152nd Annual Meeting of the American Psychiatric Association New Research Program and Abstracts NR504, pages 207–208, 1999.

Poster 6 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

GABAPENTIN IN PTSD: EFFECTS ON SLEEP DISTURBANCES

Mark B. Hamner, M.D., *Director, Department of Psychiatry, Ralph H. Johnson VA Medical Center, and PTSD Clinic, 109 Bee Street, Suite 116A, Charleston, SC 29401-5703;* Lawrence A. Labbate, M.D.; Jeffrey P. Lorberbaum, M.D.; Helen G. Ulmer, M.S.N.; Clare Tyson, B.S.; Charlotte C. Teneback, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate the potential role of gabapentin in PTSD.

SUMMARY:

Objective: Insomnia, nightmares, and other sleep disturbances are common symptoms in PTSD. Although many PTSD symptoms improve significantly with antidepressant medications, sleep difficulties are often refractory. Gabapentin, indicated for adjunctive treatment of partial complex seizure disorders, has been of interest in psychiatry as a potential mood stabilizer and anxiolytic agent (possibly via increased brain levels of GABA). The agent also has a relatively benign drug interaction and side-effect profile.

Method: We reviewed records of 23 patients meeting DSM-IV criteria for PTSD associated with combat, diagnosed in a multi-disciplinary PTSD clinic. Gabapentin was added to the existing medication regimens of patients who had continued sleep disturbances. The dose of gabapentin ranged from 300–900mg, generally given at bedtime.

Results: All patients were noted to have moderate or greater improvement in duration of sleep and most noted a decrease in the frequency of nightmares. Sedation and mild dizziness were the only reported side effects.

Conclusions: This preliminary retrospective series suggests that gabapentin may be efficacious for sleep difficulties associated with chronic PTSD. Controlled studies are needed to further explore this clinical obser-

vation and to investigate effects of gabapentin on core PTSD symptoms.

REFERENCES:

1. Morris GL: Gabapentin. Epilepsia 1999; (40) suppl 5: 563–70.
2. Pande AC, Davidson JRT, Jefferson JW, Janney CA, et al: Treatment of social phobia with gabapentin: a placebo-controlled study. J Clin Psychopharm 1999; (19): 341–348.

Poster 7 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

SWITCHING TO OLANZAPINE TREATMENT IN COMMUNITY PSYCHIATRIC CARE

Supported by Eli Lilly and Company

Christopher O'Keefe, M.A., *Director of Clinical Research, Mental Health Center of Greater Manchester, 1555 Elm Street, Manchester, NH 03101*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize the outcomes associated with the combination of atypical antipsychotic medication and case management with psychosocial rehabilitation in a community mental health setting.

SUMMARY:

Objective: The goals of this study are to evaluate outcomes of the decision to switch to olanzapine treatment in a CMHC setting and to explore whether simultaneous access to rehabilitation and olanzapine leads to enhanced functional improvement.

Methods: This report presents 12-month outcomes of a consecutive series of 104 patients who switched from another antipsychotic medication to olanzapine in conjunction with case management and psychosocial rehabilitation. Forty-nine patients who continued to take conventional antipsychotics were followed as a reference group.

Results: The olanzapine group demonstrated significant improvement compared with baseline across multiple measures of symptoms and psychosocial function. The olanzapine group was more symptomatic at baseline and demonstrated significantly greater improvement at follow-up on the BPRS and all subscales, Mini Psychiatric Rating Scale negative symptoms, disorganization, anxiety, depression and medication side effects, CGI and case manager's rating scale + illness factors scale compared with the reference group. There was a trend toward superior improvement in psychosocial functioning among the olanzapine group which achieved significance when patients in acute relapse at baseline were excluded.

Conclusions: Olanzapine is effective in managing markedly to severely ill patients with psychotic disorders in a CMHC setting. We have also found evidence suggestive of a synergistic interaction between a novel antipsychotic and psychosocial rehabilitation, indicating that further study is warranted. This session is of particular relevance to individuals practicing in a community mental health setting.

This project was funded by a grant from Lilly Research Laboratories.

REFERENCES:

1. Noordsy DL: Evaluation of outcomes for atypical antipsychotic therapy and psychosocial rehabilitation in a community mental health center setting. American Journal of Managed Care 1999; 5(suppl): 591–600.
2. Noordsy DL, OKeefe C: Effectiveness of combining atypical antipsychotics and psychosocial rehabilitation in a community mental health center setting. J Clin Psychiatry 1999;60 (suppl. 19): 47–51.

Poster 8 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

VOCATIONAL REHABILITATION FOR PERSONS WITH PSYCHIATRIC DISABILITIES: A COMPREHENSIVE OVERVIEW

Barbara Granger, Ph.D., *Director of Training and Dissemination, Matrix Research Institute, 100 North 17th Street, 10th Floor, Philadelphia, PA 19103;* Michael J. Bradley, B.A., *Research Assistant, Matrix Research Institute, 100 North 17th Street, 10th Floor, Philadelphia, PA 19103;* Mark Salzer, Ph.D.

EDUCATIONAL OBJECTIVES:

To give the participant(s) a comprehensive overview of 20 years worth of investigation into employment as a tool for attaining positive treatment outcomes for multiple sub-populations of individuals with psychiatric illness. At the conclusion of this presentation, the participant should be able to demonstrate a broader knowledge of the benefits of employment for potential clients, recognize and supplement clients' desire to work, and, ideally, promote employment as a complimentary treatment. Lastly, this poster session will foster interdisciplinary contacts between physicians and a nationally recognized resource on psychiatric disability and work.

SUMMARY:

The integration of effective pharmacological and psychosocial interventions for individuals with severe and persistent mental illness will result in greater treatment outcomes than either of the two working separately. (Vaccaro et al, 1993; Prendergast, 1995; Becker, 1988). Of these psychosocial interventions, employment has become a central vehicle by which these individuals both learn and maintain their recovery. Working collaboratively, Matrix Research Institute and the University of Pennsylvania's Center for Mental Health Policy and Services Research have set and maintained an agenda of innovative research, training, dissemination, and demonstration initiatives that address the vocational issues of individuals with psychiatric disabilities. Resulting is a body of information that speaks directly to the corresponding need for broader, deeper treatment options for these individuals. Geared toward clinical professionals (MDs, PhDs, and clinical social workers), this poster session will reflect 20 years of findings that are directly related to psychiatric rehabilitation through employment. Specifically, quantitative and qualitative data to be summarized will include best practices in employment services, long-term employment supports, technical problems concerning the ADA and Social Security, long-term career patterns, sociodemographic influences on vocational experiences, vocational curriculum for psychiatric residents and nurses, issues of disclosure, employer/employee relationships, and models of rapid employment placement. Populations of interest include adults, young adults, women, and people of diverse ethnic and racial backgrounds with severe and persistent mental illness.

REFERENCES:

1. Granger B, Baron R, Robinson S: Findings from a national survey of job coaches and job developers about job accommodations arranged between employers and people with psychiatric disabilities. Journal of Vocational Rehabilitation 1997; 9(3):235–251.
2. Rutman I: Vocational Rehabilitation for Persons With Psychiatric Rehabilitation: A Vision for the Year 2000. Philadelphia, Matrix Research Institute, 1999.

Poster 9 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

USE OF DIVALPROEX SODIUM AND LITHIUM CARBONATE AUGMENTATION IN THE TREATMENT OF OUTPATIENTS WITH SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDER: A RETROSPECTIVE CHART REVIEW

Supported by Abbott Laboratories

Robert E. Litman, M.D., *Medical Director, Centers for Behavioral Health, 14915 Broschart Road, Suite 250, Rockville, MD 20850;* Patrick H. Farley, B.A.; Nina Gallauresi, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be proficient in clinical indications for mood stabilizer augmentation therapy in schizophrenia and chizoaffective patients, side effects associated with mood stabilizer augmentation therapy, and clinical characteristics and predictors of response to mood stabilizer therapy in schizophrenia.

SUMMARY:

While lithium carbonate may augment treatment response in schizophrenia and schizoaffective disorder, there is less information regarding augmentation with other mood stabilizers. A recent controlled study suggests that augmentation of neuroleptic with divalproex is more effective than neuroleptic alone for the acute exacerbation of psychosis in schizophrenia and schizoaffective patients. We assessed the use of divalproex sodium and lithium to augment typical and atypical neuroleptic threatment in 13 schizophrenia and five schizoaffective (n = 18) stable patients seen from 1994-present. Of the total schizophrenia and schizoaffective patients followed in a privated psychopharmacology practice, 40% were reviewed. Sixteen patients were treated with divalproex sodium, of those five were treated with combination divalproex sodium and lithium; two patients were treated with lithium only. Indications for initiating mood stabilizer therapy included treatment of psychosis, hypomania, anxiety, disturbed sleep, and clozapine-induced seizures. CGI-C scores abstracted by a blind rater from the chart notes revealed minimal to much improvement in 56.2% of patients after six months of treatment. Mood stabilizer augmentation was well tolerated, with the majority of patients experiencing sedation or sleep disturbances.

REFERENCES:

1. Dose M, Hellweh R, Tassouridis A, et al: Combined treatment of schizophrenic psychoses with haloperidol and valproate. Pharamcopsychiat 1998; 31:122–125.
2. Wassef AA, Dott SG, Harris A, et al: Randomized, placebo controlled pilot study of divalproex sodium in the treatment of acute exacerbations of chronic schizophrenia. Journal of Psychopharmacology, accepted, May 1999.

Poster 10 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

TOWARD GENETIC LITERACY IN PSYCHIATRY

Karen K. Milner, M.D., *Assistant Clinical Professor of Psychiatry, University of Michigan, 1500 East Medical*

Center Drive, Ann Arbor, MI 48109-0020; Anne C. Madeo; Lauren B. Smith; Kirsten A. Neudoerffer; Elizabeth M. Petty, M.D.

EDUCATIONAL OBJECTIVE:

At the end of this presentation, the participant should be able to recognize a need for continued education for psychiatrists.

SUMMARY:

With the completion of the Human Genome Project, mental health professionals will increasingly be asked by clients to comment on applications and implications of genetic technology. Professionals will need to be more aware of genetic concepts and applied genetic technology, as well as related ethical and social issues. We conducted a survey to assess genetic literacy, genetic education, and current utilization of genetic services among psychiatrists. We also obtained information about preferred methods of continuing genetic education. The survey was mailed to 900 psychiatrists in the Michigan Psychiatric Society. Analysis of 213 completed surveys revealed that most psychiatrists understood basic principles about genetics. Greater genetic literacy correlated most strongly with recent graduation from medical school. Most pyschiatrists routinely obtained a family history, but few referred clients with a positive family history of mental illness for genetic counseling. Some confusion about currently available genetic tests for psychiatric conditions was noted. Diverse opinions regarding genetic contributions to mental illness were obtained. However, psychiatrists indicated that they would like to know more about genetics. The preferred method of continuing education in genetics was CME conferences. Results from this survey suggest that more basic genetics education should be available for psychiatrists.

REFERENCES:

1. Milner KK, Han T, Petty EM: Support for the availability of prenatal testing for neurological and psychiatric conditions in the psychiatric community. Genetic Testing 1999; 3:279–286.
2. Milner KK, Collins EE, Connors, GR. Petty EM: Attitudes of young adults to prenatal screening and genetic correction for human attributes and psychiatric conditions. American Journal of Medical Genetics 1998; 76:111–119.

Poster 11 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

SCHIZOPHRENIA: DOES COMORBID ANXIETY REALLY MATTER?

Sanjay M. Vaswani, M.D., *Resident, Department of Psychiatry, University of Kansas Medical Center, 3901 Rainbow Boulevard, Kansas City, KS 66160;* Elizabeth C. Penick, Ph.D., *Professor of Psychiatry, University of Kansas Medical Center, 3901 Rainbow Boulevard, Kansas City, KS 66160;* Elizabeth Nickel, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the clinical implications of patients suffering from schizophrenia who also meet criteria for a comorbid anxiety disorder.

SUMMARY:

Objective: To contrast the familial, clinical, and treatment histories of a large group of outpatient schizophrenics who did or did not satisfy criteria for one of three anxiety disorders.

Method: Over a five-year period, all new admissions to the outpatient psychiatry service of a large Midwestern teaching hospital were examined with a structured diagnostic interview (Psychiatry Diagnostic Interview) and other self-report measures before seeing the clinic physician. Of the 1,458 patients who participated, 192 or 13.2% met Feighner criteria for schizophrenia. Ninety-five of the 192 (49.5%) also met criteria for one or more anxiety disorders. Of the 192 patients with schizophrenia: 15% had OCD only, 8% had only panic attacks, 4% had phobia only, 7% had OCD plus panic, 6% had phobia plus panic attacks, 4% had OCD plus phobia, and 6% had all three anxiety disorders comorbid with schizophrenia. Schizophrenia patients with and without a comorbid anxiety disorder were compared for sociodemographic characteristics and a family history of mental disorder as well as the onset and course of the psychosis, the level of social impairment, utilization of treatments, and psychiatric comorbidity.

Results: Schizophrenics with an anxiety disorder were younger, however no race, gender, religion, marital status, or educational differences were found. Psychosis and anxiety disorder did not distinguish the family histories of the two groups; alcoholism was slightly more prevalent in the anxiety disorder subgroup. Onset of psychosis began earlier in the schizophrenic patients with anxiety disorder. Schizophrenics with anxiety disorder acknowledged significantly more symptoms on the SCL-90-R and more psychotic symptoms on the structured interview. Psychiatric comorbidity was greater in the anxiety disorder schizophrenic subgroup; this difference was due to an increased prevalence of depression, anorexia nervosa, and somatization disorder in the schizophrenic subgroup with an anxiety disorder. Schizophrenics with a comorbid anxiety disorder reported more problems in childhood, poorer health currently, less efficient psychosocial functioning, and lower self-satisfaction. Despite the greater severity, diversity of symptoms, and suffering among the schizophrenics, only one treatment difference was found. Schizophrenic

patients with an anxiety disorder were more likely to have been prescribed an antidepressant at the time patients were first seen in the clinic. No differences were found in the two subgroups in the prescription of antipsychotic, antianxiety, or antimanic medication at the time patients were first seen in the clinic.

Conclusions: Our findings suggest that schizophrenics with one or more anxiety disorders may comprise a recognizable subtype with specific treatment needs that must be addressed in order to maximize the therapeutic intervention.

TARGET AUDIENCE:

Clinicians.

REFERENCES:

1. Hofman SG: Relationship between panic and schizophrenia. Depression and Anxiety 1999; 9:101–106.
2. Tollefson GD: Anxious-depressive symptoms in schizophrenia: a new treatment target for pharmacotherapy? Schizophrenia Research 1999; 35:Suppl: 13–21.

Poster 12 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

SELF-REPORTED WEIGHT GAIN ASSOCIATED WITH OLANZAPINE OR RISPERIDONE TREATMENT IN A COMMUNITY SAMPLE OF PATIENTS WITH SCHIZOPHRENIA

Supported by Eli Lilly and Company

Brian K. Dulisse, Ph.D., *Research Scientist, Stats/Math Department, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285;* Bryan M. Johnstone, Ph.D.; Danielle L. Loosbrock, M.H.A.; P. Joseph Gibson, Ph.D.; Bruce J. Kinon, M.D.; Lisa Whitecotton, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to gain insight into the prevalence and impact of weight gain associated with antipsychotic pharmacotherapy in community care for schizophrenia.

SUMMARY:

Objective: We compared self-reported weight gain associated with olanzapine (OLZ) or risperidone (RIS) therapy in a community sample of 156 persons with schizophrenia.

Methods: Data were obtained by self-administered questionnaire from patient respondents. We compared outcomes for patients receiving OLZ or RIS alone or in combination with other agents.

Results: The treatment groups did not differ in the proportion reporting frequent or very frequent weight gain associated with pharmacotherapy in the past month (OLZ 38%, n = 86; RIS 43%, n = 70) or the proportion reporting no weight gain during this period (OLZ 26%, RIS 27%). Findings were similar when these comparisons were limited to patients receiving antipsychotic monotherapy with OLZ or RIS and patients who did not receive any other psychiatric medications. Annual kilograms gained did not differ among patients receiving antipsychotic monotherapy with OLZ ($\bar{X}$ = 6.7±9.8kg. median = 4.5) or RIS ($\bar{X}$ = 5.6±7.5kg, median = 4.5) or among the subset who reported any weight increase (OLZ $\bar{X}$ = 10.3.±10.6kg, median = 8.4; RIS $\bar{X}$ = 10.0±7.6kg, median = 9.1). Sixteen percent of patients who discontinued OLZ (2% of all OLZ patients) and 35% of patients who discontinued RIS (6% of all RIS patients) cited weight gain as the reason for stopping or switching medications.

Conclusions: The perceived frequency and amount of weight gain associated with olanzapine or risperidone therapy did not differ in this community sample. Weight gain was cited as a reason for medication nonadherence or switching in a minority of instances.

REFERENCES:

1. Wetterling T, Mussigbrodt HE: Weight gain: side effect of atypical neuroleptics? J Clin Psychopharmacol. 1999; 19:316–21.
2. Hansen TE, Casey DE, Hoffman WF: Neuroleptic intolerance. Schizophr Bull 1997; 23:567–82.

Poster 13 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

USE OF OLANZAPINE AND RISPERIDONE AT BASELINE IN A PROSPECTIVE STUDY OF THE COURSE OF TREATMENT FOR SCHIZOPHRENIA

Supported by Eli Lilly and Company

Danielle L. Loosbrock, M.H.A., *Research Associate, Eli Lilly and Company, One Lilly Corporate Center, Drop 1850, Indianapolis, IN 46285;* Bryan M. Johnstone, Ph.D.; Brian K. Dulisse, Ph.D.; P. Joseph Gibson, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will gain insight into atypical antipsychotic medication utilization patterns for treatment of schizophrenia in large systems of community care.

SUMMARY:

Objectives: To profile utilization of olanzapine and risperidone for treatment of schizophrenia.

Methods: The first 1,231 patients enrolled in the U.S. Schizophrenia Care and Assessment Program, a prospective study of treatment for schizophrenia in community systems of care, were evaluated.

Results: 45 percent of patients received olanzapine (n = 321) or risperidone (n = 231) over a six-month baseline interval were evaluated. Olanzapine-treated patients received a median dose of 10.4 mg/day (mean 13.0, mode 10). Risperidone-treated patients received a median dose of 6.0 mg/day (mean 5.6, mode 6). Among patients receiving both medications, risperidone was two times more likely to precede olanzapine than the reverse order. Patients initiating olanzapine treatment were significantly more likely to receive prior clozapine and/or depot antipsychotic treatment ($p < .01$) than risperidone-treated patients. Olanzapine-treated patients were significantly less likely to receive antiparkinsonian or anticholinergic agents ($p < .01$) during the treatment interval than risperidone-treated patients.

Conclusions: Dosages of olanzapine and risperidone in this large community sample of patients receiving usual care were consistent with expectations from controlled studies. Olanzapine-treated patients were more likely to receive prior therapies associated with treatment resistance or noncompliance than risperidone-treated patients, suggesting the likelihood of greater severity in the olanzapine treatment group, and were less likely to receive antiparkinsonian or anticholinergic medications during therapy.

REFERENCES:

1. Foster R, Goa K: Olanzapine: a pharmacoeconomic review of its use in schizophrenia. Pharmacoeconomics. 1999; 15:611–640.
2. Foster RH, Goa KL: Risperidone: a pharmacoeconomic review of its use in schizophrenia. Pharmacoeconomics. 1998; 14:97–133.

Poster 14 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

A COMMUNITY-BASED PSYCHOSOCIAL SKILLS TRAINING PROGRAM FOR SCHIZOPHRENIA AND OTHER SEVERE MENTAL ILLNESSES

Mona Goldman, Ph.D., *Research Investigator, Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Box 0120, Ann Arbor, MI 48109;* Nancy Mann, R.N.; Elizabeth Realmuto, M.P.H.; Lorelei Simpson, B.S.; Patrick Kraft, R.N.; Rajiv Tandon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe elements of a new psychosocial skills training program for persons with severe mental illnesses and evaluate its effectiveness in community-based settings.

SUMMARY:

Objective: There is growing consensus that the optimal treatment for schizophrenia is a combination of pharmacotherapy and psychosocial interventions. In this study we describe the design, implementation, and evaluation of a psychosocial skills training program for community-based settings.

Method: Based on the modular approach pioneered by Liberman, our Life Skills program uses educational techniques such as didactic learning, role-play, and a patient workbook to teach 21 topics that include problem solving, communication skills, and symptom identification and medication. The core program of 21 hour-long weekly classes is followed by 12 weekly review sessions, all taught by two psychiatric nurses.

Evaluation: The evaluation protocol includes assessment of process (number of classes attended; and satisfaction with classes) and outcomes (change in difficulty with tasks and quality of life). Program directors at each site use the Clinical Global Impression and the Global Assessment of Functioning scales to assess baseline severity of illness and functional impairment, respectively.

Results: Eighty-one people with severe mental illnesses are currently enrolled in the Life Skills program at four diverse sites: a residential treatment facility; a client-run clubhouse; a client-managed clubhouse; and a university-based outpatient clinic (mean number of classes attended: 8.0). The participants are about 60% female, 80% Caucasian, and 60% are over age 35. Change in skill level, change in quality of life, and client satisfaction scores will be presented. The impact of program location and client demographic and clinical factors on those measures will be examined.

This work is supported in part by the Ethel and James Flinn Family Foundation.

REFERENCES:

1. Heinssen RK, Liberman RP, Kopelowicz: Psychosocial skills training for schizophrenia: lessons from the laboratory. Schizophrenia Bulletin 2000; 26:21–46.
2. Liberman RP, DeRisi WD, Mueser KT: Social Skills Training for Psychiatric Patients. Boston, Allyn and Bacon, 1989.

Poster 15 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

PSYCHIATRIC NURSE PRACTITIONERS' DIFFERENCES AND PSYCHOPHARMACOLOGY

Milena D. Djuric, M.D., *Fellow in Psychiatry, Bangor Mental Health Institute, Community Link and Support*

Program, 656 State Street, Bangor, ME 04401; Charles D. Hanson, M.D., *Director of Psychiatry, and Elderly Care, CLASP Department, Bangor Mental Health Institute, P.O. Box 926, Bangor, ME 04401;* Christopher Van Kleeck, Psy.D.; Arkadiusz Kielpinski, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize a novel technique useful in supervision of psychiatric nurse practitioners, a technique capable of application also in supervision of other prescribing clinicians; and to recognize some kinds of idiosyncrasy or bias that may be found in consultations by psychiatric nurse practitioners (and probably by other consultants as well).

SUMMARY:

Background: Prescribing patterns have been studied by means of interview and by focus on a pattern for an institution as a whole, but review of literature shows a paucity of direct data as to differences in prescription patterns of psychiatric nurse practitioners (i.e., of data drawn from actual review of medical records). In nursing home care, an increasingly significant portion of the treatment decisions involving psychotropic medicines are made by psychiatric nurse practitioners. With this background, a pilot effort to determine and evaluate patterns of nurse practitioner treatment decisions was designed permitting their psychiatrist-supervisor (the same psychiatrist for all) to identify possible deficiencies or imbalances and to form some impressions as to trends or biases in geripsychiatric pharmacotherapy.

Methods: Retrospective chart review was made of 65 consecutive medication management visits performed by each of several psychiatric nurse practitioners in July 1999 in nursing homes. Patient and treatment characteristics were identified, recommendations by the nurses were tabulated including dose adjustments and starting new or discontinuing current medications, and "future" or multiple-step recommendations (providing a schedule of sequential medicine adjustments) were distinguished from isolated or single-step recommendations.

Results: It was noted that although the groups of 65 patients were highly comparable in diagnosis, age, and sex distribution and in frequencies of medicine-use among various classes of medicine, prescribing practices differed strikingly within classes of medicines. The nurses differed sharply not only in choices they made of specific medications but also in their handling of dose adjustment and in their perseverance with a medicine versus switching to another.

Conclusions: In a pilot study examining medical records with regard to patterns of recommendations made by nurse practitioners, data emerged raising questions useful for supervision; identifying characteristic patterns of recommendations made by different nurse practitioners provides a basis for discerning their idiosyncrasies and biases and may yield clues as to their needs for continuing education. With increasing computerization of medical records, attention to such clinical patterns may become a practical tool in supervisory process.

REFERENCES:

1. Avora J, Gurwitz JH: Drug use in the nursing home. Ann Intern Med 1995; 123:195–204.
2. Lasser RA, Sunderland T: Newer psychotropic medication use in nursing home residents. J Am Geriatric Soc 1998; 46;202–207.

Poster 16 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

AN INTEGRATED INPATIENT AND PARTIAL HOSPITAL TEACHING SERVICE

Edward Kim, M.D., *Assistant Professor, Department of Psychiatry, University Medical and Dental of New Jersey, Robert Wood Johnson Medical Center, 671 Hoes Lane, Piscataway, NJ 08855;* Irina Efremova, M.D., *Assistant Professor, Department of Psychiatry, University of Medical and Dental Studies of New Jersey, Robert Wood Johnson Medical Center, 671 Hoes Lane, Piscataway, NJ 08855;* Pradeep Arora, M.D.

EDUCATIONAL OBJECTIVES:

To recognize the value of a combined inpatient and partial hospital service for patient care and resident education.

SUMMARY:

The trend toward rapid turnover of patients and shortened episodes of inpatient care raises concerns regarding the quality of educational experience offered to psychiatric residents on acute inpatient units. Integrating inpatient and partial hospital programs has been suggested as a means of providing continuity of residents' treatment experience with patients. We describe a core teaching service that integrates inpatient (IP), partial hospital (PH), and intensive outpatient (IOP) treatment. In this service, each multidisciplinary treatment team treats patients on all three levels of care. In fiscal year 1999, the inpatient unit received 686 admissions with an average length of stay of 7.8 days. Of these, 42.9% were transferred to the partial hospital/IOP. The partial hospital/IOP admitted 395 patients with an average length of stay of 7.4 days. Total PH/IOP admissions consisted of 294 (74.4%) transfers from the inpatient unit and 101 (25.6%) direct admissions from outpatient offices. This teaching service allows residents to follow patients for an average of 2.5 weeks during an acute episode of

care. The increased duration of treatment reduces patient turnover encountered on short-stay inpatient services and allows residents additional contact to develop a richer understanding of their patients. We believe that this service model may better prepare residents for the current demands of psychiatric practice.

REFERENCES:

1. Houghtalen RP, Guttmacher LB: Facilitating effective residency education on short-term inpatient units. Psychiatric Quarterly 1996; 87:2:111–124.
2. Houghtalen RP, Talbot NL: A combined inpatient and partial hospital program. Psychiatric Services 1997; 48:242–244.

Poster 17 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

BRIEF PSYCHIATRIC INPATIENT TREATMENT IN AN AGE OF COMMUNITY SERVICES

Keith A. Wood, Ph.D., *Director of Mental Health, Grady Health, 80 Butler Street, Atlanta, GA 30335*

EDUCATIONAL OBJECTIVES:

To diagnose acute psychiatric problems, use effective biopsychosocial interventions, employ sensitive clinical monitoring, and integrate community resources during brief psychiatric inpatient treatment.

SUMMARY:

The amount and type of psychiatric inpatient treatment being delivered is seriously affected by social, financial, and philosophical pressures to address acute mental illness-related crises using community-based services. Procedures previously used to reduce the use of institutional hospitalization are being applied to local inpatient units. Frequently hospitalization during psychiatric emergencies is delayed until the problem poses a serious threat and then is limited to a form of environmentally controlled, brief chemical stabilization. High rates of emergency room and brief-stay hospital recidivism and expressed concern by providers, family members, and consumers suggest limitations to providing such abbreviated interventions. This poster presents a brief psychiatric inpatient treatment approach that emphasizes diagnosing acute psychiatric problems, initiating and using crisis-oriented psychoeducational and psychosocial interventions, employing interdisciplinary team-targeted symptom and psychosocial stressor monitoring, and integrating community supports and resources. The importance of providing quality services using several indicators including recidivism, reported satisfaction, and community functioning is discussed.

TARGET AUDIENCE:

Community mental health, psychiatric inpatient, and community outreach service clinicians and clinical administrators.

REFERENCES:

1. Yohanna D, Christopher NJ, Lyons JS, et al: Characteristics of short-stay admissions to a psychiatric inpatient service. Journal of Behavioral Health Service Research 1998; 25:337–345.
2. Goren S: Pursuit of the ordinary: Short-term inpatient treatment. Archives of Psychiatric Nursing 1997; 11:82–87.
3. Wickizer TM, Lessler D, Travis KM: Controlling inpatient psychiatric utilization through managed care. American Journal of Psychiatry 1996; 153:339–345.

Poster 18 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

GENETIC INVESTIGATION IN A RESIDENTIAL MENTAL RETARDATION POPULATION

Supported by Janssen Pharmaceutica and Research Foundation

Richelle M. Kirrane, M.D., *Psychiatrist, St. Vincent's Hospital, Elm Park, Dublin 4, Ireland;* Mary Staines, M.D.

EDUCATIONAL OBJECTIVES:

To recognize the importance of genetic causes of mental retardation and of genetic testing in a residential mental retardation population; to understand the need for criteria to prioritize genetic testing and referral, and to appreciate resource and consent implications of repeat testing using newer techniques.

SUMMARY:

In 40%–50% of patients with mental retardation (MR), the etiology is genetic. We aimed to establish the level of genetic investigation (karyotyping and Fragile X testing) done in a residential MR population and the implications for future testing. We determined testing done, family history of MR, and clinical evidence of dysmorphism in 151 residential MR patients. The sex ratio was 1.3 M > F. Etiology was established in 38% (chromosomal 41%, perinatal 27%, metabolic 7%, postnatal 14%, other 8%, Fragile X 0%). In the remaining 62% (mental retardation cause unknown [MRCU]), 88% had karyotyping. Of this MRCU group, 14% had a first-degree relative with MR, and 17% a second- or third-degree relative with MR. Of family-history-positive patients, 90% were karyotyped. All 11 dysmorphic MRCU

patients were karyotyped. Of nondysmorphic MRCU patients 2% had Fragile X testing. Techniques improved in 1986, but in 91% of patients tested, testing was done earlier.

In conclusion, most patients received testing, with high rates in family-history-positive and dysmorphic patients. Etiology was determined in one-third; two-thirds remain undiagnosed. Most of these had karyotyping done. Few had Fragile X testing, and those who did were tested before PCR became available. We suggest criteria to prioritize testing and referral to genetic services. Repeat testing may be indicated in many patients, with significant cost, consent, and clinical implications.

TARGET AUDIENCE:

The target audience for this poster includes psychiatrists working in MR and in psychiatric genetics, and health care managers.

REFERENCES:

1. Curry CJ, et al: Evaluation of mental retardation: recommendations of a consensus conference. American Journal of Medical Genetics 1997; 72:468–477.
2. Hecimovic S, et al: DNA analysis of the fragile X syndrome in an at risk pediatric population in Croatia. Hum Hered 1998; 48:256–265.

Poster 19 **Thursday, October 26 3:30 p.m.-5:00 p.m.**

FACTORS MOTIVATING PATIENTS TO SIGN-OUT AGAINST MEDICAL ADVICE

Patricia T. Green, M.S.N., *Nurse Manager, Behavioral Health Department, VA Medical Center, University and Woodland Avenues, Philadelphia, PA 19104;* Diane Watts, B.S.N., *Staff Nurse, Department of Nursing, VA Medical Center, University and Woodland Avenues, Philadelphia, PA 19104;* Vasant P. Dhopesh, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to discuss variables related to the incidence of premature termination of treatment among inpatient dual diagnosis patients, and describe alternatives that facilitate continuation of treatment for inpatients and aftercare.

SUMMARY:

Background and Objective: The phenomenon of AMA (against medical advice) discharges from psychiatric units and substance abuse treatment unit has been extensively reported. Correlation with age, type of substance abuse, day of the week, etc. have been commented on in the literature. The objective of this study was to explore the reasons motivating patients to sign out against medical advice on our dual-diagnosis unit.

Methods: A total of 754 admissions including repeat admissions from 11/12/98 to 8/5/98 were reviewed. At the time of the AMA discharge nurses asked the patient specific reasons for leaving AMA. Answers were tabulated.

Results: There were a total of 45 AMA discharges, in the seven-month period. One was ineligible for VA services and two were disciplinary discharges. Of the remaining 42 AMA discharges, 27 (64.2%) left AMA for personal reasons, which included family emergency, financial and personal obligations; reconciliation with spouse, family, girlfriend, a court date; etc. Eight (19%) refused treatment and five (11.9%) left because of no-smoking policy. Twenty-seven (64.2%) left during the day, 14 (33.3%) left in the evening, and none left at night.

Conclusions: A vast majority of our AMA discharged patients left because of personal reasons and obligations. Strategies to reduce AMA discharges should focus on counseling patients in handling personal psychosocial problems soon after admission. This will help patients against taking the impulsive decision of leaving prematurely.

REFERENCES:

1. Armenian SH, Chutuape MA, Stizer ML: Predictors of discharge against medical advice from a short-term hospital detoxification unit. Drug and Alcohol Dependence 1999; 56:1–8.
2. Greenberg WM, Otero J, Villanueva L: Irregular discharges from a dual discharge unit. Am J Drug and Alcohol Abuse 1994; 20:355–371.

Poster 20 **Thursday, October 26 3:30 p.m.-5:00 p.m.**

PATIENT-CENTERED ACUTE INPATIENT ALTERNATIVE FOR VETERANS: PRELIMINARY FINDINGS

Supported by the VA Health Services Research and Development

James B. Lohr, M.D., *Chief, Department of Psychiatry, Veterans Hospital, 3350 La Jolla Village Drive, Code 116-A, San Diego, CA 92161-0002;* William B. Hawthorne, Ph.D., *Executive Director, Community Research Foundation, 1202 Morena Boulevard, Suite 300, San Diego, CA 92110;* Elizabeth E. Green, Ph.D.; Brian Mittman, Ph.D.; Martin Lee, Ph.D.

EDUCATIONAL OBJECTIVES:

To 1) identify characteristics of an acute inpatient alternative to psychiatric hospitalization being studied

in a randomized clinical trial involving seriously mentally ill veterans; 2) understand the preliminary comparative findings regarding short-term outcomes in symptoms, functioning, patient satisfaction, and patients' evaluation of patient-centered aspects of treatment.

SUMMARY:

A controlled randomized trial comparing a patient-centered acute psychiatric treatment alternative (known as Short-Term Acute Residential Treatment, or START) with traditional Veterans hospital inpatient treatment is being conducted. Preliminary findings based on the subjects entering the study during the first six months of data collection (n = approximately 50–75) will be presented, including descriptive characteristics of the two forms of treatment and of the study participants, as well as comparative outcome data on multiple measures between admission and discharge, and preliminary two-month follow-up data on a subset of subjects for which it is available. Instruments include the SCID (Structured Clinical Interview for DSM-IV), information on drug and alcohol use from the Alcohol Severity Index, and change between admission and discharge on the SCI-PANSS (Structured Clinical Interview for Positive and Negative Syndrome Scale), SF-36V (Short-Form-36 for Veterans), and the QWB (Quality of Well-Being). Assessment of patient satisfaction and patients' perspectives on the presence or absence of patient-centered aspects of care will be determined based on the Perceptions of Care and the Ward Atmosphere Scale.

REFERENCES:

1. Hawthorne WB, Green EE, Lohr JB, et al: Comparison of outcomes of acute care in short-term residential treatment and psychiatric hospital settings. Psychiatric Services 1999; 50:401–406.
2. Gerteis N, Edman-Levitan S, Daley J, Delbanco TL (eds): Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care. San Francisco, Jossey-Bass, 1993.

Poster 21 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

ILLUSTRATED PSYCHODYNAMIC PSYCHOTHERAPY: A SECRET OF SUCCESSFUL CARTOONING

Lawrence K. Richards, M.D., *Consultant on Human Development and Disabilities, 714 South Lynn Street, Champaign, IL 61820-5817*

EDUCATIONAL OBJECTIVES:

To illustrate how cartoons employ psychodynamics to hold the reader's attention and achieve humor while providing a colorful and usually enjoyable demonstration of psychodynamics notable in everyday life.

SUMMARY:

The basic idea for the future therapist to remember is that often that which makes the cartoon jocular is encompassed in the old proverb: "You can't see the forrest for the trees." Cartoons have a way of unmasking matters and being interpretive to the psyche, particularly those aspects relating to childhood, family, fantasy, and interpersonal themes. Since printed cartoons are ubiquitous in civilized societies, most children and adults are aware of them even if they do not read them.

Cartoons' popularity is obvious, and this can be used in parenting, teaching, and entertainment. Even therapy can occur for the reader. This may take the form of insight, self confrontation, or just plain laughing at oneself. Those of us who knew Karl Menninger will recall his criteria for excellent mental health included being able to laugh at oneself.

Cartoons can also be incorporated in more formal therapy setting. It is possible that an alert patient will perceive matters and bring the achieved stimuli into a therapy session. Some of the author's patients brought him cartoons, particularly those dealing with psychiatrists. Certainly a psychiatrist could expound upon areas associatable to the cartoon, and the cartoons are often an indirect way for material to be presented by the patient to the doctor.

Several cartoon panels will be presented in the poster format so as to achieve an enjoyable time and method for learning and discussion.

REFERENCES:

1. Robinson J: The Comics: An Illustrated History of Comic Strip Art. G.P. Putnams Sons, New York, 2, 1974.
2. The Smithsonian Collection of Newspaper Comics. Edited by Blackbeard B, Williams L. Smithsonian Inst. Press, Wash, D.C. and Harry U. Abrams, Inc., New York, 1977.

Poster 22 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

INTERCESSORY PRAYER FOR THE ALLEVIATION OF ILL HEALTH

Irshad Ahmed, M.D., *Psychiatrist, Capital Regional Mental Health Center, 500 Vine Street, Hartford, CT 06112;* Noorulain A. Aqeel, M.D., *Psychiatry Resident in Training, PGY IV, Capitol Region Mental Health Center, St. Vincents Hospital, 101 West 15th Street, #6-KN, New York, NY 10011;* Leanne Roberts, B.A.; Steven Hall

EDUCATIONAL OBJECTIVES:

To review the effectiveness of prayer as an additional intervention for those with health problems; to recognize the importance of systematic reviews in the field of health care.

SUMMARY:

Background: Prayer is an ancient and widely used intervention for alleviating illness and promoting good health. This review focuses specifically on intercessory prayer, which is organized, regular, and committed, and those who practice it will almost inevitably hold some committed belief that they are praying to God. Whilst the outcomes of trials of prayer cannot be interpreted as ''proof/disproof'' of God's response to those praying, there may be an effect of prayer not dependent on divine intervention. This may be quantifiable, making this investigation of a most widely used health care intervention both possible and important.

Objectives: To review the effectiveness of prayer as an additional intervention for those with health problems already receiving standard medical care.

Selection criteria: Randomized trials of personal, focused, committed and organized intercessory prayer on behalf of anyone with a health problem were considered. Outcomes such as achievement of desired goals, death, illness, quality of life and well-being for the recipients of prayer, those praying and the caregivers were sought.

Data collection and analysis: Studies were reliably selected and assessed for methodological quality. Data were extracted by two reviewers working independently. Dichotomous data were analysed on an intention-to-treat basis.

Results: There was no evidence that prayer affected the numbers of people dying from leukemia or heart disease (OR 1.11, CI 0.79-1.56, n = 1424). Intercessory prayer did not clearly decrease the odds of people with heart problems experiencing a bad or intermediate outcome (OR 0.8, CI 0.64-1.00, n = 1444), but this finding was moved towards the null by inclusion of a negative assumption for those who were dropped from the analysis in one study. Prayer increased the odds of readmission to the coronary care unit (OR 1.54 CI 1.02-2.33, n = 1406) but these results are made significantly negative by the inclusion of an assumption of poor outcome for those not accounted for in the final analyses.

Conclusions: Data in this review are too inconclusive to guide those wishing to uphold or refute the effect of intercessory prayer on health care outcomes. In the light of the best available data, there are no grounds to change current practices. There are few completed trials of the value of intercessory prayer, and the evidence presented so far is interesting enough to justify further study. If prayer is seen as a human endeavour it may or may not be beneficial, and further trials could uncover this. It could be the case that any effects are due to elements beyond present scientific understanding that will, in time, be understood. If any benefit derives from God's response to prayer it may be beyond any such trials to prove or disprove.

REFERENCES:

1. Harris WS, Gowda M, Kolb JW, et al: A randomized, controlled trial of the effects of remote, intercessory prayer on outcomes in patients admitted to the coronary care unit. Arch Intern Med 1999; 159:2273–8.
2. DeLashmutt M, Silva MC: The ethics of long-distance intercessory prayer. Nursingconnections 1998; 11:37–40.

Poster 23 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

THE MEDICAL STAFF CODING COMMITTEE: ITS ROLE IN PSYCHIATRIST BILLING COMPLIANCE

Nelson P. Gruber, M.D., *Associate Professor, Department of Psychiatry, University of Texas, Houston Medical School, 2800 South MacGregor Way, HCPC 2D-08, Houston, TX 77021-1032*

EDUCATIONAL OBJECTIVES:

To a) discuss government anti-fraud efforts regarding physician documentation and billing, b) recognize the role a medical staff coding committee (MSCC) can play in ensuring regulatory compliance, c) gain familiarity with the composition, scope, and benefits of an MSCC, and d) better understand Medicare E/M Services and Teaching Physician documentation guidelines.

SUMMARY:

Physician billing compliance with government regulations is essential given the government's significant and growing anti-fraud efforts. Academic medicine in particular, has been the subject of intensive scrutiny. At the UT-Harris County Psychiatric Center, a 250-bed university/public psychiatric hospital, issues of documentation, CPT coding, and medical necessity have been a top priority given the potential of grave financial/legal consequences for compliance failure. It is a special challenge, as the focus of Medicare guidelines is not directed towards psychiatric care.

Two years ago, a medical staff coding committee (MSCC) was formed to assist the center and its psychiatrists in dealing with these issues; the presenters share their experience as committee leaders.

The MSCC has evolved into a highly effective and important component of the center's compliance program. The committee has had a major impact on ensuring appropriate and more uniform clinical care documenta-

tion, enhancing CPT coding, assuring that teaching-physician guidelines are followed, and capturing lost revenue from inadequate documentation. Core contributions include its systematic clarification of all E/M guidelines for hospital-based psychiatric care and related documentation. Regular review of all psychiatrists' charting with detailed feedback regarding deficiencies supports committee effectiveness; follow-up shows nearly 100% compliance.

REFERENCES:

1. Coles TS, Babb EF: Accurate documentation, correct coding, and compliance: its your best defense. Mo Med 1999; 96:236–9.
2. Guglielmo WJ: The feds take aim at fraud and abuse. Med Econ 1998; 75:166-6, 171-4, 177-8.

POSTER SESSION II

Posters 24–47

Poster 24 **Friday, October 27**
10:00 a.m.-11:30 a.m.

ANTIDEPRESSANT EARLY RESPONSE AND REMISSION OF VENLAFAXINE AND FLUOXETINE IN GERIATRIC OUTPATIENTS

Supported by Wyeth-Ayerst Laboratories

Alan F. Schatzberg, M.D., *Professor and Chairman, Department of Psychology and Behavior, Stanford University School of Medicine, 401 Quarry Road, Suite 300, Stanford, CA 94305-5717;* Marc Cantillon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the efficacy and safety of venlafaxine in treating depression in the geriatric population, encouraging the use of this antidepressant for the importance of a rapid onset of action for this patient population.

SUMMARY:

Objective: To evaluate antidepressant efficacy and tolerability of venlafaxine (immediate-release formulation) and fluoxetine in geriatric outpatients with major depression.

Method: In this eight-week, double-blind, placebo-controlled study, efficacy data were available for 288 patients (93 venlafaxine, 99 fluoxetine, 96 placebo). Venlafaxine dose ranged from 75 mg/d to 225 mg/d; fluoxetine dose ranged from 20 mg/d to 60 mg/d. Outcome of response was measured by a 50% decrease from baseline HAM-D or MADRS scores, or a score of 1 or 2 on the CGI-Global Improvement (CGI-I) scale; remission was measured by a HAM-D total score of ≤8. Safety was assessed by monitoring adverse events.

Results: Statistically significant differences were not seen at end point; however, they were noted for response on MADRS total and CGI-I scores, but not on HAM-D. By week 3, CGI-I response frequency for venlafaxine (50%) was significantly different ($P < 0.05$) from placebo (35%) and fluoxetine (41%). By week 4, venlafaxine was significantly ($P < 0.05$) superior to fluoxetine and placebo in reducing HAM-D depressed mood item. By week 6, MADRS response frequency for venlafaxine (55%) was significantly different ($P < 0.05$) from placebo (36%) and fluoxetine (36%). Both venlafaxine and fluoxetine were well tolerated in these patients.

Conclusion: These data suggest venlafaxine had a more rapid onset of action, demonstrating a significantly greater response than fluoxetine as early as week 3. No significant safety concerns were evident.

TARGET AUDIENCE:

Psychiatrists, primary care physicians.

REFERENCES:

1. Dierick M, Ravizza L, Realini R, Martin A: A double-blind comparison of venlafaxine and fluoxetine for the treatment of major depression in outpatients. Prog Neuropsychopharmacol Biol Psychiatry 1996; 20:57–71.
2. Rudolph RL, Feiger AD: A double-blind, randomized, placebo-controlled trial of once-daily venlafaxine extended release (XR) and fluoxetine for the treatment of depression. J Affect Disord 1999; 56:171–181.

Poster 25 **Friday, October 27**
10:00 a.m.-11:30 a.m.

MIRTAZAPINE AND PAROXETINE IN ELDERLY DEPRESSED PATIENTS

Supported by Organon Inc.

Alan F. Schatzberg, M.D., *Professor and Chair, Department of Psychology and Behavioral Science, Stanford University School of Medicine, 401 Quarry Road, Suite 300, Stanford, CA 94305-5717;* Charlotte Kremer, M.D., *Director, CNS Phase IV Clinical Trials, Organon Inc., 347 Mt. Pleasant Avenue, West Orange, NJ 07052;* Heidi Rodrigues

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the design and methods of this clinical trial comparing mirtazapine with paroxetine;

discuss the results of this study and its implications for the clinical use of mirtazapine in elderly patients.

SUMMARY:

Purpose: This multicenter, double-blind, eight-week study was performed to evaluate the antidepressant efficacy and safety of mirtazapine (15–45 mg/day) compared with paroxetine (20–40 mg/day) in patients aged 65 or older.

Methods: Two hundred outpatients aged 65 years or older, who met DSM-IV criteria for major depression, were included if they had a baseline HAM-D 17 score of ≥18 and an age-adjusted MMSE above the lowest 25th percentile. Assessments for efficacy and cognitive performance were obtained. Blood samples were obtained for determining genetic polymorphisms.

Results: Preliminary analysis for this study was performed without breaking the study blind. Dropouts due to adverse events occurred at rates of 18% (Treatment A) and 28.6% (Treatment B). A total of 100 patients received Treatment A and were matched for baseline demographics to the 98 patients who took Treatment B. Based on LOCF analysis, percent responders (decrease of at least 50% compared with baseline) were 28.3% and 15.2% ($p = 0.029$) at Week 2 for Treatments A and B, respectively, and 58.6% and 54.3% at Week 8 (NS). The percentage of patients in remission (HAM-D 17 ≤ 7), for Treatments A and B respectively, were 11.1% and 4.3% ($p = 0.093$) at Week 2, and 37.4% and 32.6% at Week 8 (NS).

Conclusion: Both treatments were shown to be effective and well tolerated. As indicated by percent responders and remitters, Treatment A demonstrates a potential for earlier onset of action. This study was supported by a grant from Organon Inc., West Orange, NJ.

REFERENCES:

1. Schatzberg AF, Cole JO, DeBattista C: Manual of Clinical Psychopharmacology, 3rd Edition. Washington, DC, Am Psych Press, 1997.
2. Schatzberg AF, Nemeroff CB, eds: Textbook of Psychopharmacology, 2nd Edition. Washington DC, Am Psych Press, 1998.

Poster 26 **Friday, October 27**
10:00 a.m.-11:30 a.m.

MIRTAZAPINE VERSUS SERTRALINE AFTER SSRI NONRESPONSE

Supported by Organon Inc.

Michael E. Thase, M.D., *Professor, Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hare Street, Pittsburgh, PA 15213;* Charlotte Kremer, M.D., *Director, CNS Phase IV Clinical Trials, Organon Inc., 347 Mt. Pleasant Avenue, West Orange, NJ 07052;* Heidi Rodrigues

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the design and methods of this clinical trial of mirtazapine as a possible alternative for SSRI nonresponders; discuss the results of this study, with respect to the efficacy and safety of switching patient with major depression who have failed fluoxetine, paroxetine or citalopram to mirtazapine or sertraline.

SUMMARY:

Objective: To evaluate the efficacy and safety of mirtazapine and sertraline in patients with major depression who had failed to respond to fluoxetine, paroxetine or citalopram.

Methods: A total of 250 outpatients with major depression according to DSM-IV criteria and lack of response to an adequate trial of fluoxetine, paroxetine, or citalopram were randomized to treatment with mirtazapine (15–45 mg per day) or sertraline (50–200 mg per day) for a maximum of eight weeks.

Results: A total of 115 patients took mirtazapine (mean daily dose 29.9 mg) while 125 patients received sertraline (mean daily dose 118.2 mg); both groups were matched for baseline demographics. Discontinuation due to adverse events was 20.7% (mirtazapine) and 12.8% (sertraline). Response (at least 50% decrease in HAM-D 17) rates for mirtazapine and sertraline were, respectively, 37.4% and 24% at Week 3 ($p = 0.008$), 40.9% and 28.8% at Week 4 ($p = 0.024$), and 50.4% and 52.8% at Week 8 (NS). Remission (HAM-D 17 ≤ 7) rates for mirtazapine and sertraline were, respectively, 13.0% and 4.8% at Week 2 ($p = 0.029$), and 37.4% and 29.6% at Week 8 (NS).

Conclusion: Mirtazapine and sertraline are effective and well-tolerated for SSRI non-responders. Response rates at Week 3 and 4 and remission rates at Week 2 are consistent with an earlier onset of action for mirtazapine.

This study was supported by a grant from Organon Inc., West Orange, NJ.

REFERENCES:

1. Thase ME, Blomgren SL, Birkett MA, et al: Fluoxetine treatment inpatients with major depressive disorder who failed initial treatment with sertraline. Journal of Clinical Psychiatry 1997; 58:16–21.
2. Poirier MF, Boyer P: Venlafaxine and paroxetine in treatment-resistant depression. Double-blind, randomized comparison. British Journal of Psychiatry 1999; 174:12–16.

Poster 27 **Friday, October 27**
10:00 a.m.-11:30 a.m.

CITALOPRAM TREATMENT IN PATIENTS WHO HAVE FAILED FLUOXETINE

Supported by Forest Laboratories, Inc.

Michael E. Thase, M.D., *Professor, Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hare Street, Pittsburgh, PA 15213;* R. Bruce Lydiard, M.D., Ph.D.; Joseph Calabrese, M.D.; Peter D. Londborg, M.D.; John P. Feighner, M.D.

EDUCATIONAL OBJECTIVES:

To appreciate that citalopram can be used to treat patients who have failed fluoxetine.

SUMMARY:

In this study we examined whether patients treated unsuccessfully with one SSRI (fluoxetine) could be treated successfully with a second SSRI (citalopram). Patients with DSM-IV major depression who failed to respond to, or were unable to tolerate, fluoxetine treatment (≥20 mg/day) were eligible. In fluoxetine nonresponsive patients (N = 58), open-label citalopram 20 mg/day was initiated on the day after the last fluoxetine dose. Fluoxetine-intolerant patients (N = 55) entered a two-to-four-week, single-blind, placebo-washout period. When adverse events resolved, patients were switched to open-label citalopram 20 mg/day. Dosing was adjusted depending on response and tolerability. Efficacy parameters included the Clinical Global Impression of Improvement (CGI-I) scale and the 24-item Hamilton Depression Rating Scale (HAMD). Eighty-one percent of fluoxetine nonresponders completed the trial. The "next day" switch to citalopram was well tolerated. Among completers, 76% were rated as responders on the CGI-I, and average HAMD scores fell from 27.5 at baseline to 13.1 at study termination. Ninety-five percent of fluoxetine-intolerant patients completed the trial, and none discontinued citalopram treatment due to adverse events. Adverse events associated with discontinuation of fluoxetine did not commonly recur with citalopram. Citalopram was also efficacious in fluoxetine-intolerant patients; 67% of completers were rated as responders on the CGI-I. In both groups, HAMD scores were significantly reduced after one week of treatment with citalopram. These results indicate that citalopram is an effective and safe agent for patients who are nonresponsive to or intolerant of fluoxetine.

REFERENCES:

1. Fava M: Management of nonresponse and intolerance: switching strategies. J Clin Psychiatry. 2000:61 Suppl 2:10–2. Review.
2. Thase ME, Blomgren SL, Birkett MA, et al: Fluoxetine treatment of patients with major depressive disorder who failed initial treatment with sertraline. J Clin Psychiatry 1997; 58(1):16–21.

Poster 28 **Friday, October 27**
10:00 a.m.-11:30 a.m.

REMISSION RATES WITH DIFFERENT DOSAGES OF VENLAFAXINE VERSUS SSRIS AND PLACEBO IN MDD

Supported by Wyeth-Ayerst Laboratories

Richard Entsuah, Ph.D., *Associate Director, Global Clinical Research, Wyeth-Ayerst Research Laboratories, 145 King of Prussia Road, Radnor, PA 19807*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to recognize the more favorable efficacy profile of venlafaxine compared with the SSRIs in achieving remission in the treatment of major depressive disorder and improving the clinical status of depressed patients.

SUMMARY:

Objective: To evaluate various dosages of venlafaxine, selective serotonin reuptake inhibitors (SSRIs), and placebo in the treatment and remission of major depressive disorder (MDD).

Methods: Data from over 2000 patients with moderate to severe MDD were pooled for analysis. Patients received venlafaxine (≤75 mg, 76–150 mg, 151–225 mg, or >225 mg), an SSRI (fluoxetine, paroxetine, or fluvoxamine), or placebo for ≤8 weeks. Remission (HAM-D_{17} total ≤7), absence of depressed mood (ADM; HAM-D Item 1 = 0), and response to treatment (≥50% reduction from baseline on HAM-D_{21}) were assessed.

Results: Remission rates for all venlafaxine dosages (43% to 45%) were significantly higher than those achieved with the SSRIs (35%; $P < 0.001$) or placebo (25%; $P < 0.001$). ADM rates ranged from 33% to 43% for venlafaxine ($P < 0.001$ vs placebo), 31% for the SSRIs, and 20% for placebo; venlafaxine ≤75 mg was significantly better than the SSRIs. Response rates ranged from 61% to 66% for venlafaxine, compared with 57% for the SSRIs and 42% for placebo; the high dosage of venlafaxine was significantly better than placebo ($P < 0.05$).

Conclusions: At established safe dosages, venlafaxine was superior to the SSRIs and placebo in achieving remission of MDD, as well as in the resulting rates of ADM and response to treatment.

TARGET AUDIENCE:

Psychiatrists, mental health specialists.

REFERENCES:

1. Nierenberg AA, Wright EC: Evolution of remission as the new standard in the treatment of depression. J Clin Psychiatry 1999; 60(suppl 22):7–11.
2. Rush AJ, Trivedi MH: Treating depression to remission. Psychiatric Annals 1995; 25:704–709.

Poster 29 **Friday, October 27**
10:00 a.m.-11:30 a.m.

A POOLED ANALYSIS COMPARING VENLAFAXINE AND SSRIS

Supported by Wyeth-Ayerst Laboratories

Richard Entsuah, Ph.D., *Associate Director, Global Clinical Research, Wyeth-Ayerst Research Laboratories, 145 King of Prussia Road, Radnor, PA 19807;* Richard L. Rudolph, M.D.; David Hackett, M.S., B.Sc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the superior efficacy and faster onset of action of the dual mechanism of action venlafaxine over the single mechanism SSRIs, encouraging the use of this antidepressant for patients with depression.

SUMMARY:

Objective: To compare the efficacy of venlafaxine, selective serotonin reuptake inhibitors (SSRIs) (fluoxetine, paroxetine, and fluvoxamine), or placebo in patients with depressive disorder using meta-analysis of pooled efficacy data.

Methods: Efficacy data were pooled from eight comparable active-controlled studies, four of which were also placebo-controlled. Patients meeting the DSM-III-R or DSM-IV criteria for major depression or major depressive disorder were randomized to receive venlafaxine immediate or extended release (n = 865; 50–375 mg/d), an SSRI (n = 757; 20–200 mg/d), or placebo (n = 450) for six to 12 weeks. Efficacy was evaluated using total scores for HAM-D_{21} and MADRS, and the CGI-Improvement item (CGI-I) score for the last-observation-carried-forward data.

Results: CGI-I scores indicated that the response rate for venlafaxine treatment was significantly greater than that for placebo ($P = 0.01$) and SSRI ($P < 0.05$). Both active treatments demonstrated improvement in symptoms compared with placebo. Venlafaxine showed a significantly higher improvement in HAM-D scores than SSRIs ($P < 0.001$). Relative to placebo, statistically significant improvement with venlafaxine was observed at two weeks of treatment ($P < 0.001$) compared with four weeks for SSRIs ($P < 0.05$). Similar results were derived from the MADRS scores.

Conclusions: Venlafaxine treatment exhibited a significantly greater improvement in depression scores compared with SSRI and placebo treatment and elicited a more rapid onset of antidepressant effects than the SSRIs.

TARGET AUDIENCE:

Psychiatrists, primary care physicians.

REFERENCES:

1. Dierick M, Ravizza L, Realini R, Martin A: A double-blind comparison of venlafaxine and fluoxetine for treatment of major depression in outpatients. Prog Neuropsychopharmacol Biol Psychiatry 1996; 20:57–71.
2. Rudolph RL, Feiger AD: A double-blind, randomized, placebo-controlled trial of once-daily venlafaxine extended release (XR) and fluoxetine for the treatment of depression. J Affect Disord 1999; 56:171–181.

Poster 30 **Friday, October 27**
10:00 a.m.-11:30 a.m.

VENLAFAXINE DEMONSTRATES SUPERIOR SUSTAINED REMISSION COMPARED WITH SSRIS OR PLACEBO

Supported by Wyeth-Ayerst Laboratories

Richard Entsuah, Ph.D., *Associate Director, Global Clinical Research, Wyeth-Ayerst Research Laboratories, 145 King of Prussia Road, Radnor, PA 19807*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize that maintaining remission is a definitive measure for antidepressant success; recognize the importance of maintaining sustained remission for antidepressant success; and understand the effectiveness of venlafaxine to maintain remission longer than fluoxetine, paroxetine, fluvoxamine, and placebo.

SUMMARY:

Objective: Maintaining remission of depression is the ultimate measure of antidepressant success. The maintenance of remission was compared among venlafaxine, selective serotonin reuptake inhibitors (SSRIs), and placebo.

Methods: Eight clinical studies comparing venlafaxine and SSRIs were pooled. Data on 851 venlafaxine-treated patients, 749 SSRI-treated patients, and 446 placebo-treated patients were pooled. The active controls

in the SSRI group were fluoxetine, paroxetine, and fluvoxamine. Remission was defined by HAM-D scores <8 at week 4; sustained remission was measured by maintaining remission through week 8 of treatment.

Results: Of the 213 patients on venlafaxine who attained remission at week 4, 184 (86.4%) sustained their remission through week 8. A total of 145 patients on SSRIs attained remission at week 4, with 103 (71%) patients achieving sustained remission at week 8. Placebo-sustained remission was attained in 42 of 60 (70%) patients. Significant differences were observed between venlafaxine and SSRIs ($P < 0.001$) and between venlafaxine and placebo ($P < 0.001$).

Conclusion: Venlafaxine treatment was associated with a significantly higher rate of sustained remission than the SSRIs or placebo. The ability of venlafaxine to maintain remission longer than the SSRIs is perhaps attributed to its dual serotonin and norepinephrine reuptake inhibition.

TARGET AUDIENCE:

Psychiatrists and clinicians.

REFERENCES:

1. Silverstone PH, Ravindran A, for the Venlafaxine XR 360 Study Group: Once-daily venlafaxine extended release (XR) compared with fluoxetine in outpatients with depression and anxiety. J Clin Psychiatry 1999; 60: 22–28.
2. Stahl SM: Why settle for silver, when you can go for gold? Response vs. recovery as the goal of antidepressant therapy. J Clin Psychiatry 1999; 60: 213–214.

Poster 31 **Friday, October 27**
10:00 a.m.-11:30 a.m.

SUBSTANCE USE DISORDERS AMONG COCAINE-DEPENDENT PATIENTS

Ashwin A. Patkar, M.D., *Assistant Professor, Department of Psychiatry, Thomas Jefferson University School of Medicine, 1201 Chestnut Street, 15th Floor, Philadelphia, PA 19107;* Raman N. Gopalakrishnan, M.D., *Psychiatry Resident, Belmont Center, 4200 Monument Road, Philadelphia, PA 19131;* Allan Lundy, Ph.D.; Stephen P. Weinstein, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the clinical importance of changing patterns of substance use, particularly the increasing prevalence of polysubstance abuse among cocaine-dependent patients in treatment.

SUMMARY:

Objective: Studies have indicated that dependence on more than one drug worsens prognosis, with polysubstance abuse linked to poor outcome. As a part of a large study investigating biological and clinical correlates of treatment outcome, we employed standardized instruments to diagnose current and lifetime substance use disorders among cocaine-dependent patients.

Method: Consecutive admissions to an intensive outpatient substance abuse treatment program affiliated to a university hospital in Philadelphia were studied. Inclusion criteria included cocaine as the primary drug. Subjects with comorbid bipolar disorders, schizophrenia, or current major depression were excluded from the study. Consenting patients underwent the Structured Clinical Interview (SCID) for DSM-IV and current and lifetime diagnoses of substance use disorders were recorded. Chi square tests and tests of correlation were used for data analyses.

Results: Eighty-eight African-American subjects (74% men, mean age 35.5) with a primary diagnosis of cocaine dependence were studied. Only 12.5% of subjects have a current diagnosis of cocaine dependence alone (excluding nicotine dependence). 55.7% had a current diagnosis, and 56.8% had a lifetime diagnoses of alcohol abuse or dependence. About 76% had a lifetime diagnosis of nicotine dependence. Nearly 24% had current and 55.7% had lifetime diagnoses of cannabis abuse or dependence. About 5% were currently dependent on opiates and 11.4% had abused or were dependent on opiates in their lifetime. As expected, the number of lifetime and current substance abuse/dependence diagnosis were significantly correlated ($r = .421$, $p < 0.01$). About 13% had a current diagnosis of substance induced mood or anxiety disorder and approximately 15% had a lifetime history of panic disorder or major depression, which was significantly correlated with the number of lifetime diagnosis of substance use disorders ($r = .47$, $p < 0.01$)

Conclusion: The frequency of polysubstance abuse and dependence, especially alcohol, marijuana, and nicotine among cocaine-dependent patients seeking treatment is very high, at least in inner-city treatment settings. In fact, very few patients were "pure" cocaine abusers. These clinical syndromes may have implications for treatment and outcome.

(Funded by NIDA grant #DA340-02).

TARGET AUDIENCE:

Psychiatrists, psychopharmacologists, and biological researchers.

REFERENCES:

1. Weiss RD, Martinez-Raga J, Hufford C. The significance of a coexisting opioid use disorder in cocaine

dependence: an emperical study Am J Drug Alcohol Abuse, 1996; 22(2):173–184.
2. Miller NS, Gold MS, Belkin BM, Klahr AL: The diagnosis of alcohol and cannabis dependence in cocaine dependents and alcohol dependence in their families Br J Addict 1989; 84:1491–1498.

Poster 32 **Friday, October 27**
10:00 a.m.-11:30 a.m.

SERUM PROLACTIN LEVELS AND TREATMENT OUTCOME AMONG COCAINE-DEPENDENT PATIENTS

Supported by the National Institute on Drug Addiction

Ashwin A. Patkar, M.D., *Assistant Professor, Department of Psychiatry, Thomas Jefferson University School of Medicine, 1201 Chestnut Street, 15th Floor, Philadelphia, PA 19107;* Kevin Hill, B.A., *Medical Student, Department of Psychiatry, Jefferson University School of Medicine, 1201 Chestnut Street, Philadelphia, PA 19107;* Robert C. Sterling, Ph.D.; Edward Gottheil, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that dopaminergic systems may be involved in cocaine dependence and may mediate treatment outcome.

SUMMARY:

Objective: Considerable evidence indicates that dopaminergic (DA) mechanisms may modulate the central effects of cocaine. We investigated a) whether serum prolactin (PRL), an indirect measure of central DA activity, differed between cocaine dependent (CD) subjects and controls, and b) whether PRL levels among CD patients were related to their treatment outcome.

Method: Eighty seven African-American (AA) cocaine-dependent (DSM-IV) subjects (74% male, mean age 35.5) attending an intensive outpatient treatment program in Philadelphia and 35 AA (63% male, mean age 32.8) drug-free controls were studied. Blood samples were obtained after an overnight fast. Sera were separated and PRL concentrations were measured by radioimmunoassay. The outcome measures were number and proportion of negative urine drug screens, and counselor ratings of improvement (meeting treatment goals). T-tests and tests of correlation were used for data analyses.

Results: The mean PRL levels among cocaine patients (9.08 $\pm$ 4.10) were significantly higher compared to controls (7.14 $\pm$ 3.36) ($t = 2.48$, $p < 0.02$). About 5% of patients had mean PRL levels above 18.0 ng/ml indicating hyperprolactinemia (assay range 3–18). Interestingly, there was a significant difference in PRL levels between patients who were rated by counselors as not meeting any treatment goals ($n = 47$, PRL = 9.91 $\pm$ 4.78) and those who met some or all goals ($n = 40$, PRL = 7.97 $\pm$ 2.95) ($t = 2.16$, $p < 0.05$). However, there were no significant relationships between PRL levels and number and proportion of negative urine drug screens.

Conclusion: The high PRL levels among cocaine patients compared to controls indicate that DA activity may be lower among cocaine-dependent patients compared to controls. However, the relationship between PRL levels and outcome seems to be more complex. Although lower DA activity was related to unfavorable counselor ratings, it was not related to urine drug screens. Further studies on larger sample of subjects and neuroendocrine challenge tests are under way to confirm these findings.

(Funded by NIDA grant # DA340-02).

TARGET AUDIENCE:

Psychiatrists, counselors, psychopharmacologists, and biological researchers.

REFERENCES:

1. Kranzler HR, Waillington DJ: Serum prolactin level, craving and early discharge from treatment in cocaine dependent patients Am J Drug Alcohol Abuse 1992; 18(2):187–195.
2. Budyns-Branchey L, Branchey M, Fergeson P, et al: The meta-chlorophenylpiperazine challenge test in cocaine addicts: Hormonal and psychological responses Biol Psychiatry 1997; 41:1071–1086.

Poster 33 **Friday, October 27**
10:00 a.m.-11:30 a.m.

SMOKING HABITS OF MEDICAL AND NURSING STUDENTS

Cynthia M. Purcell, M.S., *Forensic Coordinator, Department of Psychiatry, Thomas Jefferson University School of Medicine, 1201 Chestnut Street, 15th Floor, Philadelphia, PA 19107;* Ashwin A. Patkar, M.D., *Assistant Professor, Department of Psychiatry, Thomas Jefferson University School of Medicine, 1201 Chestnut Street, 15th Floor, Philadelphia, PA 19107;* Sandra B. Weibel, M.D.; Allan Lundy, Ph.D.

EDUCATIONAL OBJECTIVES:

To understand the differences in smoking habits of medical and nursing students, including the changes, if any, during their educational years and prior to entering school.

SUMMARY:

Future physicians and nurses will play a vital role in reducing tobacco-related morbidity and mortality by encouraging smoking cessation among their patients. Their approach and credibility as treatment providers may depend on their own smoking habits. We therefore investigated patterns of smoking among medical and nursing students.

Method: 357 Thomas Jefferson University medical students (53% male, median age 24) and 126 nursing students (83% female, median age 25) were surveyed using a modified version of the Fagerstrom's Tolerance Questionnaire (FTQ). T-tests and analyses of variance were used for data analyses.

Results: Only 4% of medical students smoked compared with 13.5% of nursing students ($p < 0.05$). However, there were no significant differences in ex-smokers among medical students (10%) compared with nursing students (19%). About 87% of medical students and 64% of nurses had never smoked. The mean FTQ score among medical students (2.3) was significantly less than that for nursing students (4.5) ($p < 0.01$). Comparing individual items on the FTQ nursing students had significantly higher scores on five of the six items: smoking on waking up ($p < 0.01$), difficulty in giving up morning cigarette ($p < 0.01$), number of cigarettes smoked ($p < 0.01$), smoking while ill ($p < 0.05$), and smoking during earlier part of the day ($p < 0.05$). The quit rates did not differ across class years among both medical and nursing students; however, unlike nursing students, time since quitting differed across class years for medical students. The median time since quitting was less than two years for year 1, 2 1/4 years for year 2, 3 years for third and fourth year students.

Conclusion: Nursing students smoke at a higher rate and more heavily compared with medical students. Interestingly, although smoking habits seem to change little during the course of education for both medical and nursing students, many smokers may have quit just prior to entering medical school but not nursing school.

TARGET AUDIENCE:

Medical and nursing students, educators, physicians and nurses.

REFERENCES:

1. Dekker HM, Adriaanse HP: Smoking prevalence among medical students, in Tobacco and Health. edited by Slame K. New York, Plenum Press, 1995; 715–716.
2. Daudt AW, Alberg AJ, Prola JC, et al: A first step incorporating smoking education into a Brazilian medical school curriculum: results of a survey to assess the cigarette smoking knowledge, attitudes, behavior, and clinical practices of medical students. Journal of Addictive Diseases 1999; 18:19–29.

Poster 34 **Friday, October 27**
10:00 a.m.-11:30 a.m.

OUTCOME OF INTEGRATED PHARMACOLOGICAL AND BEHAVIORAL SMOKING CESSATION PROGRAM

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EDUCATIONAL OBJECTIVES:

To understand the effectiveness of different pharmacological and behavioral treatment approaches in smoking cessation.

SUMMARY:

Current evidence suggests that combining behavioral and pharmacological treatment modalities may be more effective than either approach alone in the treatment of smokers. We investigated the outcome of an intensive smoking cessation program.

Method: Twenty-seven consecutive subjects (63% men, mean age 48.1) admitted to a structured university-based, multi-disciplinary smoking cessation program were studied. Subjects underwent a medical and psychosocial evaluation including the Fagerstrom's Tolerance Questionnaire (FTQ) and participated in weekly individual and group therapy along with regular physician follow-up for six weeks. Bupropion and nicotine replacement therapy (NRT) were used alone or in combination as clinically appropriate. Outcomes were measured independently by self-reported continuous abstinence rates at six months or longer. Chi-square tests were used for data analysis.

Results: The mean FTQ score of patients was 6.6 and nearly 80% had made previous attempts to quit using medications/NRT. About 22% had a current psychiatric disorder and nearly 19% abused alcohol. Approximately 63% received both bupropion and NRT, 26% were prescribed bupropion alone, and 8% received only NRT. Twenty (74%) patients completed six weeks of treatment and 67% were abstinent at ≥6-month follow up. As expected individuals with alcohol abuse were significantly less likely to be abstinent ($p < 0.05$) and a similar trend was observed in patients with psychiatric disorders ($p = 0.07$). No significant relationships were observed between FTQ scores and treatment outcome. Patients with bupropion or NRT alone did as well in treatment as those receiving both.

Conclusion: An integrated behavioral and pharmacological approach has the potential to improve abstinence rates among heavy smokers, although alcohol abuse and psychiatric disorders seem to adversely affect treatment outcome. Randomized studies are planned to confirm these findings.

TARGET AUDIENCE:

Physicians, nurses, psychologists and counselors.

REFERENCES:

1. Agency for Health Care Policy and Research: Smoking cessation clinical practice guidelines. JAMA 1996; 275:1270–1280.
2. Hughes JR: Combining Behavioral Therapy and Pharmacotherapy for Smoking Cessation: An Update. Integrating Behavior Therapies with Medication in the Treatment of Drug Dependence, NIDA Research Monograph. Washington, US Govt Printing Office, 1995, pp. 92–109.

Poster 35 **Friday, October 27**
10:00 a.m.-11:30 a.m.

JOINT IMPROVEMENTS IN PSYCHIATRIC SYMPTOMS AND EPS: A COMPARISON OF QUETIAPINE AND RISPERIDONE IN OUTPATIENTS WITH PSYCHOTIC DISORDERS

Supported by AstraZeneca Pharmaceuticals

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EDUCATIONAL OBJECTIVES:

At the end of this presentation the participant should be able to identify possible differences between the atypical antipsychotic agents quetiapine and risperidone with respect to the incidence of extrapyramidal symptoms.

SUMMARY:

The selection of an antipsychotic medication involves balancing the benefits and risks. Using data from a four-month, multicenter, open-label trial of quetiapine fumarate (n = 553) and risperidone (n = 175) in adult outpatients with psychotic disorders, we present simple end points that incorporate both efficacy and tolerability. Assessments included the Clinical Global Impression (CGI), the Positive and Negative Syndrome Scale (PANSS), and an EPS checklist. Patients were flexibly dosed. Both the quetiapine and risperidone groups had improvements in all efficacy measures. The proportion of patients rated as "much or very much improved" using the CGI was higher in the quetiapine group throughout the trial, but was significantly so ($P < .05$) at only two time points. EPS events in both groups declined during the treatment period. Patients in the risperidone group were more likely to have an EPS event and more likely ($p < 0.001$) to have EPS that required adjustment of study medication or adjunctive medication than were patients in the quetiapine group. However, throughout the trial, more patients in the quetiapine group were rated as "much or very much improved" (according to the CGI) with no worsening of any EPS symptoms, and were significantly so at all assessments between two weeks and three months ($P < .05$). Similarly, significantly ($P < .02$) more patients in the quetiapine group showed greater than 30% improvement in the PANSS total score with no worsening of any EPS symptoms at all assessments. These results illustrate that significant differences in clinical benefit may be overlooked by separate analyses of efficacy and safety.

Funded by a grant from AstraZeneca.

REFERENCES:

1. Mullen J, Reinstein M, Bari M, Ginsberg L, Sandler N: Quetiapine and risperidone in outpatients with psychotic disorders: results of the QUEST trial. Schizo Res 1999; 36:290.
2. Arvanitis LA, Miller BG: Multiple fixed doses of "Seroquel" (quetiapine) in patients with acute exacerbation of schizophrenia: a comparison with haloperidol and placebo. The Seroquel Trial 13 Study Group. Biol Psychiatry 1997; 42:233–246.

Poster 36 **Friday, October 27**
10:00 a.m.-11:30 a.m.

LOW INCIDENCE OF PERSISTENT TARDIVE DYSKINESIA WITH QUETIAPINE

Supported by AstraZeneca Phamaceuticals

Paul P. Yeung, M.D., M.P.H., *Medical Research and Communications Group, AstraZeneca Pharmaceuticals, De Corp Center, 2 Righter Parkway, Wilmington, DE 19803;* Sherry Liu, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the participant will have a better understanding of the low incidence of persistent tardive dyskinesia with the atypical antipsychotic, quetiapine, in elderly patients with psychotic disorders.

SUMMARY:

Tardive dyskinesia (TD) is often a serious side effect of antipsychotic drug treatment, because these involun-

tary, hyperkinetic, abnormal movements are potentially irreversible. Elderly patients are particularly susceptible to TD; patients over 45 years of age are five to six times more likely to develop TD than patients younger than 45. However, the relationship of TD and extrapyramidal symptoms (EPS) is not well understood. There is some evidence from prospective studies that the occurrence of EPS early in the course of antipsychotic treatment predicts the later development of TD. Quetiapine, an atypical antipsychotic, is effective in treating the positive and negative symptoms of psychosis, is well tolerated, and does not differ from placebo in the incidence of EPS across the entire dose range. Therefore, quetiapine may be less likely to cause TD than conventional antipsychotics. We analyzed data from patients (n = 1447) with acute exacerbations of schizophrenia or schizoaffective disorder, aged 18 to 65, from three phase III clinical trials of quetiapine. In addition, we analyzed data from a trial of quetiapine in elderly patients (n = 184) with psychotic disorders (mean age 76.7 years). The incidence of TD was assessed using the Abnormal Involuntary Movement Scale (AIMS). The appearance of TD was analyzed using the Schooler-Kane criteria. The results of this analysis suggest a several-fold lower TD incidence in quetiapine-treated patients than has been reported in the literature with typical neuroleptics in adult and geriatric populations.

REFERENCES:

1. Jeste DV, Caligiuri MP, Paulsen JS, et al: Risk of tardive dyskinesia in older patients - a prospective longitudinal study of 266 patients. Arch Gen Psychiatry 1995; 52:756–765.
2. Schooler NR, Kane JM: Research diagnosis for tardive dyskinesia (letter). Arch Gen Psychiatry 1982; 39:486–487.

Poster 37 **Friday, October 27**
10:00 a.m.-11:30 a.m.

PSYCHIATRIC COMORBIDITY AND TREATMENT DROPOUT IN A CONVENIENCE SAMPLE OF FIVE LOCAL CORRECTIONS PROGRAMS IN CALIFORNIA AND NEW YORK

Thomas M. Brady, Ph.D., *Service Fellow, Applied Studies Department, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, 5600 Fishers Lane, Room 16-105, Rockville, MD 20857*

EDUCATIONAL OBJECTIVES:

To state the prevalence of mental health disorders in the corrections population, and identify risk factors for dropping out of substance abuse treatment located in correctional facilities.

SUMMARY:

Objective: The purpose of this paper is to illustrate the role of psychiatric comorbidity in dropout and completion of substance abuse treatment located in local correctional facilities. Early dropout from corrections-based substance abuse treatment has been found to be associated with having a history of psychiatric treatment.

Methods: The data were collected by sampling 722 offenders who entered and exited treatment programs. Participants were interviewed by a NCCD researcher at both program admission and release. Three of the programs were located in California and two programs were in New York State. The main independent variable is history of mental illness (has inmate ever been treated for a mental illness). The dependent variable is program exit type, either termination for violation of program policy or voluntary exit from program prior to completion. Additional background information obtained about the participating offenders includes sex, race, age, education, marital status, and employment status, as well as history of drug use, previous drug treatment, inpatient/outpatient episodes, and offenses and sentencing. Data were analyzed using descriptive statistics and logistic regression. The original study regarding recidivism was conducted by the National Council on Crime and Delinquency (NCCD.)

Results: 9% of the sample self-reported history of mental health problems. Controlling for sex, race, education, prior treatment attempts, and drug use at admission (alcohol, heroin, marijuana, and cocaine), differences in treatment completion persisted. After statistical adjustment for confounding variables, offenders with a history of mental health treatment were 2.8 times as likely to drop out of substance abuse programming than individuals without a history of mental health treatment (OR 2.8, 95% C.I. (1.5.5.3). Wald test 10.4309, $p < .01$.) Controlling for treatment programs, however, the effects of history of mental health treatment were no longer significant.

Implications: The data suggest that psychiatric comorbidity may be an important correlate of treatment success. Reviews of mental health issues in the corrections environment have recommended careful screening of incoming jail detainees; diversion to the mental health system of mentally ill persons who have committed minor offenses; and provision of appropriate mental health treatment. Recommendations also include assertive case management; outpatient commitment; and court-ordered treatment. Future research should incorporate program characteristics in statistical models designed to identify risk factors for dropping out of substance abuse treatment located in correctional facilities.

Funded under NIJ grant 91-DD-CX-K052.

REFERENCES:

1. Hiller ML, Knight K, Simpson DD: Risk factors that predict dropout from corrections-based treatment for drug abuse. Prison Journal 1999; 79:411–430.
2. Lamb HR, Weinberger LE: Persons with severe mental illness in jails and prisons: a review. Psychiatric Services 1998; 49:483–492.

Poster 38 **Friday, October 27**
10:00 a.m.-11:30 a.m.

THE ROLE OF DRUG USE IN INITIATING LATE PRENATAL CARE IN AN URBAN SAMPLE AT RISK OF DELIVERING LOW BIRTH WEIGHT INFANTS

Thomas M. Brady, Ph.D., *Service Fellow, Applied Studies Department, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, 5600 Fishers Lane, Room 16-105, Rockville, MD 20857*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to articulate the importance of the timely utilization of prenatal care, define late prenatal care, and identify three demographic risk factors for late prenatal care.

SUMMARY:

Objective: To investigate drug use correlates of late or no prenatal care in a Washington, D.C. sample of women at risk for delivering low-birth-weight infants.

Methods: Self-report data about illicit drug, alcohol, and tobacco use were collected from 1.042 women who had just given birth in participating hospitals. Women with a history of recent drug use were oversampled to maximize the number of drug-using women included in the study. The analysis describes prenatal care utilization by demographics, insurance coverage, attitudes toward pregnancy, maternal depression, and drug use. Comparisons are made between women who initiated prenatal care in their first and second trimester and women who initiated care in their third trimester or received no prenatal care. This study also employs a multivariate logistic regression model.

Results: 12.8% of women received late or no prenatal care. Similar to previous reports, in the preliminary analyses late initiation of prenatal care was associated with race, education, income, marital status, and multi-parity. Drug use was an important barrier to the timely utilization of prenatal care. In crude associations, cigarette, marijuana, crack, and heroin users had elevated odds of receiving late prenatal care; however, only crack users had significantly higher odds of late prenatal care after statistical adjustment. Controlling for patient demographics, health system variables, other drug use, maternal depression, and attitudes towards pregnancy, women who smoked crack during their pregnancy were more than three times as likely to initiate late prenatal care than women who did not smoke crack (Wald test 5.5558. prevalence odds ratio 3.644, 95% confidence interval (1.2, 10.7)).

Conclusion: These data suggest that there are significant barriers to prenatal care for women substance abusers, especially women who smoke crack. Prenatal care resources and outreach activities should continue to target pregnant women who use drugs. Among the many avenues policy makers have to increase access to prenatal care among medically underserved women, comprehensive maternal addiction treatment programs that colocate prenatal care and substance abuse treatment may be able to successfully address drug users late entry into prenatal care. More study is warranted into the health-seeking behaviors of urban women at risk for low-birth-weight infants and the factors that impede drug using women from timely initiation into prenatal care.

Funded by the National Institute on Drug Abuse.

REFERENCES:

1. Bray RM, Marsden ME: Drug Use in Metropolitan America. Sage, Thousand Oaks, Calf., 1999, pp. 235–263.
2. Howell EM, Heiser N, Harrington M: A review of recent findings of substance abuse treatment for pregnant women. Journal of Substance Abuse Treatment 1999; 16:195–219.

Poster 39 **Friday, October 27**
10:00 a.m.-11:30 a.m.

PRETREATMENT PATIENT DIFFERENCES: CHOICE OF DRUG THERAPY WITHIN SCHIZOPHRENIA

Supported by Eli Lilly and Company

P. Joseph Gibson, Ph.D., *Senior Research Scientist, Health Outcomes Department, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Danielle L. Loosbrock, M.H.A.

EDUCATIONAL OBJECTIVES:

To understand what patient characteristics may have been associated with differences in choice of atypical medication, with implications for adjustment in analyses of observational studies.

SUMMARY:

Objective: To examine differences in characteristics of patients with schizophrenia treated with olanzapine and risperidone, as reported in epidemiologic studies.

Method: All 14 nonrandomized studies with olanzapine and risperidone cited in Medline or presented at major conferences (APA, ECNP, WPA, ISPOR) through 1999 were included. The direction, magnitude, and statistical significance from all comparisons of pretreatment characteristics for patients initiating therapy on olanzapine or risperidone are summarized.

Results: Several studies found olanzapine patients were more likely to be younger and male. One found younger mean age at onset, though prior duration of illness results had no consistent direction. Other specific comparisons were only included in one or two studies. History of hospital admission results were mixed, though olanzapine patients had significantly higher prior hospitalization costs. Patients initiated on olanzapine were more likely to have prior use of clozapine, depot antipsychotics, and/or antidepressants, whereas patients initiated on risperidone were more likely to have anticholenergic use at therapy start. In one study, patients initiated on olanzapine had mean CGI scores and/or GAF scores indicative of greater severity.

Conclusions: When evaluated, significant pretreatment patient differences were often found. Physicians may be choosing olanzapine therapy for schizophrenic patients with greater disease severity, indicated by prior services use, medication use, and clinical assessment scores.

REFERENCES:

1. Ho B-C, Miller D, Nopoulos P, Andreasen N: A comparative effectiveness study of risperidone and olanzapine in the treatment of schizophrenia. J Clin Psychiatry 1999; 60:658–663.
2. Kapur S. Zipursky RB, Remington G: Clinical and theoretical implications of 5-HT, and D_2 receptor occupance of clozapine, risperidone, and olanzapine in schizophrenia. Am J Psychiatry 1999; 156:286–293.

Poster 40 **Friday, October 27**
10:00 a.m.-11:30 a.m.

ANTIPSYCHOTIC MEDICATION: IMPACT ON CORONARY ARTERY DISEASE RISK FACTORS

Donna Wirshing, M.D., *Assistant Professor, Department of Psychiatry, GLAVA Health System, 11301 Wilshire, Building 210, Room B-151-H, Los Angeles, CA 90073;* William C. Wirshing, M.D., *Professor, Department of Psychiatry, GLAVA Health System, 11301 Wilshire, Building 210, Room B-151-H, Los Angeles, CA 90073;* Jennifer A. Boyd, Pharm.D.; Laura R. Meng, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to learn about the effects of novel antipsychotic medications on risk factors for coronary artery disease.

SUMMARY:

Introduction: Novel antipsychotic medications such as clozapine (CLOZ), and olanzapine (OLZ) have been linked to increases in weight and dysregulation of glucose control. Because of these side effects we retrospectively examined the records of subjects in our hospital to see if there were perturbations in weight gain, glucose, cholesterol, and triglycerides—risk factors for coronary artery disease.

Method: This pilot study is a retrospective chart review of patients on one or more of the following medications: CLOZ (N = 39), OLZ (N = 39), risperidone (N = 45), quetiapine (QUE) (N = 13), haloperidol (N = 41), or fluphenazine (N = 38). Medication records of patients who have received refills of any these medications were generated from pharmacy records. Weight gain, glucose, cholesterol, and triglyceride data were obtained. Patients were included in the study if they had record of two or more blood glucose levels, and/or a cholesterol panel, with at least one record before initiation of the target medications and one lab record one or more weeks after initiation of the target medication.

Results: CLOZ, OLZ, and QUE treated subjects all had statistically significant increases in weight. All medication groups were overweight (BMI > 25). From the available data we found that there were statistically significant differences in total cholesterol ($F = 2.4$, $p = .04$, $df = 5, 151$) and triglyceride levels ($F = 4.7$, $p = -.0006$, $df = 5, 125$) among the antipsychotic groups. CLOZ, OLZ, and QUE treated subjects had statistically significant increases glucose levels. CLOZ and OLZ treated subjects had significant increases in triglyceride levels, whereas QUE treated subjects had decreases in triglycerides.

Conclusions: The novel antipsychotics offer a favorable EPS profile but have their own troublesome side effects. Weight gain, glucose elevation, and dyslipidemias may be linked phenomena. The novel antipsychotics differ in their effects on these factors. Clinicians need to be aware of these potential side effects and intervene to prevent these risk factors for coronary artery disease.

REFERENCES:

1. Wirshing DA, Spellberg B, Erhart SM, et al: Novel antipsychotics and new onset diabetes. Biological Psychiatry 1998; 44:778–783.
2. Wirshing DA, Wirshing WC, Kysar L, et al: Novel antipsychotics: comparison of weight gain liabilities J Clin Psychiatry 1999; 358–363.

Poster 41 **Friday, October 27**
10:00 a.m.-11:30 a.m.

THE COMMUNITY RE-ENTRY PROGRAM FOR SCHIZOPHRENIA: PRELIMINARY FINDINGS

Donna Wirshing, M.D., *Assistant Professor, Department of Psychiatry, GLAVA Health System, 11301 Wilshire, Building 210, Room B-151-H, Los Angeles, CA 90073;* William C. Wirshing, M.D., *Professor, Department of Psychiatry, GLAVA Health System, 11301 Wilshire, Building 210, Room B-151-H, Los Angeles, CA 90073;* Lorena Gonzalez, B.S.; Elizabeth Rossoto, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to learn about the Community Re-entry Program—a program that can help patients transition into the community.

SUMMARY:

Objective: A series of psychoeducational training classes was designed to teach individuals with schizophrenia to recognize the signs and symptoms of their illness, the importance of medication treatment and side effects, to make and keep appointments, and to elaborate viable emergency plans. These classes are implemented during brief hospitalizations (e.g., 8–15 days) for exacerbations of chronic schizophrenia. It is anticipated that the skills subjects obtain in these classes will decrease rehospitalization rates and bed-days and increase compliance with medication and outpatient appointments.

Method: 80 patients with DSM-IV diagnosed schizophrenia or schizoaffective disorder were randomly assigned to either the experimental psychoeducational treatment group, the Community Re-Entry Program (CREP) (N = 39) or to a standard series of Illness Education Classes (N = 41). All subjects were given both a pre-test and a post-test of their knowledge of illness-pertinent issues within the CREP training module. All subjects were also given a psychopathology, extrapyramidal, and neurocognitive test battery. Neurocognitive test battery included: Wisconsin Card Sorting Test, California Verbal Learning Test, Continuous Performance Task, and Digit Span Distractibility Test. Psychopathology ratings included: Brief Psychiatric Rating Scale, Schedule of Assessment for Negative Symptoms, and Global Assessment of Functioning.

Results: 75% of the patients in the CREP group made their first outpatient appointment, and 56% of the patients in the Illness Education group made their first appointment. Patients in the CREP group were more knowledgeable than controls about side effects of medications ($t = 4.01$, $p = .0002$, d.f. = 45), making appointments ($t = 2.2$, $p = .03$, d.f. = 45), and emergency plans ($t = 2.4$, $p = .02$, d.f. = 45). The California Verbal Learning Test correlated highly with the ability of patients to perform well on the CREP knowledge test ($r = .41$, $p = .007$, $N = 44$).

Conclusions: During brief hospitalization it is possible to impact patients' outcome with a psychoeducational program. Outcome may be further enhanced by other predictors, such as neurocognitive functioning.

REFERENCES:

1. Green MF, Marshall BD, Wirshing WC, et al: Does risperidone improve verbal working memory in treatment resistant schizophrenia? Am J Psychiatry 1997; 154:799–804.
2. Liberman RP: Social and independent living skills: the Community Re-entry Program. Research Center or Schizophrenia and Psychiatric Rehabilitation, University of North Carolina Wilmington, 1994.

Poster 42 **Friday, October 27**
10:00 a.m.-11:30 a.m.

COGNITIVE EFFECTS OF RISPERIDONE AND OLANZAPINE IN PATIENTS WITH SCHIZOPHRENIA

Supported by Janssen Pharmaceutica and Research Foundation

Philip D. Harvey, Ph.D., *Associate Professor of Psychiatry, Mt. Sinai School of Medicine, 100th Street and Madison Avenue, New York, NY 10029*

EDUCATIONAL OBJECTIVES:

To compare the cognitive effects of risperidone and olanzapine in patients with schizophrenia or schizoaffective disorder.

SUMMARY:

Background: Novel antipsychotic medications have been reported to enhance cognition in patients with schizophrenia, in contrast to the negligible effects of conventional medications. In this study, the relative cognitive enhancing effects of risperidone and olanzapine, the two most commonly used of the newer medications, were compared.

Methods: A total of 377 outpatients with schizophrenia or schizoaffective disorder were randomized to eight weeks of double-blind treatment with 2–6 mg/day of risperidone or 5–20 mg/day of olanzapine. The patients were rated with assessments of clinical symptoms and side effects (reported separately) and with a cognitive functioning battery examining secondary and working memory, vigilance, visuomotor speed, executive functioning, and verbal fluency.

Results: Statistically significant improvements over baseline functioning with risperidone and olanzapine were found for spatial working memory, Trail-making A and B, Wisconsin Card Sorting Test (WCST) categories, total errors and perseverative errors, phonological fluency and category fluency, CPT performance and California Verbal Learning Test (CVLT) learning, recall and recognition. There were no statistically significant differences between the two medications in the extent of cognitive enhancement on any of the measures.

Implications: Wide-ranging improvements in cognitive functioning were detected, encompassing nearly all cognitive functions known to predict functional outcome. There were no differences between medications in group mean or proportionate improvement rates. When these analyses were repeated considering the effects of anticholinergic medications, results were still statistically significant, and no effects of anticholinergic medication were statistically significant. These data are likely to be representative because they were obtained using current dosing standards, and the dropout rate for the study was low. A previous report of olanzapine superiority was not confirmed.

REFERENCES:

1. Keefe RSE, Silva SG, Perkins DO, Lieberman JA: The effect of atypical antipsychotic drugs on neurocognitive impairment in schizophrenia: a review and meta-analysis. Schizophrenia Bulletin 1999; 25:201–222.
2. Meltzer HY, McGurk SR: The effects of clozapine, risperidone, and olanzapine on cognitive function in schizophrenia. Schizophrenia Bulletin 1999; 25:233–255.

Poster 43 **Friday, October 27**
10:00 a.m.-11:30 a.m.

LONG-TERM COGNITIVE EFFECTS OF RISPERIDONE TREATMENT IN SCHIZOPHRENIA

Supported by Janssen Pharmaceutica and Research Foundation

Philip D. Harvey, Ph.D., *Associate Professor of Psychiatry, Mt. Sinai School of Medicine, 100th Street and Madison Avenue, New York, NY 10029*

EDUCATIONAL OBJECTIVES:

To demonstrate the long-term cognitive effects of risperidone treatment in schizophrenia.

SUMMARY:

Background: Cognitive enhancement has been demonstrated with novel antipsychotic medications. The duration of these studies has been quite short, and there is no information available about the long-term, cognitive-enhancing effects of these medications.

Methods: A total of 367 clinically stable, community-dwelling patients with schizophrenia were randomized to one year's treatment with risperidone or haloperidol. The patients were examined at 16 and 52 weeks after baseline with assessment of clinical symptoms and cognitive functioning. Rates of relapse were also examined.

Results: 121 subjects completed the 52-week protocol, while 25% of the risperidone patients and 40% of the haloperidol patients relapsed ($p < .01$). Total learning on the California Verbal Learning Test was the one aspect of cognitive functioning that was significantly enhanced by treatment with risperidone at both 16 and 52 weeks ($p < .05$). At 52 weeks, 45% of the patients treated with risperidone improved by more than 0.5 SD on this index of learning efficiency, resulting in their having scores in the clinically normal range at the end of the study.

Implications: In addition to preventing relapse in stable patients with more efficiency than haloperidol, risperidone improved memory performance as well. This improvement was clinically as well as statistically significant, indicating that risperidone treatment improves certain aspects of cognitive functioning even in patients who are selected for the absence of notable clinical symptoms.

REFERENCES:

1. Kern RS, Green MF, Marshall BD Jr, et al: Risperidone versus haloperidol on secondary memory: can newer medications aid learning? Schizophr Bull 1999; 25:223–32
2. Meltzer HY, McGurk SR: The effects of clozapine, risperidone, and olanzapine on cognitive function in schizophrenia. Schizophr Bull 1999; 25:233–55.

Poster 44 **Friday, October 27**
10:00 a.m.-11:30 a.m.

ATYPICAL ANTIPSYCHOTIC AGENTS AND GLUCOSE METABOLISM: BERGMAN'S MINIMAL MODEL ANALYSIS

David C. Henderson, M.D., *Associate Director, Psychotic Disorders Program, and Assistant Professor of Psychiatry, Harvard Medical School, 25 Staniford Street, Boston, MA 02114*

EDUCATIONAL OBJECTIVES:

To demonstrate the effects of clozapine, olanzapine, and risperidone on glucose metabolism in schizophrenia.

SUMMARY:

Recently, atypical antipsychotic agents have been linked to diabetic ketoacidosis and adult-onset diabetes mellitus in uncontrolled clinical reports. The purpose of this study was to examine, in a cross-sectional design, the effect of the atypical antipsychotic agents, clozapine, olanzapine, and risperidone, in schizophrenia subjects, on glucose metabolism with a frequent sampled intravenous glucose tolerance test (FSIVGTT) using Bergman's Minimal Model Analysis (MINMOD). The MINMOD allows for examination of insulin sensitivity (SI) and glucose effectiveness (SG). After fasting overnight, subjects were admitted to the GCRC at Massachusetts General Hospital and underwent a FSIVGTT. Data were analyzed using an analysis of variance comparing the values of the three treatment groups. Twenty-five subjects completed the study. There were no differences between the three groups for age, race, BMI, fasting glucose, fasting insulin, and insulin 20 minutes post glucose injection. There were significant differences between groups for glucose concentrations 20 minutes post glucose injection ($p = 0.02$) and for SI to ($p = 0.0022$). SI significantly differed between groups comparing clozapine (mean $2.44 \pm 2.25 \times 10 - 4^{*}\text{min} - 1^{*}\text{ml} - 1$) to risperidone (mean $10.45 \pm 7.00 \times 10 - 4^{*}\text{min} - 1^{4}\text{ml} - 1$) ($p = 0.0007$) and olanzapine (mean $4.257 \pm 2.48 \times 10 - 4^{*}\text{min} - 1^{*}\text{ml} - 1$) to risperidone ($p = .0051$). Controlling for gender, differences between the three groups for SG were not significant ($p = 0.15$), although clozapine (mean 0.015 ± 0.005 min $- 1$) differed from risperidone (mean 0.021 ± 0.006 min $- 1$) ($p = .067$), and olanzapine (mean 0.016 ± 0.008 min $- 1$) differed form risperidone ($p = .09$) at trend levels. Preliminary results suggests that the three groups differ significantly for insulin sensitivity, with clozapine and olanzapine associated with abnormally low insulin sensitivity. Larger sample sizes are needed to elucidate any effect on SG.

REFERENCES:

1. Henderson DC, Cagliero E, Gray C, et al: Clozapine, diabetes mellitus, weight gain, and lipid abnormalities: a five-year naturalistic study. Am J Psychiatry 2000; 157:975–981.
2. Bergman RN: Lilly lecture 1989. Toward physiological understanding of glucose tolerance: minimal-model approach. Diabetes 1989; 38:1512–27.

Poster 45 **Friday, October 27**
10:00 a.m.11:30 a.m.

DIABETES MELLITUS INDUCED BY ATYPICAL ANTIPSYCHOTICS

Naveed Iqbal, M.D., *Director, Psychiatric Observation Suite, Montefiore Medical Center, 111 East 210th Street, Bronx, NY 10467-2407;* Raquel L. Oldan, M.D., *Attending Internist, Kingsborough Psychiatric Center, Brooklyn, New York, 111 East 210th Street, Bronx, NY 10467;* Gordon L. Baird, M.D.; Bruce J. Schwartz, M.D.

EDUCATIONAL OBJECTIVES:

To demonstrate the prevalence of new-onset diabetes mellitus and the development of ketoacidosis in schizophrenia patients treated with atypical antipsychotics.

SUMMARY:

Methods: We reviewed the medical records of all patients with a DSM-IV diagnosis of schizophrenia, admitted to Kingsboro Psychiatric Center in New York, and who were referred to the medical/endocrinology consultation service at this hospital for evaluation and treatment of new-onset diabetes mellitus secondary to treatment with atypical antipsychotic medications. Nine patients were recorded to have developed new-onset diabetes mellitus over a two year period. Eight patients were on olanzapine, and one patient had received clozapine. Two of the patients on olanzapine had also developed ketoacidosis. One of the patients who had developed ketoacidosis became euglycemic when treatment was changed from olanzapine to risperidone.

Conclusions: The nine case reports will be presented with details of the psychiatric and medical treatment, as well as patient clinical characteristics. The high prevalence of new-onset diabetes mellitus with or without weight gain and the development of ketoacidosis in schizophrenic patients treated with some of the atypical antipsychotic medications will be discussed. The need for early detection, comprehensive weight management strategies, and adequate and alternative treatment strategies for patients developing diabetes mellitus secondary to some of the atypical antipsychotics will be reviewed and discussed.

REFERENCES:

1. Mujgerhee S, Decina P, Boccola V, et al: Diabetes mellitus in schizophrenic patients. Compr Psychiatry 1996; 37:68–73.
2. Wirshing DA, Spellberg BJ, Erhar SM, et al: Novel antipsychotics and new-onset diabetes. Biol Psychiatry 1998; 44:778–783.

Poster 46 **Friday, October 27**
10:00 a.m.-11:30 a.m.

CURRENT TRENDS IN THE MANAGEMENT OF ATYPICAL ANTIPSYCHOTICS IN A LONG-TERM CARE DEMENTIA POPULATION: FOCUS ON ADVERSE EVENTS AND ASSOCIATED COST

Supported by Janssen Pharmaceutica and Research Foundation

Michael Slyk, Pharm.D., *President, Pharmacotherapy Associates, P.O. Box 188, Cortland, OH 44484;* Harlan Martin, R.Ph., *President, Pharma-Care Incorporated, 35 Walnut Avenue, Clark, NJ 07066*

EDUCATIONAL OBJECTIVES:

To compare the efficacy and costs of risperidone and olanzapine in elderly patients with dementia.

SUMMARY:

Purpose: This observational analysis compares risperidone and olanzapine in elderly patients with dementia with respect to the incidence of adverse events (AEs) that require treatment and the cost of managing antipsychotic-associated AEs with added pharmacological treatment.

Method: This analysis involves four geographic regions in the U.S. Approximately 10,000 residents will be screened to reach a sample size of 1,000 elderly residents with dementia receiving the target medications (n = 500 each for risperidone and olanzapine). Patients receive either risperidone 0.25–2 mg/day or olanzapine 2.5–10 mg/day. AE data are collected from physicians' and nurses' progress notes, psychotropic monitoring forms, and physicians' order forms. Medical records are evaluated for three months before and three months after the start of treatment.

Results: A preliminary analysis in 38 patients (mean age, 76 years) showed that the target behaviors "verbally aggressive" and "physically aggressive" were present in 88.9% and 62.8% of patients, respectively. The use of nonpharmacological management for target behaviors decreased after three months of treatment. The average daily doses of both drugs were below HCFA guideline: average doses at day 91 were 13 mg/day risperidone and 5.6 mg/day olanzapine. Preliminary data on laxative use showed no change in the percentage of residents with laxative orders from seven days before treatment and the last week of treatment in either group. Treatment with the olanzapine was associated with a slight increase in laxative use.

Conclusion: The preliminary study population is too small to provide statistically valid conclusions. The final data will provide critical information for the management of elderly residents with dementia and behavioral disturbances.

REFERENCES:

1. Katz IR, et al: Comparison of risperidone and placebo for psychosis and behavioral disturbances associated with dementia: a randomized, double-blind trial. J Clin Psychiatry 1999; 60:107–115.
2. De Deyn PP, et al: A randomized trial of risperidone, placebo, and haloperidol for behavioral symptoms of dementia. Neurology 1999; 53:946–955.

Poster 47 **Friday, October 27**
10:00 a.m.-11:30 a.m.

A RETROSPECTIVE STUDY OF MIRTAZAPINE AND THREE SSRIS IN A LONG-TERM CARE DEPRESSED POPULATION

Supported by Organon Inc.

I. Barton Frenchman, B.S., R.Ph., *Consultant, Pharmacist and President, Pharm Rx Consultants, Inc., 1238 Stuyvesant Avenue, Union, NJ 07083*

EDUCATIONAL OBJECTIVES:

To recognize adverse events and depression treatment outcome for mirtrazapine, sertraline, paroxetine, and fluoxetine in a depressed nursing home population.

SUMMARY:

Objective: To compare the side effects and effectiveness of mirtazapine, sertraline, paroxetine, and fluoxetine in residents with depression in nursing facilities.

Methods: Residents diagnosed with depression were identified from a nursing home population of 5,000 beds in New Jersey and Pennsylvania. Residents were included if they were taking either mirtazapine, sertraline, paroxetine, or fluoxetine as single therapy. Data were collected over a two-month period on age, gender, weight, depression diagnosis, depression outcome, other concurrent psychoactive medications, weight gain or loss, drug interactions, adverse events (AEs), and concomitant medications believed to be prescribed for the adverse events. Outcome of therapy was determined by physicians' or nurses' notes. AEs and the medications prescribed for them were taken from the first month of therapy.

Results: While improvement in depression was not statistically different, there were fewer AEs associated with mirtazapine (21%) than with sertraline (43%), paroxetine (43%), and fluoxetine (43%) and also fewer concomitant medications were needed for them. In addition, lack of weight loss, which is generally considered a positive outcome in this population, was found in 76%

of patients taking mirtazapine versus 52% for sertraline, 55% for paroxetine, and 47% for fluoxetine.

Conclusion: This retrospective study may have important implications for overall patient safety, effectiveness, and adverse events in a long-term-care depressed population.

REFERENCES:

1. Small GW, Rabins PV, Barry PB, et al: Consensus statement of the American Association for Geriatric Psychiatry, the Alzheimer's Association, and the American Geriatrics Society. JAMA 1997; 278:1363–1371.
2. Devanand DP, Jacobs DM, Tang M-X, et al: The course of psychopathology in mild to moderate Alzheimer's disease. Arch Gen Psychiatry 1997; 54:257–263.

POSTER SESSION III

Posters 48–73

Poster 48 **Friday, October 27 3:30 p.m.-5:00 p.m.**

PREVALENCE, INCIDENCE AND RISK FACTORS OF COGNITIVE IMPAIRMENT AND DEPRESSIVE DISORDERS OF THE ELDERLY IN THE COMMUNITY: A TWO-STAGE, ONE AND ONE-HALF-YEAR FOLLOW-UP STUDY

Maeng J. Cho, M.D., Ph.D., *Professor, Department of Psychiatry, Seoul National University College of Medicine, 28 Yongun-Dong, Chongno-Gu, Seoul, Korea 110-744*; Bong Jin Hahm, M.D., *Instructor, Department of Psychiatry, Kachon University College of Medicine, 1198 Guwoouldong Namdongugu, Inchon, Korea 405760*; Seong-Jin Cho, M.D.; Dong-Woo Suh, M.D.; Jang-Kyu Kim, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should know the prevalence and incidence of cognitive impairment and depression among the Korean elderly in a rural community.

SUMMARY:

Objectives: To evaluate the prevalence, incidence, and risk factors of cognitive impairment and depression among the elderly in a Korean rural community, Yonchon.

Methods: Subjects were 790 elderly persons, 65 years and over, randomly selected in a cross-sectional prevalence survey of dementia and depression one and a half years ago. They were revisited and interviewed by trained interviewers using the Korean version of Psychogeriatric Assessment Scale.

Results: A total of 631 (79.9%) persons completed the interviews in this follow-up study. The prevalences of cognitive impairment and depression were 21.4% (11.9% in males; 28.3% in females); and 8.4% (6.3% in males; 10.0% in females), respectively. The one and a half-year incidences of cognitive impairment and depression were 11.4% (5.7% in males: 16.2% in females) and 5.0% (2.9% in males; 6.5% in females). Risk factors of the new cases of cognitive impairment were low education, old age, female sex, history of stroke, poor economy, and alcohol use disorders. Those of depression were history of stroke, disrupted marriage, and poverty.

Conclusion: Incidences of cognitive impairment and depression were higher than expected. Identified risk factors indicated the need for more strong and comprehensive health care and social supports for those who had stroke, were widowed, and in a lower social class.

REFERENCES:

1. Jorm AF, Korten AE, Henderson AS: The prevalence of dementia: a quantitative integration of the literature. Acta Psychiatr Scand 1987; 76:465–479.
2. Devanand DP, Sano M, Tang MX, et al: Depressed mood and the incidence of Alzheimer's disease in the elderly living in the community. Arch Gen Psychiatry 1996; 53:175–182.

Poster 49 **Friday, October 27 3:30 p.m.-5:00 p.m.**

A THREE-WEEK, DOUBLE-BLIND, RANDOMIZED TRIAL OF ZIPRASIDONE IN ACUTE MANIA

Supported by U.S. Pharmaceuticals, Pfizer Inc.

Paul E. Keck, Jr., M.D., *Biological Psychiatry Program, University of Cincinnati, P.O. Box 670559, 231 Bethesda Avenue, Cincinnati, OH 45267-0559*; Kathleen Ice, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the pharmacologic profile of suprasidone and to understand the potential antimania efficacy of suprasidone in acute mania.

SUMMARY:

Objective: A randomized, double-blind study to compare flexible-dose oral ziprasidone 80–160 mg/day (n = 131) with placebo (n = 64) over three weeks in inpatients with acute mania.

Method: Bipolar patients with acute mania and a baseline SADS-C Mania Rating Scale Score (MRS) ≥14 were assessed using the SADS-C, PANSS, CGI-S, Simpson-Angus, Barnes Akathisia, and AIMS scales. The SADS-C was administered at days 2, 4, 7, 14, and 21. Primary efficacy analysis was change from baseline to endpoint (LOCF) on the SADS-C MRS (ANCOVA, controlling for baseline and center).

Results: Groups were comparable at baseline. Robust improvements in the MRS score were observed with ziprasidone compared with placebo at all time points after baseline ($p \leq 0.05$). Ziprasidone was also effective in reducing overall psychopathology. The effective dose range was similar to that for acute exacerbation of schizophrenia and schizoaffective disorder. Ziprasidone was well tolerated.

Conclusions: Ziprasidone was well tolerated and appears to offer a rapidly effective treatment for bipolar mania.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Keck Jr P, Buffenstein A, Ferguson J, Feighner J, Jaffe W, Harrigan EP, Morrissey MR, and the Ziprasidone Study Group: Ziprasidone 40 and 120 mg/day in the acute exacerbation of schizophrenia and schizoaffective disorder: a 4-week placebo-controlled trial. Psychopharmacol 1998; 140:173–184.
2. Frye MA, Ketter TA, Altshuler LL, Denicoff K, et al: Clozapine in bipolar disorder: treatment implications for other atypical antipsychotics. J Affect Disord 1998; 48:91–104.

Poster 50 **Friday, October 27**
3:30 p.m.-5:00 p.m.

OLANZAPINE IS NOT ASSOCIATED WITH EXACERBATION OF BIPOLAR MANIA

Supported by Eli Lilly and Company

Robert W. Baker, M.D., *Clinical Research Physician, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46219*; Mauricio Tohen, M.D., Ph.D.; Denai R. Milton, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the effect of olanzapine versus placebo in regards to induction of manic-like symptoms in patients with bipolar mania.

SUMMARY:

Background: Several case reports describe apparent induction or exacerbation of manic-like symptoms during treatment with olanzapine or other atypical antipsychotic drugs. To date, such reports are from uncontrolled clinical experience and therefore cannot clarify whether olanzapine caused such manic-like states or simply failed to prevent them. Presumably, bipolar patients would be at increased risk for this putative adverse event. Therefore, data from controlled trials in mania may shed light on this question.

Methods: Two inpatient double-blind, randomized trials investigating the efficacy of olanzapine 5–20 mg daily versus placebo for the treatment of acute mania were combined. Two hundred and fifty-four subjects participated (placebo n = 129; olanzapine n = 125) in the two studies. Severity of mania was quantified with the 11-item Young-Mania Rating Scale (Y-MRS). In a post-hoc analysis, after double-blind therapy up to three weeks, categorical comparison of olanzapine and placebo groups was made for any worsening and worsening by 10% or 20% from baseline Y-MRS scores (LOCF).

Results: The percentage of subjects with exacerbation at endpoint were: any worsening: placebo 37.7%, olanzapine 21.8% ($p = 0.006$); ≥10% worsening: placebo 24.6%, olanzapine 14.5% ($p = 0.046$); ≥20% worsening: placebo 15.6%, olanzapine 8.1% ($p = 0.068$).

Conclusion: Mania rating scores worsened for some patients during olanzapine therapy. In an uncontrolled setting, such worsening might be misinterpreted as olanzapine *causing* mania exacerbation. However, results from these controlled studies demonstrated that such worsening occurred more often on placebo than on olanzapine.

REFERENCES:

1. Tohen M, Jacobs TG, Grundy SL, et al.: Efficacy of olanzapine in acute bipolar mania: a double-blind, placebo-controlled trial. Arch Gen Psychiatry, in press.
2. Tohen M, Sanger TM, Tollefson GD, et al.: Olanzapine versus placebo in the treatment of acute mania. Am J Psychiatry 1999; 156:702–709.

Poster 51 **Friday, October 27**
3:30 p.m.-5:00 p.m.

DEPRESSION DURING MANIA: TREATMENT RESPONSE TO OLANZAPINE OR PLACEBO?

Supported by Eli Lilly and Company

Robert W. Baker, M.D., *Clinical Research Physician, Eli Lilly and Company, One Lilly Corporate Center,*

Indianapolis, IN 46219; Mauricio Tohen, M.D., Ph.D.; Richard C. Risser, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the effect of olanzapine in reducing depressive symptoms in patients with acute mania.

SUMMARY:

Background: The objective of this post-hoc analysis was to explore olanzapine's effectiveness for both manic and depressive symptoms in acute bipolar I manic patients with prominent concurrent depressive symptoms.

Methods: Two double-blind, randomized trials compared olanzapine 5-20 mg daily with placebo for the treatment of acute mania. Efficacy measures included the 11-item Young-Mania Rating Scale (Y-MRS) and the 21-item Hamilton Depression Rating Scale (HAM-D). A subset of subjects with depressive mania, identified by baseline HAM-D ≥ 20, was analyzed. The mean change in baseline to endpoint (LOCF) for up to three weeks of treatment was compared for Y-MRS and HAM-D scores. Secondly, we investigated categorical worsening of depression, defined as any HAM-D rating during treatment three or more points higher than baseline.

Results: Twenty-eight percent of all subjects had baseline HAM-D ≥ 20 (olanzapine n = 33; placebo n = 35). Baseline Y-MRS mean scores were 31.7 in the olanzapine group and 29.9 in the placebo group. The olanzapine-treated group had superior mania improvement on Y-MRS (decrease of 12.7 versus 4.6 for placebo, p = .008). Baseline HAM-D mean scores were 25.9 in the olanzapine group and 25.0 in the placebo group. The olanzapine-treated group had superior depressive symptom improvement on HAM-D (decrease of 11.5 versus 6.8 for placebo, p = .035). Categorical worsening of depression was not significantly different (p = .307) between olanzapine (3/33, 9%) and placebo (7/35, 20%).

Conclusion: In acutely ill manic patients with significant concurrent depressive symptoms, olanzapine effectively treats mania and may reduce depressive symptoms as well.

REFERENCES:

1. Tohen M, Jacobs TG, Grundy SL, et al.: Efficacy of olanzapine in acute bipolar mania: a double-blind, placebo-controlled trial. Arch Gen Psychiatry, in press.
2. Tohen M, Sanger TM, Tollefson GD, et al.: Olanzapine versus placebo in the treatment of acute mania. Am J Psychiatry 1999; 156:702–709.

Poster 52

Friday, October 27
3:30 p.m.-5:00 p.m.

OLANZAPINE VERSUS DIVALPROEX SODIUM FOR THE TREATMENT OF ACUTE MANIA

Supported by Eli Lilly and Company

Mauricio Tohen, M.D., Ph.D., *Medical Advisor, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285*; Robert W. Baker, M.D., Denai R. Milton, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the differences in efficacy and safety in patients with acute mania treated either with olanzapine or divalproex.

SUMMARY:

Objectives: Olanzapine and divalproex sodium are effective in treating acute mania. Efficacy for each drug has been demonstrated in two placebo-controlled trials. Heretofore, no controlled data have compared olanzapine and divalproex. This study explores the relative efficacy and safety of these two agents with mood stabilizing properties for the treatment of acute mania.

Methods: A three-week, randomized, double-blind trial compared flexibly-dosed olanzapine (5–20 mg/day) with divalproex (500–2500 mg/day) for the treatment of acute manic or mixed episodes of bipolar I disorder. The primary efficacy instrument was the 11-item Young-Mania Rating Scale (Y-MRS). Several safety measures were employed. At baseline, subjects were hospitalized and acutely ill (Y-MRS ≥ 20). The design allowed monitoring of valproate serum levels and dosage adjustment while maintaining double-blind conditions.

Results: Mean Y-MRS improvement for subjects treated with olanzapine (n = 125) was −13.4 (baseline: 27.4) versus −10.4 for those on divalproex (n = 126; baseline: 27.9; p = 0.028). Two *a priori* categorizations defined response rates: 54.4% of olanzapine-treated patients experienced a ≥50% reduction in Y-MRS scores as compared with 42.3% of divalproex-treated patients (p = 0.058); 47.2% of olanzapine-treated patients had endpoint Y-MRS ≤ 12, versus 34.1% on divalproex (p = 0.039). The most common treatment-emergent adverse events occurring more frequently with olanzapine (p ≤ 0.05) were dry mouth, increased appetite, and somnolence, and those occurring more frequently with divalproex (p ≤ 0.05) were diarrhea and nausea.

Conclusions: Patients with acute manic or mixed episodes of Bipolar I Disorder experienced superior clinical response with olanzapine compared to divalproex.

REFERENCES:

1. Tohen M, Jacobs TG, Grundy SL, et al.: Efficacy of olanzapine in acute bipolar mania: a double-blind, placebo-controlled trial. Arch Gen Psychiatry, in press.
2. Tohen M, Sanger TM, Tollefson GD, et al.: Olanzapine versus placebo in the treatment of acute mania. Am J Psychiatry 1999; 156:702–709.

Poster 53 **Friday, October 27 3:30 p.m.-5:00 p.m.**

RAPID REDUCTION IN HYPERPROLACTINEMIA UPON SWITCHING TREATMENT TO OLANZAPINE FROM CONVENTIONAL ANTIPSYCHOTIC DRUGS OR RISPERIDONE

Supported by Eli Lilly and Company

Bruce J. Kinon, M.D., *Senior Clinical Research Physician, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285*; Bruce R. Basson, M.S.; Jeff Wang, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the effect switching to olanzapine therapy from conventional antipsychotics or risperidone therapy has on serum prolactin levels.

SUMMARY:

Objective: To determine whether serum prolactin (PRL) levels were reduced in patients switched to treatment with olanzapine during a three-week clinical trial that studied the medication switching phenomenon.

Method: This multi-site study was designed to compare strategies for switching patients from previous antipsychotics to olanzapine. Outpatients with a diagnosis of schizophrenia or schizoaffective disorder and with documented clinical stability while being treated with a conventional antipsychotic or risperidone were randomized to one of four medication switching paradigms. Patients completing the study had been on olanzapine 10 mg/day as monotherapy for one to three weeks. PRL data were collapsed across all four switching groups.

Results: Baseline and endpoint serum PRL were obtained in 176 out of 209 patients. The prevalence of hyperprolactinemia among patients previously taking conventional antipsychotics (n = 131) dropped from 36% to 13% after three weeks of the study ($p < 0.001$). For those previously on risperidone (n = 45), the prevalence dropped from 76% to 22% after three weeks of the study ($p < 0.001$). For patients switched from conventional antipsychotics, mean serum PRL dropped from 24.01 + 24.31 ng/ml to 13.68 + 14.67 ng/ml ($p < 0.001$); for those switched from risperidone, levels decreased from 48.80 + 38.14 ng/ml to 16.54 + 17.51 ng/ml ($p < 0.001$).

Conclusions: Stable outpatients who switch to olanzapine from conventional antipsychotics or risperidone may demonstrate a significant reduction in prevalence of hyperprolactinemia and a reduction in mean serum PRL over a three-week switching process.

REFERENCES:

1. Green AI, Faraone SV, Brown WA: Prolactin shifts after neuroleptic withdrawal. Psychiatric Research 1990; 32:213–219.
2. Dickson RA, Glazer W: Neuroleptic induced hyperprolactinemia. Schizophrenia Research 1999; 35:575–586.

Poster 54 **Friday, October 27 3:30 p.m.-5:00 p.m.**

EFFECT OF LONG-TERM OLANZAPINE TREATMENT ON WEIGHT CHANGE IN SCHIZOPHRENIA

Supported by Eli Lilly and Company

Bruce J. Kinon, M.D., *Senior Clinical Research Physician, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285*; Julie A. Gilmore, Ph.D.; Bruce R. Basson, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the effect of olanzapine on weight change and serum glucose over a three year period.

SUMMARY:

Objective: Changes in weight and non-fasting serum glucose were determined in schizophrenic patients who received treatment with olanzapine (OLZ) for up to three years. Baseline body mass index (BBMI) and dose were investigated as predictors of long-term weight change.

Method: Patients treated with OLZ (n = 573) and observed for at least 39 weeks (0.75 years) were included in an analysis of data up to 156 weeks. Median time observed was 132 weeks or 2.54 years. Patients were selected from a double-blind, controlled study of patients (N = 1996) who were randomized 2:1 to either OLZ (N = 1,304) 5 to 20mg/day, or haloperidol (HAL; N = 660), 5 to 20 mg/day.

Results: OLZ patients showed no significant change in mean weight gain after 0.75 years (pairwise $p \geq 0.077$). Patients with higher BBMI gained significantly less weight than patients with lower BBMI. Median serum glucose at endpoint was 99.1 mg/dl, and levels were not

significantly associated with the magnitude of weight change at endpoint ($p = 0.096$). OLZ dose did not significantly affect long-term changes in weight or serum glucose.

Conclusions: Mean weight gain associated with OLZ treatment appeared to plateau after the initial 39 weeks of treatment with no further significant gain out to three years. Higher BBMI was predictive of lesser long-term weight gain. Endpoint serum glucose was not found to be significantly associated with weight change.

REFERENCES:

1. Tollefson GD, Beasley CM, Tran P, et al: Olanzapine versus haloperidol in the treatment of schizophrenia and schizoaffective and schizophreniform disorders: Results of an international collaborative trial. Am J of Psychiatry 1997; 154:457–465.
2. Stanton JM: Weight gain associated with neuroleptic medication: a review. Schizophrenia Bull 1995; 21:463–472.

Poster 55 **Friday, October 27**
3:30 p.m.-5:00 p.m.

PSYCHIATRIC DISORDERS AMONG PHYSICIANS: BREAKING THE SILENCE

Daniel P. Chapman, Ph.D., M.Sc., *Psychiatric Epidemiologist, Department of Health Care, Centers for Disease Control and Prevention, 4770 Buford Highway, N.E., MS K-45, Atlanta, GA 30341*; Keith E. Wyche, M.D., *Cardiology Fellow, Emory University School of Medicine, 1639 Pierce Drive, 319 WMB, Atlanta, GA 30322*; Michael F. Meyers, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe psychiatric disorders most frequently associated with admission to impaired physician programs and to identify barriers to diagnosis and treatment of physicians.

SUMMARY:

While substance abuse has long been recognized as a potential source of physician impairment, the prevalence and significance of psychiatric disorders among physicians have not been widely investigated. A MEDLINE search identified articles referenced to keywords *mental disorders* and *physician impairment* and *physicians* published between 1989 and 1999 (N = 11). Major depression, anxiety disorders, and narcissistic personality disorder were cited as diagnoses prompting entry into a state impaired physicians program, with psychiatric disorder prevalence estimates ranging from 25.6% to 48.2% of admissions. Moreover, the presence of a comorbid psychiatric disorder has been reported to significantly elevate the risk for substance abuse relapse to 72%, primarily due to a greatly increased percentage of relapsers with narcissistic personality disorder. Self-treatment with psychotropic medications may be particularly problematic among physicians with psychiatric disorders, and benzodiazepine self-prescription has been associated with an increased risk of suicide among physicians. Stigma attached by physicians to psychiatric disorders may be even greater than that associated with substance abuse. Physicians' colleagues frequently ignore signs of psychiatric disorders among their peers whose behavior is not disruptive to their practice. Appropriate diagnosis and treatment are thereby often needlessly delayed, suggesting expanded state medical association educational outreach efforts for physicians with psychiatric disorders are urgently needed.

REFERENCES:

1. Myers MF: Treatment of the mentally ill physician. Can J Psychiatry 1997; 42:1–6.
2. Pilowski L, O'Sullivan G: Mental illness in doctors. Br Med J 1989; 298:269–270.

Poster 56 **Friday, October 27**
3:30 p.m.-5:00 p.m.

CARDIAC EFFECTS OF NEWER ANTIDEPRESSANTS: SSRIS AND BEYOND

Daniel P. Chapman, Ph.D., M.Sc., *Psychiatric Epidemiologist, Department of Health Care, Centers for Disease Control and Prevention, 4770 Buford Highway, N.E., MS K-45, Atlanta, GA 30341*; Keith E. Wyche, M.D., *Cardiology Fellow, Emory University School of Medicine, 1639 Pierce Drive, 319 WMB, Atlanta, GA 30322*; Robert F. Anda, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to evaluate cardiac effects of newer antidepressants and to recognize appropriate considerations when prescribing these drugs to patients with cardiac disease.

SUMMARY:

Tricyclic antidepressants (TCAs) can cause adverse cardiac effects, including ventricular arrhythmias and orthostatic hypotension, which may contraindicate their use in some patients. Moreover, the increased catecholamine activity precipitated by these drugs may result in cardiac overstimulation rendering tricyclic overdose lethal. While generally characterized by a more benign side-effect profile than TCAs, a number of cardiac effects have been reported among serotonin specific reuptake inhibitors (SSRIs) and other newer antidepressants. A MEDLINE search identified articles published since

1996 referenced to the names of newer antidepressants and to the textwords *cardiac* and *cardiovascular* (n = 51). A growing number of case reports have associated dysrhythmias, such as bradycardia, atrial fibrilation, and syncope with SSRI treatment and overdose. Spectral analyses of heart period variability have revealed a decrease in low frequency band power potentially attributable to both antimuscarinic effects and to a reduction of cardiac sympathetic activity associated with paroxetine administration. While nefazadone has been associated with asymptomatic reduced systolic blood pressure and sinus bradycardia, these effects do not appear to be clinically significant. Dose-dependent supine diastolic blood pressure elevations and ischemia have been reported with venlafaxine. While SSRIs and other newer antidepressants are generally less cardiotoxic than TCAs, it is premature to conclude they are necessarily safe for all patients presenting with cardiac disease.

TARGET AUDIENCE:

Psychiatrists, primary care physicians.

REFERENCES:

1. Roose SP, Spatz E: Treating depression in patients with ischemic heart disease: which agents are best to use and avoid. Drug Safety 1999; 20:459–465.
2. Stoudemire A: New antidepressant drugs and the treatment of depression in the medically ill patient. Psychiatric Clin North Am 1996; 19:495–514.

Poster 57 **Friday, October 27**
3:30 p.m.-5:00 p.m.

PRESCRIBING PATTERNS AT HOSPITAL DISCHARGE FOR GERIATRIC PATIENTS WITH A SCHIZOPHRENIA OR A BIPOLAR DISORDER

Supported by Eli Lilly and Company

Sandra L. Tunis, Ph.D., *Research Scientist, Health Outcomes Evaluation Group, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285*; Beth L. Barber, Ph.D.; Prudence Z. Lim, M.P.H.; William S. Edell, Ph.D.; Mauricio Tohen, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand current medication prescribing patterns for the treatment of schizophrenia and bipolar disorder in a geriatric cohort admitted to and discharged from inpatient treatment facilities.

SUMMARY:

American Psychiatric Association guidelines state that pharmacologic agents are a critical treatment component for patients with schizophrenia, or with bipolar disorder. For schizophrenia, guidelines recommend antipsychotics as the principal pharmacotherapy. For bipolar, guidelines recommend mood stabilizers as first-line treatment. Additionally, second-generation antipsychotics have shown efficacy as primary pharmacologic treatment for bipolar disorder, and are being increasingly prescribed. This study examined prescribing patterns at hospital discharge for a geriatric cohort with a primary DSM-IV discharge diagnosis of a schizophrenia disorder (n = 514), and for a geriatric cohort with bipolar disorder (n = 824). Data were obtained from 1996–1998 CQI+^{SM} Outcomes Measurement System. Lewisville, Tex., which tracks patients admitted to psychiatric units in over 100 U.S. hospitals. The schizophrenia and bipolar samples were largely female, with average ages of 70, and 73 years. At discharge, one out of every six geriatric patients with a schizophrenia disorder was not prescribed an antipsychotic agent. One out of every two geriatric bipolar patients was discharged without a mood stabilizer, and 28% were discharged on neither a mood stabilizer nor an antipsychotic medication. These findings help identify prescribing patterns that may be considered suboptimal for two geriatric patient cohorts hospitalized with a serious mental illness.

REFERENCES:

1. Solomon DA, et al: Polypharmacy in Bipolar I Disorder. Psychopharmacology Bulletin 1996; 32(4):579–87.
2. Verdoux H, et al: A survey of prescribing practice of antipsychotic maintenance treatment for manicdepressive outpatients. Journal of Affective Disorders 1996; 38(2–3):81–87.
3. Pincus HA, Tanielian TL, Marcus SC, et al: Prescribing trends in psychotropic medications: primary care, psychiatry, and other medical specialties. JAMA 1998; 279(7):526–531.
4. Linden M, Lecrubier Y, Bellantuono C, et al: The prescribing of psychotropic drugs by primary care physicians: an international collaborative study. Journal of Clinical Psychopharmacology 1999; 19(2):132–40.

Poster 58 **Friday, October 27**
3:30 p.m.-5:00 p.m.

OCD AND STREPTOCOCCAL INFECTION IN CHILDREN: CASE REPORT AND REVIEW

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Olson, M.D.; Gregory L. Hanna, M.D.; Thomas E. Fluent, M.D.; Daniel Fischer, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the correlation between childhood onset OCD and streptococcal infection. The OCD in this subgroup of patients have a fluctuating course and characteristic set of symptoms. Alternative therapeutic interventions such as intravenous immunoglobulin (IVIG) and plasmapheresis (PEX) might be recommended in the future for refractory patients.

SUMMARY:

Poststreptococcal autoimmunity has been postulated as another potential cause of childhood-onset obsessive compulsive disorder (OCD). This hypothesis was based on the findings associated with Sydenham's chorea (SC), which is a neuropsychiatric disorder associated with infection by group A B-hemolytic streptococcal infections (GABHS). We report on two cases of sudden and dramatic worsening of OCD symptoms in association with streptococcal infections. The patients developed the OCD symptoms before age three, which included mainly, intrusive thoughts about being medically ill, and fears about the occurrence of natural disasters. The predominant compulsive behaviors included touching, exactness, and symmetry rituals. It was the comorbidity of the patients' OCD with major depressive disorder (MDD) that motivated their families to seek psychiatric care. They responded remarkably to a combination of cognitive behavioral therapy (CBT) and Pharmacotherapy. These data supports the hypothesis that early-onset OCD might be an autoimmune psychiatric disorder associated with streptococcal infection.

REFERENCES:

1. Swedo S, Leonard H, Garvey M, et al: Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection: clinical description of the first 50 cases. Am J Psychiatry 1998; 155:264–269.
2. Peterson B, Leckman J, Tucker D, et al: preliminary findings of antistreptococcal antibody titers and basal ganglia volumes in tic, obsessive-compulsive, and attention-deficit/hyperactivity disorders. Arch G psychiatry 2000; 57:364–372.

Poster 59 **Friday, October 27 3:30 p.m.-5:00 p.m.**

ECT AND MENTAL RETARDATION: A REVIEW AND CASE REPORTS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that psychiatric disorders have a high prevalence in mentally retarded patients which ranges from 30 to 70 percent. Biologically and cognitively, mentally retarded persons tend to be especially sensitive to medications and vulnerable to developing pronounced side effects. ECT is an effective and safe treatment for mentally retarded patients.

SUMMARY:

ECT use in patients with mental retardation is an area of limited study and experience. Specific difficulties in using ECT for this patient population include diagnostic indications, measuring outcome, and monitoring side effects. We report on two cases in which ECT was applied in treating severe psychotic and catatonic symptoms. In case I, the patient has a history of moderate mental retardation, bipolar disorder, and recent history of neuroleptic malignant syndrome (NMS). He was admitted to manage his disruptive behavior and psychotic symptoms. The patient responded well to six ECT treatments with diminution of his psychotic symptoms and behavioral disturbances. In case II, the patient has a history of moderate mental retardation and schizoaffective disorder. She was admitted because of catatonic symptoms and change in mental status. The patient successfully responded to 11 ECT treatments. Her symptoms, including rigidity, hallucinations, poor self-care, and lack of appetite, improved dramatically.

Our cases suggest that ECT can be utilized safely and effectively in patients with mental retardation and severe or refractory psychiatric symptoms.

REFERENCES:

1. Thuppal M, Fink M: Electroconvulsive therapy and mental retardation. J ECT 1999; 15(2):140–9n.
2. Chanpattana W: Maintenance ECT in mentally retarded, treatment-resistant schizophrenic patients. J ECT 1999; 15(2):150–3.

Poster 60 **Friday, October 27 3:30 p.m.-5:00 p.m.**

DELUSIONAL MISIDENTIFICATION SYNDROME: CASE REPORT AND REVIEW

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Mellow, M.D., Ph.D.; Michael D. Jibson, M.D., Ph.D.; Gregory W. Dalack, M.D.; Stephan F. Taylor, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the seriousness of the violence associated with the delusional misidentification syndrome (DMS). Screaning every psychiatric patients who presents with violent behaviors specially towards a family member at the psychiatric emergency services, is essential to prevent or minimize the bad outcome associated with the violence in the DMS.

SUMMARY:

Delusional misidentification syndromes (DMS) is a discrete neuropsychiatric symptom, which has interested clinicians and researchers for the past 75 years. Many theories are proposed to help understanding the pathogenesis of DMS and the danger associated with it, but non of them alone could totally account for this. We report on three cases with history of paranoid schizophrenia who developed DMSs. Two of them acted out with their delusional thinking toward the misidentified objects, which happened to be their sons. Case 1, managed to kill the child and case 2, was caught twice trying to choke the son. Our case reports and review indicate that an integration between psychodynamic theories, represented by emotional ambivalence, depersonalization, and regression; and neurobiological theories, presented by the cerebral dysrrythmias, face-recognition processing abnormalities, and focal cerebral lesions, is important for better understanding of DMS. The degree of threats perceived by the patients from the delusionally misidentified objects is the most important factor in determining the patient's response to the delusions. Alcohol and substance intoxication facilitate the patient's acting out on their delusions, but don't explain the genesis of the delusions. There is a need to continue to study patients with DMS because they are likely to provide the opportunity for greater understanding of the relationships between psychopathology, neuropsychological process, neurological function, and their neuroanatomic basis.

REFERENCES:

1. Signer SF: Localization and lateralization in the delusion of substitution Psychopathology 1994; 27:168–76.
2. Silva JA, Ferrari MM, Leong GB, Weinstock R: The role of mania in the genesis of dangerous delusional misidentification. J Forensic Sci 1997; 42(4):670–4.

Poster 61 **Friday, October 27**
3:30 p.m.-5:00 p.m.

VENLAFAXINE XR IN BIPOLAR DEPRESSION

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the potential safety and efficacy of venlafaxine XR in the treatment of bipolar depression.

SUMMARY:

Objective: The treatment of depression in bipolar disorders has not been established. Although data, particularly from open studies, support the use of bupropion as well as others, little is definitive. Venlafaxine, with effects on serotonin, norepinephrine, and dopamine, mainly at higher doses, may combine benefits of bupropion and SSRIs. Thus, it was hypothesized that a venlafaxine dosage of 225 mg/day might be effective in patients with major depression in the context of bipolar history and that their response might be related to baseline measures of platelet 5-HT content as seen with SSRIs (Goodnick et al, 1995), and plasma MHPG as seen with bupropion (Goodnick et al. 1998).

Methods: This initial open-label study consisted of patients aged 18–65, with a history of mania or hypomania, a DSM-IV MDE, single or recurrent, and a baseline HDRS of ≥18 (17-item). They received 112.5 mg of venlafaxine XR during days 1–7, then 225 mg on days 8–57. At screening, baseline, and the ends of weeks 1, 2, 4, and 8, patients were evaluated on the HDRS, BDI, and YMRS. Blood samples were collected for evaluation of platelet 5-HT content and plasma MHPG at baseline and conclusion. Venlafaxine blood levels were also measured at conclusion.

Results: To date, data are available on eight patients 4M and 4F, mean age of 48.1 years of whom six have completed. HDRs has improved from 21.2 to 17.4 at week 1 ($P < 0.01$) and final 5.4 ($P < 0.001$); BDI from 30.6 to final 11.2 ($P = 0.001$). No changes were found in YMRS, HR, BP, RR, weight; plasma results are pending.

Conclusion: Venlafaxine merits further double-blind studies to establish efficacy in bipolar major depression.

TARGET AUDIENCE:

Psychiatrists and other clinicians.

REFERENCES:

1. Redrobe JP, Bourin M, Colombel MC, Baker GB: Dose-dependent noradrenergic and serotonergic

properties of venlafaxine in animal models indicative of antidepressant activity. Psychopharmacology 1998; 138:1–8.
2. Silverstone PH, Ravindran A: Once-daily venlafaxine extended release (XR) compared with fluoxetine in outpatients with depression and anxiety. J Clin Psychiatry 1999; 60:22–28.

Poster 62 **Friday, October 27**
3:30 p.m.-5:00 p.m.

NARRATIVES OF SPIRITUALITY AND RECOVERY FROM SEVERE TRAUMA

Lynne M. Gaby, M.D., *Instructor in Psychiatry, George Washington University Medical Center, 2150 Pennsylvania Avenue, N.W., Washington, DC 20037*; James L. Griffith, M.D., *Professor of Psychiatry, George Washington University School of Medicine, 2150 Pennsylvania Avenue, N.W., Washington, DC 20037-3201*; Melissa E. Griffith, M.S.N.; Judy Okawa, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize how narratives of spiritual experience that emerge during trauma treatment can support recovery by fostering hope, communion with others, sense of self-agency, and sense of coherency of experience.

SUMMARY:

Objective: To study how narratives of spiritual experience play a role in recovery from severe trauma among religious individuals.

Methods: Narrative accounts of survival from prolonged violent assault or political torture were provided by nine individuals who attributed their survival to spiritual resources (e.g., prayer, God's intervention, support of religious community, religious rituals). These narratives were examined to determine the relative prominence of six existential themes: hope vs. despair, communion vs. isolation, purpose vs. meaninglessness, personal agency vs. helplessness, coherence vs. confusion, and joy vs. sorrow. The prominence of each theme was rank ordered to create a score for each.

Results: The scored prominence of existential themes among the narratives were: 88 (of possible 108) for hope vs. despair; 82 for communion vs. isolation; 80 for self-agency vs. helplessness; 74 for coherence vs. confusion; 48 for purpose vs. meaninglessness; and 20 for joy vs. sorrow.

Conclusion: The findings from this pilot study suggest that narratives of spiritual experience aid persons coping with severe trauma by helping to sustain hope, communion with others, a sense of personal agency, and a sense of coherence of experience. Narratives of spirituality appear not to buffer the intensity of sorrow. These findings suggest that narratives of spiritual experience play a particular role in enabling trauma survivors to express distress fully while protecting against retraumatization in telling the story. These findings may be relevant for the practices of clinicians from multiple disciplines who work with survivors of severe trauma and political torture.

REFERENCES:

1. Holtz TH: Refugee trauma versus torture trauma: a retrospective controlled cohort study of Tibetan refugees. J Nerv Ment Dis 1998; 186:24–34.
2. Basoglu M, Mineka S, Paker M, et al: Psychological preparedness for trauma as a protective factor in survivors of torture. Psychological Medicine 1997; 27:1421–1433.

Poster 63 **Friday, October 27**
3:30 p.m.-5:00 p.m.

WORK STRESS AND EMOTIONAL HEALTH IN THE U.S. AIR FORCE

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the relationship between occupational stress and psychiatric illness and how this applies to the military as a specific work environment.

SUMMARY:

Objective: Almost 30% of American workers report exposure to mental stress at work, and 14% believe that their experience of work stress could be deleterious to their mental health. This study examined the incidence of occupational stress and its relationship to mental illness in military personnel.

Methods: Military personnel (N = 334) answered a 65-item survey that included items on the perception of occupational stress and reported life changes. It incorporated the 43-item Schedule of Recent Experiences (SRE). By adding the weighted values assigned to the 43 items, each respondent was given an SRE score, which is a measure of overall stress and has been shown to be predictive of future illnesses.

Results: Military personnel reported levels of job stress similar to the general American working population—26% reported suffering from significant work stress, 15% reported that work stress was causing them significant emotional distress, and 8% reported suffering from work stress that was so severe that it was considered to be damaging to their emotional health. The average

SRE score for all respondents was 160, reflecting increased risk for future illnesses. Generic work stressors were endorsed more frequently than military-specific stressors.

Conclusions: These results support research that suggests that work stress may be a significant occupational health hazard in the U.S. military. Using these data, interventions can be planned to mitigate the impact of stress caused by the military work environment on the mental health of military personnel.

TARGET AUDIENCE:

General, military and occupational psychiatrists.

REFERENCES:

1. Pflanz SE, Skop B: Occupational stress and psychiatric illness in the military. Southern Medical Journal 1998; 91:S63.
2. Pflanz SE: Psychiatric illness and the workplace: perspectives for occupational medicine in the military. Military Medicine 1999; 164:401–406.

Poster 64 **Friday, October 27 3:30 p.m.-5:00 p.m.**

EFFECTIVENESS OF A 1-800-PHONE NUMBER IN PROMOTING ACCESS TO AND UTILIZATION OF COST-EFFICIENT PUBLIC MENTAL HEALTH SERVICES

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate an understanding of the reasons for and possible effects of implementing a toll-free phone service to provide community access to a regional public mental health system.

SUMMARY:

In 1994, California committed to implementing mental health care reform through the establishment of managed care systems for its Medicaid (Medi-Cal) beneficiaries. On April 1, 1998, in conjunction with the transition to managed care, the San Francisco Department of Public Health, Community Mental Health Services introduced a toll-free number to provide community access to referrals and authorizations for mental health services. Within the system, this number became the primary resource for screening, referral, and coordination with other services. In San Francisco, two of the primary goals of public-sector managed mental health care are to increase the overall service enrollment of Medi-Cal eligible clients and to provide appropriate referrals and interventions that reduce unnecessary use of high-cost emergency and inpatient care. The purpose of this study was to examine the service utilization of all adult clients for the two six-month periods preceding and following the toll-free "access" number implementation to determine whether managed care effectively met these goals. The study found that from the six-month period prior to the implementation to the six-month period following this period, there was an approximately 3% cost-reduction of $2 million (total systemwide costs of $73 million and $71 million, respectively). In addition, there was a 10% increase in the total number of clients served from the pre- "access" six-month period (14,463) to the post-"access" six-month period (15,921). The cost savings were attributable to decreases in use of acute inpatient, long-term locked psychiatric facility, and skilled nursing facility services and increases in outpatient services utilization. While there are many possible explanations, some of which are discussed in this paper, these results strongly suggest that the toll-free number did affect the accessibility of services to clients and utilization of less intense and costly services.

REFERENCES:

1. Hoge MA, Davidson L, Griffith EEH, et al: Defining managed care in public-sector psychiatry. Hospital and Community Psychiatry 1994; 45:1085–1089.
2. Rosenfield S, Caton C, Nachumi G, Robbins E: Closing the gaps: the effectiveness of linking programs connecting chronic mental patients from the hospital to the community. Journal of Applied Behavioral Science 1986; 22:411–423.

Poster 65 **Friday, October 27 3:30 p.m.-5:00 p.m.**

SUICIDE PREVENTION: DETERMINING THE BEST SETTINGS FOR PREVENTION INTERVENTION

Peter L. Forster, M.D., *Associate Clinical Professor of Psychiatry, University of California at San Francisco, 211 Gough Street, Suite 211, San Francisco, CA 94102*; Patricia A. Arean, Ph.D.; Carol J. Peng, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate an understanding of public health care utilization trends of suicidal individuals and recognize the best health care settings to target for suicide prevention interventions.

SUMMARY:

Increased recognition and treatment of individuals with suicide potential is crucial to the reduction of suicide rates, which significantly outnumber homicide rates across the country. But where, if anywhere, are suicidal individuals most likely to be seen in the health care system? This study examined the public health, mental health, and substance abuse services utilization of all reported suicide victims in the city of San Francisco and from the Golden Gate Bridge (N = 413) prior to their deaths between July 1, 1995, and December 31, 1997. Specifically, we were interested in the service utilization of residents of the city and county of San Francisco, of whom there were 317.

The names of these individuals were cross-referenced to San Francisco Department of Public Health administrative databases. Forty-four percent of these individuals received services through the city and county's public health care system at some point in their lives. From one to six months prior to the date of death, 19 percent of these individuals visited the emergency room, 13 percent were inpatients, and 14 percent received outpatient services. Within the same month of committing suicide, five percent visited the emergency room, eight percent were inpatients, and 12 percent received outpatient services. Twenty-three percent of all the suicide victims had received mental health services through the city system at some point in their lives. One-third of these individuals had some contact from one to six months prior to the date of death. Approximately one-quarter had received services within the same month of death. Nine percent of all suicide victims had received services from the public substance abuse program. These data point to a quite high utilization of the public healthcare system by suicide victims but indicate that non-mental health settings (particularly the emergency room) are much more likely to be the site of the latest health care visit before suicide.

TARGET AUDIENCE:

Administrators, clinicians, researchers in public health, mental health, emergency care, and substance abuse services.

REFERENCES:

1. Appleby L, et al: Suicide within 12 months of contact with mental health services: A national clinical study. British Medical Journal 1999; 31(8): 1235–1239.
2. Isometsa ET, et al: The last appointment before suicide: Is suicide intent communicated? American Journal of Psychiatry 1995; 152(6):919–22.

Poster 66 **Friday, October 27**
3:30 p.m.-5:00 p.m.

SPANISH PSYCHIATRIST'S ATTITUDE TOWARDS SEXUAL ISSUES IN CHRONIC MENTALLY ILL WOMEN

Natalia Sartorius Calamai, M.D., *Psychiatrist, Hospital 12 Octubre, Avenida Andalucía KM 5400, Madrid, Spain 28041*; José A. Pérez, M.D., *Psychiatry Resident, Hospital 12 de Octubre, Avenida Andalucía KM 5400, Madrid, Spain 20841*; Olga Córdoba, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand Spanish psychiatrists' attitudes toward sexuality, motherhood, and gynecological care in chronic mentally ill women.

SUMMARY:

Objective: Spanish psychiatrists' attitudes toward sexuality, motherhood, and gynecological care in chronic mentally ill women are described.

Methods: 126 charts from chronic psychotic women (schizophrenia or schizoaffective disorder), attending a CMHC during the last 10 years are reviewed. A search of information regarding sexuality, reproduction, and gynecological care was conducted. A specific questionnaire regarding these issues was answered by 20 psychiatrists working in the same CMHC.

Results: Data obtained from charts were analyzed. Questionnaires revealed that psychiatrists seldom deal with these issues when treating this specific population.

Conclusions: This poster shows that we systematically exclude large areas of information from our assessment, classification, and understanding of patients. This is especially true with chronic mentally ill women. Mental health professionals tend to deny important issues in these women's lives: sexuality, reproduction, and motherhood. We stress the importance of setting up specific programs for this target population.

REFERENCES:

1. Miller LJ, Finnerty M: Family planning knowledge, attitudes and practices in women with schizophrenic spectrum disorder. J Psychosom Obst Gynaec 1998; 19:210–217.
2. Mc Lennan JD, Ganguly R: Family planning and parenthood needs of women with severe mental illness: clinicians perspective. Community Mental Health J 1999; 35:369–80.

Poster 67 **Friday, October 27 3:30 p.m.-5:00 p.m.**

USE OF TOPIRAMATE IN TREATMENT-REFRACTORY BIPOLAR DISORDER

Supported by Janssen Pharmaceutica and Research Foundation

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to investigate use of topinamate in combination therapy for the treatment of refractory bipolar disorder.

SUMMARY:

The study objective was to evaluate efficacy and safety of topiramate, a novel antiepileptic, as combination therapy in treatment-refractory bipolar disorder. BPD patients (n = 21), diagnosed according to the DSM-IV criteria and considered BPD treatment resistant with lithium, carbamazepine and valproate, were included. Increasing topiramate doses were administered adjunctively for manic (n = 9), depressive (n = 6), hypomanic (n = 3), or mixed (n = 3) symptoms. Other psychotropic drug dosages were unaltered during the six-week follow-up. Outcome measures included YMRS, HAM-D, and CGI-BP. Of the 21 patients in the study, 15 completed the six-week preliminary follow-up. Six patients discontinued due to: lost to follow-up (n = 3), lack of efficacy or worsening of disorder (n = 2), poor compliance (n = 1). At endpoint, the mean dose of topiramate was 158mg/day. Six patients (40% of completers) were considered responders to topiramate (>50% reduction in YMRS or HAM-D and a decrease of 2 points in CGI-BP). In patients initially presenting with depression, topiramate was ineffective. Topiramate was well tolerated; the most common adverse event was paresthesia (n = 2), and only one patient discontinued due to adverse events. Ten patients experienced moderate weight loss during the follow-up study. These initial results indicate that topiramate could be useful as combination therapy in bipolar disorder and shows promise in the management of treatment-refractory patients.

REFERENCES:

1. Chengappa KNR, Rathore D, Levine J, et al: Topiramate as add-on treatment for patients with bipolar mania. Bipolar Dis 1999; 1:42–53.
2. Marcotte D: Use of topiramate a new antiepileptic as a mood stabilizer. J Affect Disord 1998; 50:245–251.

Poster 68 **Friday, October 27 3:30 p.m.-5:00 p.m.**

TREATMENT OF BIPOLAR DISORDER WITH ADJUNCTIVE RISPERIDONE

Supported by Janssen Pharmaceutica and Research Foundation

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to review the results and findings of risperidone in the treatment of patients with bipolar and schizoaffective disorder in combination with other mood stabilizers.

SUMMARY:

Risperidone has shown efficacy against affective symptoms in schizophrenia and schizoaffective and BPD. We conducted an open study (n = 598) with either schizoaffective disorder, bipolar type, or bipolar disorder I or II. Inclusion criteria were 18 to 65 years, signs or symptoms of acute mania, hypomania, or mixed symptoms, and YMRS score of >7. Of the patients initially recruited, 541 were eligible for evaluation using various measures of treatment efficacy. After six months, the mean risperidone dose was 3.88mg/day. Highly significant ($p < 0.0001$) improvements were seen in mean YMRS scores (baseline, 25.6; month 6, 2.4): HAM-D scores (baseline, 12.8; month 6, 4.1); total scores (baseline, 71.9; month 6, 40.0) and positive (baseline, 20.8; month 6, 8.6), negative (baseline, 13.5; month 6, 9.8) and general psychopathology (baseline, 37.8; month 6, 21.6) subscale scores on PANSS; and CGI scores (baseline, 2.6; month 6, 0.9). Highly significant improvements were seen in most neurological side effects, including UKU subscale for extrapyramidal symptoms (baseline, 1.0; month 6, 0.5; $p < 0.0001$). The percent of patients considered responders at 6 months (according to YMRS and CGI scores) was 76%. These results demonstrate a strong indication that risperidone may have mood stabilizing properties and should prove very useful in the treatment of patients with bipolar and schizoaffective disorder in combination with other mood stabilizing medication.

TARGET AUDIENCE:

Psychiatrists with an interest in treating bipolar disorder.

REFERENCES:

1. Simpson GM, Lindnmayer JP: Extrapyramidal symptoms in patients treated with risperidone. J Clin Psychopharmacol 1997; 17:194–201.
2. Ghaemi SN, Sachs GS: Long-term risperidone treatment in bipolar disorder: 6 month follow-up. Int Clin Psychopharmacol 1997; 12:333–338.

Poster 69 **Friday, October 27**
3:30 p.m.-5:00 p.m.

RISPERIDONE AND 9-HYDROXY RISPERIDONE CONCENTRATION ARE NOT DEPENDENT ON AGE OR CREATININE CLEARANCE AMONG ELDERLY SUBJECTS

Supported by Janssen Pharmaceutica and Research Foundation

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to describe the determinants of risperidone and 9-OH concentrations in geriatric patients.

SUMMARY:

Objective: Risperidone is extensively metabolized to an active metabolite, 9-hydroxyrisperidone (9-OH), which is dependent on renal clearance. Risperidone and 9-OH clearances are reduced in the elderly when compared with younger subjects. This study hypothesized that among elderly subjects, risperidone and 9-OH clearance would further decline with increasing age and decreasing creatinine clearance (CrCl).

Methods: Twenty geriatric inpatients evaluated in a naturalistic setting with regard to total daily risperidone dose and dosing interval were studied. Baseline CrCl over eight hours and radioimmunoassay of risperidone and 9-OH steady-state concentrations were determined. Multiple linear regression was used to examine the impact of age, weight, CrCl, total dose, and dosing interval on concentrations of risperidone, 9-OH, their sum, and the ratio of 9-OH:risperidone.

Results: Mean total dose or risperidone was 1.3 ± 0.73 mg. Mean age was 76.4 ± years (range 55–91). Mean CrCl was 55.43 ± 32.8 ml/min/1.73 m^2 (17.0–141.88 ml/min/1.73 m^2). Steady-state risperidone and 9-OH concentrations were 4.14 ± 5.3 ng/ml and 9.1 ng/ml, respectively. Concentrations of risperidone, 9-OH, their sum, and 9-OH: risperidone did not correlate with any of the independent variables.

Conclusions: Among elderly subjects, risperidone and 9-OH clearance does not decline with increasing age of declining CrCl. Accumulation of 9-OH may not be as great as expected.

REFERENCES:

1. Scordo MG, Spina E, Facciola G, et al.: Cytochrome P450 2D6 genotype and steady state plasma levels of risperidone and 9-hydroxyrisperidone. Psychopharmacology (Berl) 1999; 147:300–5.
2. Sweet RA, Pollock BG: New atypical antipsychotics: experience and utility in elderly. Drugs Aging 1998; 12:115–127.

Poster 70 **Friday, October 27**
3:30 p.m.-5:00 p.m.

RISPERIDONE IN THE TREATMENT OF NEGATIVE SYMPTOMS IN ALZHEIMER'S DISEASE

Supported by Janssen Pharmaceutica and Research Foundation

Arnaldo E. Negrón, M.D., *667 Hoes Lane, Piscataway, NJ 08855*; William E. Reichman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to evaluate risperidone in treating negative symptoms in Alzheimer's disease.

SUMMARY:

Introduction: The purpose of this study was to analyze the effectiveness and safety of risperidone in the treatment of clinically significant negative symptoms in Alzheimer's disease (AD) patients.

Methods: We reviewed the charts of community-residing patients treated in a specialized university-based dementia management clinic and who had the diagnosis of probable AD based on the criteria of the National Institute of Neurological and Communicative Disorder and Stroke and the Alzheimer's Disease and Related Disorders Association. Patients were assessed at baseline and after 12 weeks of treatment. Scales included the Scale for the Assessment of Negative Symptoms m AD (SANS-AD), the Positive and Negative Syndrome Scale (PANSS), the Hamilton Scale for Depression (Ham-D), the Mini-Mental State Exam (MMSE), the Simpson-Angus Extrapyramidal Symptoms Scale (EPS), and the Abnormal Involuntary Movement Scale (AIMS).

Results: Fifty consecutive patients were included in the study; their mean age was 79.7 ± 6.0 years, 70% were female, and 88% were Caucasians. Patients had moderate cognitive impairment (MMSE score = 12.5 ± 6.90) and were not clinically depressed (Ham-D = 7.9

± 3.3). The mean dose of risperidone prescribed was 1.3 ± 0.6 mg daily (range, 0.5–3.0 mg). After 12 weeks of treatment, the seventy of negative symptoms was significantly reduced. SANS-AD total scores were reduced 22% from baseline to endpoint (27.8 ± 12.3 to 21.7 ± 13.7, F = 4.1, p = 0.05). Importantly, improvement in negative symptoms appeared to be independent of improvement in positive symptoms (SANS-AD covariate for PANSS-Pos factor, F = 3.1, p = 0.08). Conversely, cognitive function (MMSE scores) did not change after 12 weeks of treatment with risperidone (12.5 ± 6.9 to 12.2 ± 6.4, F = 0.03, p = 0.87). Severity of extrapyramidal symptoms was not affected by treatment with risperidone (EPS = 1.6 ± 2.4 to 1.1 ± 2.1, F = 0.7, p = 0.40; AIMS = 0.1 ± 0.6 to 0.1 ± 0.3 F = 0.5, p = 0.47).

Conclusion: Risperidone improved clinically significant negative symptoms without affecting cognitive function or worsening extrapyramidal symptoms in this population of AD patients.

REFERENCES:

1. Madhusoodanan S, Brecher M, Brenner R, et al.: Risperidone in the treatment of elderly patients with psychotic disorders. Am J Geriatr Psychiatry 1991; 7:132–8.
2. Evans JD, Negron AE, Palmer BW et al: Cognitive deficits and psychopathology in institutionalized versus community-dwelling elderly schizophrenia patients J Geriatr Psychiatry Neurol 1999; 12:11–5.

Poster 71 **Friday, October 27**
3:30 p.m.-5:00 p.m.

EFFECT OF A STRUCTURED FAMILY EDUCATION PROGRAM ON THE USE AND COST OF MENTAL HEALTH SERVICES BY INDIVIDUALS WITH SEVERE CHRONIC MENTAL ILLNESS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand how a structured family education program affects the use and cost of mental health services by individuals with severe chronic mental illness.

SUMMARY:

Structured psychoeducational programs have demonstrated effectiveness in helping families better understand and cope with relatives' serious mental illness, but more research is needed to determine the practical impact of such interventions on health service utilization and cost. Between 1996 and 1999, the Houston VA Medical Center developed and implemented a family education program for families of patients with chronic mental illness, mainly schizophrenia. Analysis was conducted to determine the effect of this program on health service use and cost at this facility. The target audience is mental health service providers and treatment program developers.

Twenty-one patients (whose families had completed the program) were matched on age, diagnosis, health service use history, and Global Assessment of Functioning score. A matched control group consisted of patients from the same hospital unit with similar matching characteristics, but whose family did not participate in the psycho-educational program. Outcome variables were prescription compliance, no-shows and cancellations, mental and physical health visits, and hospital days. Family involvement was predicted to result in improved patient functioning and overall lowered health service use and cost. Results of this psychoeducational program on outcome measures are presented and applied to strategies for more effective health service utilization and cost reduction.

REFERENCES:

1. Ascher H, et al: Emotional needs of families of mentally ill adults. Psychiatric Services 1997; 48:1072–1075.
2. Solomon P, et al: Effectiveness of two models of brief family education: retention gains by family members of adults with serious mental illness. American Journal of Orthopsychiatry 1997; 67:177–186.

Poster 72 **Friday, October 27**
3:30 p.m.-5:00 p.m.

RISK FACTORS FOR INSTITUTIONALIZATION IN ALZHEIMER'S DISEASE: A BRAIN BANK STUDY

Supported by Janssen Pharmaceutica and Research Foundation

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the triggers/risk factors for nursing home placement among a cohort of autopsy-confirmed AD patients.

SUMMARY:

Purpose: Alzheimer's disease (AD) affects nearly 4 million older Americans and is a frequent reason for nursing home placement. The purpose of this study was to determine triggers/risk factors for nursing home placement among a cohort of autopsy confirmed patients with AD.

Methods: We sent detailed questionnaires, followed by telephone interviews, to primary caregivers of autopsy confirmed AD patients inquiring about the reasons they placed their loved ones in nursing homes. Type of caregiver, presence/absence of general/psychiatric symptoms, and stress levels of caregiver were determined, the latter via a 1–5 point Likert scale, with 1 as mild, 3 as moderate, and 5 as being overwhelming stress at the time of decision to institutionalize.

Results: 26 caregivers completed our survey. Of these, 13 were daughters, seven wives, three husbands, and three sons; 21 of 26 patients showed psychotic symptoms at the time of nursing home placement. Of these, 18 of 26 had delusions (mostly paranoid) and 12 had hallucinations. Wandering was present in 20 of 26 patients while 20 of 26 had problems with agitation/aggressivity. Anxiety and mood disturbance were reported in 16 of 26 and 13 of 26 patients, respectively; 19 of 26 patients had significant sleep problems (mostly day/night confusion) and 19 of 26 caregivers reported stress levels of 4 or higher on the 1–5 Likert scale.

Conclusions: We conclude that the behavioral and psychological signs and symptoms of dementia, in particular psychotic symptoms, agitation/aggressivity, and wandering, are the major precursors to nursing home admission in AD patients. In addition, these symptoms are a major source of caregiver stress.

REFERENCES:

1. Jost BC, Grossberg GT: The evolution of psychiatric symptoms in Alzheimer's disease: a natural history study. J Am Geriatr Soc 1996; 44:1078–1081.
2. Chenoweth B, Spencer B: Dementia: the experience of family caregivers. Gerontologist 1986; 26:267–272.

Poster 73 **Friday, October 27**
3:30 p.m.-5:00 p.m.

TO MEDICATE OR NOT: TREATMENT DECISIONS IN PREGNANCY

Sheila M. Marcus, M.D., *Clinical Assistant Professor of Psychiatry, University of Michigan, 900 Wall Street, Ann Arbor, MI 48109*; Heather Flynn, Ph.D., *Assistant Research Scientist, University of Michigan Alcohol Research Center, 400 East Eisenhower Parkway, Suite 2-A, Ann Arbor, MI 48108*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant will learn the relative risks and benefits of continuing antidepressant medication during pregnancy.

SUMMARY:

Both treatment efficacy and fetal safety for many of the antidepressants has been demonstrated in pregnant women. However, physicians often discontinue antidepressant medication when a woman becomes pregnant. Very little evidence exists on the relative costs and benefits of this important treatment decision. Untreated depression exposes many mothers and their infants to potential risks of prematurity, low birth weight, and numerous psychosocial risks. The present study examines rates of pharmacological and nonpharmacological treatment and is part of a larger, ongoing program of research aimed at improving detection and treatment of depression in pregnancy and postpartum.

Method: Thus far, 1,780 pregnant women have been screened for depression risk (CES-D) past and current treatments for depression, and measures of alcohol and tobacco use. Women will be followed during pregnancy and at six weeks and three months postpartum to determine maternal and infant outcomes.

Results: Preliminary results suggest that only 13% of pregnant women who are at risk for depression (as measured by CES-D), reported receiving any current treatment for depression, with only 20% of those meeting full criteria for MDD receiving treatment. Clinical outcomes and costs data from all groups will be presented, and an analysis of the relative benefit of pharmacologic and prevention strategies provided.

REFERENCES:

1. Marcus S, Tandon R: Psychotropic drugs during pregnancy, in Schizophrenia & Mood Disorders. Edited by Buckley PF, Waddington JL. Woburn, MA, Butterworth-Heinemann 2000, pp. 234–252.
2. Atishuler LL, Cohen L, Szuba MP, et al.: Pharmacologic management of psychiatric illness during pregnancy: dilemmas and guidelines. Am J Psychiatry 1996; 153:592–606.

POSTER SESSION IV

Posters 74–97

Poster 74 **Saturday, October 28**
10:00 a.m.-11:30 a.m.

INTER-INFLUENCE OF RESIDUAL-ORGANIC BRAIN CHANGES AND SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVES:

In a case of development of schizophrenia in patients with residual-organic brain changes, earlier the signs of edogenous process join to cerebral-organic changes and more severe organic disturbances are, the more often and faster clinical picture of schizophrenia takes atypical course.

SUMMARY:

Objectives: Specific features of schizophrenia, originated on the background of organic brain changes, are not explored enough in the medical literature. Meanwhile, the schizophrenic process in these cases proceeds atypically and causes problems in the questions of diagnosing and treatment.

Methods: Clinical observation, as well as psychological and neurological examination of 104 patients has been carried out. The age ranged from 35 to 78 years.

Results: Our data showed that the older the cerebral-organic brain changes are, the earlier symptoms of schizophrenia manifest in patients with residual-organic brain changes, and the more profound neurological signs are, the more often and faster those changes implement their patoplasty into a clinical picture of schizophrenia. In the evening hours, visual hallucinations while clear consciousness, delirious states, twilight states, confusion states, oneiroid and asthenic features become apparent. The clinical picture of schizophrenia in the beginning proceeds atypically. However, as the process develops, and as the time from origin of residual-organic changes increases, the latest lose their role in modification of clinical picture of schizophrenia, which from this point takes its typical course.

Conclusions: In cases of development of schizophrenia in patients with residual-organic brain changes, the earlier the signs of endogenous process join to cerebral-organic changes and the more severe organic disturbances are, the more often and faster the clinical picture of schizophrenia takes an atypical course. As time intervals increase, the schizophrenia takes its typical course of duration.

REFERENCES:

1. Jordan HW, Howe G: De Clerambault Syndrome (erotomania): A review and case presentation. J Nat Med Ass 1980; 72, N 10, 979–985.
2. Strub RL, William Black F: Neurobehavioral Disorders: A clinical approach. 2nd ed. Philadelphia; PA, FA Davis Company, 1988.

Poster 75 **Saturday, October 28**
10:00 a.m.-11:30 a.m.

TREATMENT OF TARDIVE DYSKINESIA WITH DONEPEZIL

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to assess the efficacy of donepezil in treating tardive dyskinesia and become familiar with the indications and administration of this drug.

SUMMARY:

Tardive dyskinesia (TD) remains a significant clinical problem for which there is no uniformly effective treatment. The rationale for use of cholinergic drugs in this disorder derives from a theoretical conceptualization of TD as the result of an imbalance between cholinergic and dopaminergic systems in the basal ganglia. Earlier trials with acetylcholine precursors may have been disappointing because precursors may not increase central acetylcholine activity if striatal cholinergic neurons are dysfunctional in patients with TD. In contrast, new acetylcholinesterase inhibitors, developed for the treatment of dementia, may directly increase cholinergic synaptic transmission. Hence, we conducted an open, eight-week trial of donepezil in the treatment of TD. Ten patients with nonorganic psychotic disorders, who had received stable doses of antipsychotics and met research criteria for TD, were treated with donepezil 5–10 mg for six weeks after a two-week baseline period. Changes in total AIMS scores measured biweekly were assessed for significance using ANOVA for repeated measures.

Patients were also assessed using the BPRS, MMSE, Barnes Akathisia, and Simpson/Angus scales. Initial results in four patients studied thus far, show a 40% average reduction in AIMS scores within two to four weeks of treatment with 5 mg of donepezil. If confirmed in this study and future placebo-controlled, double-blind trials, these initial findings will have significant implications for treatment of TD by psychiatrists and psychopharmacologists.

REFERENCES:

1. Egan MF, Apud J, Wyatt RJ: Treatment of tardive dyskinesia. Schizophrenia Bulletin 1997; 23:583–609.
2. Mayeux R, Sano M: Treatment of Alzheimer's disease. New England Journal of Medicine 1999; 341:1670–1679.

Poster 76 **Saturday, October 28**
10:00 a.m.-11:30 a.m.

7C GOLD URINARY ASSAY OF NEURAL THREAD PROTEIN IN ALZHEIMER'S DISEASE

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that urinary AD7C-NTP is a peripheral marker for Alzheimer's disease and may be used to aid in diagnosing the disease.

SUMMARY:

AD7C-NTP is a neural thread protein (NTP) associated with the pathological changes of Alzheimer's disease (AD), and is selectively elevated in AD brain, cerebrospinal fluid, and urine. NTP levels have been shown to correlate with disease progression in AD. The overexpression of the AD7C-NTP gene in transfected cells in culture induces cell death similar to that found in AD brain. A gold particle monoclonal anti-AD7C-NTP based liquid phase immunoassay (7C Gold) has recently been developed. We have used 7C Gold to measure AD7C-NTP in 120 individuals, including AD (N = 65) and age-matched, healthy, normal controls (N = 55). The 7C Gold migration level was further validated by gel electrophoretic studies of urinary samples. Using a cutoff of 1.25 units, over 90% of AD cases tested positive, with fewer than 5% of healthy controls testing over 1.25 units. These data further validate AD7C-NTP as a useful biochemical marker for AD, and indicate that the 7C Gold test in urine is a highly practical method to determine AD7C-NTP levels in AD.

REFERENCES:

1. Ghanbari HA, et al: Biochemical assay for AD7C-NTP in urine as an Alzheimers disease marker. J Clin Lab Anal 1998; 12:285–288.
2. de la Monte SM, et al: AD7C-NTP biomarker for Alzheimer's disease. Alzheimer's Report 1999; 2:327–332.
3. Kahle PJ, et al: Combined assessment of Tau and neuronal thread protein in Alzheimer's disease CSF. Neurology 2000; 54:1498–1504.

Poster 77 **Saturday, October 28**
10:00 a.m.-11:30 a.m.

BENEFITS OF ZIPRASIDONE IN SCHIZOPHRENIC PATIENTS SWITCHED FROM OTHER DRUGS

Supported by U.S. Pharmaceuticals, Pfizer Inc.

George M. Simpson, M.D., *Interim Chair, Department of Psychiatry, University of Southern California Medical Center, 1937 Hospital Place, Graduate Hall, Los Angeles, CA 90033–1073*; Steven G. Potkin, M.D.; Peter J. Weiden, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand that symptom control in schizophrenic patients may potentially be improved by switching antipsychotic medication between the newer atypical products as well as from typical to atypical antipsychotics

SUMMARY:

Objective: Three six-week, multicenter, randomized, open-label, parallel-group trials evaluated outcome in stable outpatient schizophrenics following a switch from conventional antipsychotics (n = 93), olanzapine (n = 88), or risperidone (n = 41).

Method: Patients were randomized in each trial to a variety of dosing schedules and received ziprasidone 40–160 mg/day. Reasons for switching were related to tolerability of previous treatment and/or desire for enhanced efficacy. Assessments included PANSS and CGI-S. Significance of mean change from baseline was tested by paired t-test. Safety assessments included laboratory, vital signs, treatment-emergent adverse events, and specific movement-disorder measures.

Results: Significant improvement was observed on PANSS total, PANSS positive subscale, and PANSS negative subscale scores for each group (except PANSS positive subscale for patients switched from risperidone, which improved but not significantly) ($P < 0.05$). Significant improvement on the CGI-S was also observed for patients switched from conventionals and olanzapine ($P < 0.05$). Various dosing schedules for switching to ziprasidone were all effective and well tolerated.

Conclusion: Ziprasidone therapy was well tolerated and resulted in improvement in multiple measures of psychopathology, including positive and negative symptoms, as well as overall status. Thus, some patients may experience enhancement in antipsychotic control following a switch to ziprasidone.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Daniel DG, Zimbroff DL, Potkin SG, Reeves KR, Harrigan EP, Lakshminarayanan M, and the ziprasidone study group: Ziprasidone 80 mg/day and 160 mg/day in the acute exacerbation of schizophrenia and schizoaffective disorder: a 6-week placebo-controlled trial. Neuropsychopharmacol 1999; 20:491–505.
2. Weiden PJ, Aquila R, Dalheim L, Standard JM: Switching antipsychotic medications. J Clin Psychiatry 1997; 58:63–72.

Poster 78 **Saturday, October 28 10:00 a.m.-11:30 a.m.**

OBESITY AS A RISK FACTOR FOR ANTIPSYCHOTIC NONCOMPLIANCE

Supported by U.S. Pharmaceuticals, Pfizer Inc.

Peter J. Weiden, M.D., *Professor of Psychiatry, State University of New York Health Sciences Center, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203*; Joan A. Mackell, Ph.D.; Diana D. McDonnell

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to 1) present data on a cross-sectional survey of patients with schizophrenia regarding their attitudes about their antipsychotic medication and side effects; 2) present findings on the relationship between the patient's weight status and compliance with antipsychotic medication; and 3) discuss the clinical and public health implications of noncompliance associated with antipsychotic-induced weight gain.

SUMMARY:

Objective: Although newer, "atypical" antipsychotics have been a major improvement in terms of side effects, weight gain remains a vexing problem. Therefore, it is increasingly important to understand whether there is a relationship between obesity and compliance with antipsychotic medication.

Methods: Cross-sectional eight-page questionnaires focusing on treatment and health issues were mailed to people with schizophrenia identified through NAMI and NMHA. Self-reported frequency of missing medication was the primary dependent variable. The primary independent variable was BMI, which was categorized as normal (<25, n = 73), overweight (25 to 30, n = 104), or obese (>30, n = 100). Other independent variables included demographics, reported reasons for stopping medication, medication attitude, and treatment satisfaction.

Results: There was a significant association between obesity and noncompliance, with obese people almost three times more likely to report missing their medication than patients with normal BMI (OR = 2.9; CI = 1.1 to 7.3). Obese respondents were also more likely to stop medication because of weight gain (OR = 13.8; CI = 2.0 to 95.4). Respondents' attitudes toward medication attenuated, but did not eliminate, the relationship between obesity and noncompliance.

Conclusion: There was a significant association between obesity and noncompliance with antipsychotic medication. The association remained even when accounting for other known or possible risk factors for noncompliance.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Allison DB, Mentore JL, Heo M, Chandler LP, et al: Antipsychotic-induced weight gain: a comprehensive research synthesis. Am J Psychiatry 1999; 156:1686–1696.
2. Awad AG, Hogan TP, Voruganti LN, Heslegrave RJ: Patients' subjective experiences on antipsychotic medications: implications for outcome and quality of life. Int Clin Psychopharmacol. 1995; (Suppl 3):123–132.

Poster 79 **Saturday, October 28 10:00 a.m.-11:30 a.m.**

QUETIAPINE RESOLVES WEIGHT GAIN SIDE EFFECT

Supported by Eli Lilly and Company

Kevin J. Took, M.D., *Medical Director, Blank Children's Hospital, and Assistant Clinical Professor, De-*

partment of Psychiatry, University of Iowa, 6000 University Avenue, Suite 200, West Des Moines, IA 50266; Bridget L. Buck, M.D.; Norman Paradise, Ph.D.; Mustafa El-Dadah, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to examine the resolution of the weight gain side effect in children and adolescents when switching from risperidone to quetiapine.

SUMMARY:

Objective: To assess quetiapine as an alternative to risperidone in treating children and adolescents who experience excessive weight gain.

Method: Charts of the first 24 children and adolescents (age range 4–18 years) who met the following criteria were reviewed: (1) excessive weight gain while on risperidone, and (2) those who were switched from risperidone to quetiapine. Weight gain was felt to be excessive by the patient, the parents, or the treating physician, and was not slowing or plateauing.

Results: Average daily dose of risperidone was 1.25 mg and mean duration of treatment 11.5 months. Mean weight gain on risperidone was 35.2 lbs, and mean increase of body mass index was 5.6 kg/m^2 ($p < 0.001$). Mean daily dose of quetiapine was 192 mg, with mean duration of treatment 5.7 months. In the process of extending the treatment duration of quetiapine to equal that of risperidone. Mean weight gain on quetiapine was 2.8 lbs, mean decrease in BMI was 0.3 kg/m^2, neither of which was statistically significant.

Conclusion: This retrospective study illustrates that when children were switched from risperidone to quetiapine, they experienced no significant increase in weight. This suggests that quetiapine is a viable alternative to risperidone for children and adolescents who experience excessive weight gain.

TARGET AUDIENCE:

Psychiatrists, psychiatric, nurses, pediatricians.

REFERENCES:

1. Casey DE: The relationship of pharmacology to side effects. J Clin Psychiatry 1997; 58:55–62
2. Schreirer HA: Risperidone for young children with mood disorders and aggressive behavior. J Child Adolesc Psychopharmacol 1998; 8:49–59.

Poster 80 **Saturday, October 28**
10:00 a.m.-11:30 a.m.

THE EFFECTS OF OLANZAPINE ON ALZHEIMER'S DISEASE ASSESSMENT SCALE SCORES IN PATIENTS WITH MILD TO MODERATE ALZHEIMER'S DISEASE WITH PSYCHOSIS AND BEHAVIORAL DISTURBANCES

Supported by Eli Lilly and Company

John S. Kennedy, M.D., *Clinical Research Physician, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285*; Bruce R. Basson, M.S.; Anthony J. Zagar, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the potential effect on cognition that olanzapine may have in patients with Alzheimer's disease.

SUMMARY:

Objective: To determine the effects of olanzapine (OLZ) on ADAS-Cog scores in patients with Alzheimer's disease (AD) with psychosis and behavioral disturbances who demonstrated a mild to moderate cognitive impairment at baseline.

Methods: A post-hoc analysis was conducted on the effects of OLZ on ADAS-Cog scores in a subgroup of nursing home patients with AD participating in a multicenter, double-blind, placebo-controlled study. Mean change from baseline to endpoint in the ADAS-Cog scores was analyzed in 43 of the 206 patients randomized to one of four treatment arms (placebo, OLZ 5 mg, OLZ 10 mg, OLZ 15 mg). Correlation coefficients between the change from baseline to endpoint for the ADAS-Cog scale and Neuropsychiatric Inventory-Nursing Home Version (NPI/NH) were calculated to assess the relationship between changes in cognition and psychosis.

Results: For this subgroup, patients receiving OLZ 5mg ($n = 17$) improved on the ADAS-Cog by –0.94 points over six weeks, which was not significantly different from the worsening of 1.38 points seen in the placebo group ($n = 8$) ($p = 0.495$). Over all treatment groups, changes in ADAS-Cog scores were not significantly correlated with changes in NPI/NH Psychosis scores ($p = 0.357$; $r = 0.146$).

Conclusion: Numerically, OLZ 5 mg did not worsen cognitive function, and while no statistically significant evidence of cognitive improvement was observed, the trend indicates that OLZ 5 mg may provide cognitive benefit in mild to moderately impaired AD patients compared with placebo. Further prospective studies need to be conducted in AD patients without psychosis or

behavioral disturbances to determine the potential for beneficial cognitive effects of OLZ.

REFERENCES:

1. Street J, Clark WS, Gannon K, et al: Olanzapine in the treatment of psychosis and behavioral disturbances. Archives of Gen Psych, in press.
2. Bymaster FP, Calligaro DO, Falcone JF, et al: Radio receptor binding profile of the atypical antipsychotic olanzapine. Neuropsychopharmacology 1996; 14:87–96.

Poster 81 **Saturday, October 28 10:00 a.m.-11:30 a.m.**

CONTINUED IMPROVEMENT IN QUALITY OF LIFE DESPITE WEIGHT CHANGE DURING OLANZAPINE OR HALOPERIDOL TREATMENT

Supported by Eli Lilly and Company

Julie A. Gilmore, Ph.D., *Medical Writer Associate, Eli Lilly and Company, One Lilly Corporate Center, Indianapolis, IN 46285*; Bruce J. Kinon, M.D.; Hank Wei, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the effects of haloperidol and olanzapine in relation to weight change over one year of treatment.

SUMMARY:

Objective: Determine change in quality of life as a function of weight change in schizophrenic patients who received treatment with olanzapine (OLZ) or haloperidol (HAL).

Method: This analysis retrospectively examined 554 patients receiving OLZ or HAL treatment. Data were collected from a controlled, multicenter, double-blind, parallel clinical trial with patients (N = 1996) diagnosed with DSM-III-R schizophrenia, schizoaffective, or schizophreniform disorders. The Heinrichs-Carpenter Quality of Life Scale (QLS) and the SF-36 were used to evaluate diverse aspects of quality of life. Change in quality of life as a function of change in weight (≤5 vs. > 5 kg) was measured at 52 weeks (LOCF).

Results: After 52 weeks of treatment, OLZ-treated patients showed a significantly greater improvement in quality of life compared with HAL-treated patients as indicated by the QLS ($p = 0.001$), and no significant differences using the SF-36 mental component summary ($p = 0.4$) or the SF-36 physical component summary ($p = 0.393$). Patients who experienced > 5 kg weight gain on either OLZ or HAL did not suffer from a reduction in quality of life as demonstrated by the QLS total score ($p = 0.391$ and $p = 0.603$; respectively). Quality of life for OLZ-treated patients versus HAL-treated patients experiencing weight gain was not statistically different using the QLS total score ($p = 0.157$) and the SF-36 mental component summary score ($p = 0.218$).

Conclusions: Overall, improvement in quality of life was greater in OLZ-treated patients versus HAL-treated patients after 52 weeks and weight change (gain) during OLZ or HAL treatment generally does not detract from treatment-related improvements in key aspects of patients' quality of life.

REFERENCES:

1. Tollefson GD, Beasley CM, Tran P, Street JS: Olanzapine versus haloperidol in the treatment of schizophrenia and schizoaffective and schizophreniform disorders: results of an international collaborative trial. Am J Psychiatry 1997; 154:457–465.
2. Brier A, Hamiton S: Comparative efficacy of olanzapine and haloperidol for patients with treatment resistant schizophrenia. Society of Biol Psychiatry 1999; 45:403–411.

Poster 82 **Saturday, October 28 10:00 a.m.-11:30 a.m.**

NEUROCOGNITIVE ADVANTAGES OF QUETIAPINE

Supported by AstraZeneca Pharmaceuticals

Frederick W. Kohler, Jr., R.Ph., Ph.D., *Medical Knowledge Product Scientist, Department of Clinical Development, AstraZeneca Pharmaceuticals, 1800 Concord Pike, Wilmington, DE 19850*; Dawn I. Velligan, Ph.D., *Associate Professor, Department of Psychiatry, University of Texas Health Science Center, 7703 Floyd Curl Drive, MS 7792, San Antonio, TX 78229*; J.L. Ritch; N. Ledbetter; C.C. Bow-Thomas; A.L. Miller

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, participants will have learned that patients taking quetiapine had improved cognitive and functional outcomes than those taking conventional antipsychotic medications in standard community settings.

SUMMARY:

Objective: To examine the effectiveness of quetiapine vs conventional neuroleptics in improving cognitive and functional outcomes for patients in standard community treatment settings.

Methods: In an ongoing study, 20 stable outpatients with schizophrenia were randomly assigned to continue conventional antipsychotics or switch to quetiapine. At

study entry and after three months, patients were tested with neurocognitive and functional tests.

Results: At three months, patients on quetiapine improved significantly on global level of neurocognitive function ($p < .04$), executive function (inhibition-Trails B $p < .04$), and attention (CPT $p < .04$). In patients on conventional antipsychotics, executive function significantly worsened (inhibition-Trails B $p < .01$; verbal fluency $p < .05$). A trend suggested an overall deterioration of cognitive function ($p < .03$). ANCOVA indicated significant group differences in overall level of cognitive function ($p < .04$), verbal memory (CVLT $p < .02$), and executive function (inhibition-Trails B $p < .02$) at three months. Patients on quetiapine performed better than those on conventional antipsychotics and showed significant improvements in functioning on the Multnomah Community Ability Scale ($p < .02$).

Conclusion: Although the data are preliminary, results for neurocognitive variables are similar to those found in efficacy studies of quetiapine. Neurocognitive advantages of quetiapine relative to conventional antipsychotics may be reflected in important improvements in community adjustment.

Funded by a grant from AstraZeneca.

REFERENCES:

1. Velligan DI, Bow-Thomas CC: Executive function in schizophrenia. Semin Clin Neuropsychiatry 1999; 4:24–33.
2. Green MF: What are the functional consequences of neurocognitive deficits in schizophrenia? Am J Psych 1996; 153:321–330.

Poster 83 **Saturday, October 28**
10:00 a.m.-11:30 a.m.

EFFICACY OF QUETIAPINE IN SYMPTOMS OF SCHIZOPHRENIA

Supported by AstraZeneca Pharmaceuticals

Frederick W. Kohler, Jr., R.Ph., Ph.D., *Medical Knowledge Product Scientist, Department of Clinical Development, AstraZeneca Pharmaceuticals, 1800 Concord Pike, Wilmington, DE 19850*; Robin Emsley; A.M. Jones; Joher Raniwalla

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, participants should be able to recognize that atypical antipsychotics are effective in treating positive and negative symptoms of schizophrenia and that quetiapine is more effective than haloperidol in treating symptoms of schizophrenia.

SUMMARY:

Objective: To assess the efficacy of quetiapine in treating both the positive and negative symptoms of schizophrenia.

Method: In a study showing the effectiveness of quetiapine in treating partially responsive patients, data were reanalyzed to evaluate the effect on individual item scores of the Positive and Negative Symptom Scale (PANSS). Patients received fixed doses of quetiapine 600 mg/day or haloperidol 12 mg/day for eight weeks. PANSS scores were recorded at baseline and endpoint. For each positive and negative PANSS item, the percentage of patients whose baseline score decreased from ≥4 (moderate or worse symptoms) to ≤3 (absent, minimal, or mild symptoms) was calculated.

Results: For all PANSS-positive items, the percentage of patients with an endpoint item of ≤3 was greater for quetiapine than haloperidol. Results of the PANSS negative items for quetiapine were greater than haloperidol for blunted affect (50% vs 27%), emotional withdrawal (49% vs 34%), poor rapport (52% vs 43%), lack of spontaneity (56% vs 44%), and stereotyped thinking (49% vs 39%).

Conclusions: These results show that quetiapine is effective in treating the positive and negative symptoms of schizophrenia in partially responsive patients.

Funded by a grant from AstraZeneca.

REFERENCES:

1. Emsley, et al: Presented at the American Psychiatric Association 1999; NR222.
2. Small JG, et al: Quetiapine in patients with schizophrenia: a high- and low-dose double-blind comparison with placebo. Arch Gen Psychiatry 1997; 54:549–557.

Poster 84 **Saturday, October 28**
10:00 a.m.-11:30 a.m.

WEIGHT CHANGES WITH QUETIAPINE

Supported by AstraZeneca Pharmaceuticals

Frederick W. Kohler, Jr., R.Ph., Ph.D., *Medical Knowledge Product Scientist, Department of Clinical Development, AstraZeneca Pharmaceuticals, 1800 Concord Pike, Wilmington, DE 19850*; Martin A. Jones; U.K. Macclesfield; Ihor W. Rak, M.D.; Joher Raniwalla; Karen Melvin

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, participants should be able to understand that weight gain is prevalent with antipsychotic treatment and recognize that weight gain in patients treated with quetiapine is equal to or less then other atypical antipsychotics.

SUMMARY:

Objective: Weight gain is a side effect often associated with antipsychotic treatment that can affect compliance, quality of life, and long-term health. We report data on weight changes observed in a large cohort of patients treated with quetiapine.

Method: Patients (n = 2216) from controlled, uncontrolled, and open-label extension trials were studied. Weights were grouped using an LOCF approach, within specified time intervals.

Results: There was a small mean weight increase of 2.08 kg (±0.15; n = 778) over the first five to six weeks. Similar mean weight increases of 2.16 kg (±0.46; n = 171) at 9–10 weeks, 1.85 kg (±0.48; n = 556) at 6–9 months, and 2.77 kg (±0.56; n = 360) at nine to 12 months were observed. The average mean daily dose of quetiapine for the patients at nine to 12 months was 428 mg/day. Only one patient from the 2216 cohort (0.05%) withdrew due to an adverse event of weight gain.

Conclusion: Based on available weight gain data, the weight gain during quetiapine treatment is approximately equal to the weight gain associated with risperidone and approximately 50% of the weight gain reported with olanzapine and clozapine.

Funded by a grant from AstraZeneca.

REFERENCES:

1. Allison DB, et al: Am J Psychiatry 1999; 156:1686–1696.
2. Kinon BJ, et al: Poster Presentation at CINP, July 12–16, 1998, Glasgow.

Poster 85 **Saturday, October 28**
10:00 a.m.-11:30 a.m.

TOLERABILITY OF QUETIAPINE IN EPS-VULNERABLE PATIENT GROUPS

Supported by AstraZeneca Pharmaceuticals

Jorge L. Juncos, M.D., *Associate Professor of Psychiatry, Emory University School of Medicine, 1841 Clifton Road, N.E., Atlanta, GA 30329*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should have an understanding of the tolerability benefits of quetiapine in patients vulnerable to EPS.

SUMMARY:

Objective: Elderly patients, and those with pre-existing cerebral pathology, including parkinsonism and dementia, are particularly vulnerable to spontaneous and drug-induced extrapyramidal symptoms (EPS). Quetiapine has demonstrated advantages in EPS over other antipsychotics in a general population with schizophrenia (Arvanitis & Miller 1997; Goldstein & Arvanitis 1997). This review summarizes data on the use of quetiapine in patients vulnerable to EPS.

Methods: We conducted a selective review of this topic in recent literature from clinical studies using Medline searches, and from data presented at international meetings.

Results: In an open study of 184 elderly patients (mean age 76.1 years) treated for various psychotic disorders, the incidence of EPS events with quetiapine was 13% (Tariot et al, 1999), similar to that of younger patients administered placebo. Furthermore, quetiapine was not associated with treatment-emergent tardive dyskinesia. Analysis of the Parkinson's disease subgroup (n = 40) showed no worsening of motor symptoms (Juncos et al, 1999), and in the Alzheimer's disease subgroup (n; eq 78) SAS scores significantly improved from baseline at 12 and 52 weeks ($p < 0.05$) (Schneider et al, 1999). In another study 37/44 patients with Parkinson's disease and drug-induced psychosis were successfully maintained on quetiapine without a decline in motor function (Friedman et al, 1999).

Conclusion: These data suggest that quetiapine could be a valuable first choice antipsychotic for patient groups vulnerable to EPS.

Funded by a grant from AstraZeneca.

REFERENCES:

1. Arvanitis LA, Miller BG: Multiple fixed doses of 'Seroquel' (quetiapine) in patients with acute exacerbation of schizophrenia: a comparison with haloperidol and placebo. The Seroquel Trial 13 Study Group. Biol Psychiatry 1997; 42:233–246, 1996; 153:321–330.
2. Goldstein JM, Arvanitis LA: Seroquel (quetiapine) is not associated with dose-related extrapyramidal symptoms: overview of clinical results. Schizophrenia Res 1997; 24:198.

Poster 86 **Saturday, October 28**
10:00 a.m.-11:30 a.m.

QUETIAPINE IMPROVES COGNITION IN SCHIZOPHRENIA

Supported by AstraZeneca Pharmaceuticals

Scot Purdon, Ph.D., *Associate Professor, Department of Psychiatry, University of Alberta, 17480 Fort Road, Box 307, Edmonton, Alberta, Canada 755257*; Ashok Malla; Alain Labelle, M.D.; Wilson Lit, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to assess the efficacy of quetiapine in the reduction of cognitive impairment in schizophrenia.

SUMMARY:

Objective: To assess the efficacy of quetiapine in the reduction of cognitive impairment in schizophrenia.

Method: Twenty five patients with schizophrenia were randomly assigned to double-blind treatment with quetiapine or haloperidol for six months. Patients were evaluated after eight weeks and six months using rating scales for psychotic symptoms, mood, and EPS. Standardized neuropsychological measures of cognitive domains included fine motor skills, attention span, verbal reasoning and fluency, visuospatial construction and fluency, executive skills and visuomotor tracking, and immediate recall of verbal and non-verbal materials. Mean dosages of quetiapine and haloperidol were 468 mg/day and 16 mg/day, respectively.

Results: Within eight weeks, quetiapine improved psychosis and mood without inducing EPS. Quetiapine also enhanced cognitive skills, particularly verbal reasoning and fluency skills and immediate recall, and with long-term treatment also improved executive skills, visuomotor tracking, and the average of the six cognitive domains. While haloperidol improved the general clinical status at eight weeks and six months, there were no specific improvements in the positive syndrome, the negative syndrome, depression ratings, mood, or cognitive skills.

Conclusion: These preliminary results illustrate the potential value of quetiapine in improving cognitive impairment in schizophrenia and the importance of further research with this promising atypical antipsychotic.

Funded by a grant from AstraZeneca

TARGET AUDIENCE:

Psychiatrists and psychiatric nurses.

REFERENCES:

1. Purdon SE: Measuring neuropsychological change in schizophrenia with novel antipsychotic medications. Journal of Psychiatry and Neuroscience 25(2): 108–116.
2. Purdon SE: Cognitive improvement in schizophrenia with novel antipsychotic medications. Schizophrenia Research 35; 51–60.

Poster 87 **Saturday, October 28 10:00 a.m.-11:30 a.m.**

QUETIAPINE IN THE TREATMENT OF MANIA

Supported by AstraZeneca Pharmaceuticals

Eduardo Dunayevich, M.D., *Assistant Professor of Clinical Psychiatry, and Director, Clinical Psychobiology Program, Department of Psychiatry, University of Cincinnati, 231 Bethesda Road, Cincinnati, OH 45267*; Karen Tugrul, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, participants will understand the effects of quetiapine when used as a treatment for mania.

SUMMARY:

Objective: To examine the effects of quetiapine in the treatment of acute mania.

Method: Seven hospital inpatients with bipolar disorder, manic or mixed with psychotic features, were treated with quetiapine, either as monotherapy (n = 1) or added to ongoing mood-stabilizer regimen (n = 6). Treatment response was ascertained by retrospective review of hospitalization medical records and rated with the Clinical Global Impression Scale (CGI) and Young Mania Rating Scale (YMRS).

Results: Five of seven patients were much or very much improved per CGI change scores, including one patient previously resistant to combined mood-stabilizer and antipsychotic treatment. YMRS (signed rank test = 14, p = 0.01) and CGI (signed rank score = 14, p = 0.01) scores at discharge were significantly improved compared with those at admission. No worsening of manic symptoms was observed in this group of patients.

Conclusion: Quetiapine appears to be a safe and promising agent in the treatment of mania. Randomized, controlled trials of quetiapine in the treatment of acute mania are needed.

Funded by a grant from AstraZeneca.

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Tohen M, Zarate CA Jr: Antipsychotic agents and bipolar disorder. J Clin Psychiatry 1998 59S; 1:38–48.
2. Sajatovic M, Brescan D, Perez D, DiGiovanni S: Quetiapine in the treatment of neuroleptic-dependent mood disorders. Presented at the 11th World Congress of Psychiatry 1992; 2:128. Hamburg, 6–11 Aug.
3. Zarate CA Jr, Rothschild A, Fletcher KE, Madrid A, Zapatel J: Clinical predictors of acute response with quetiapine in psychotic mood disorders. J Clin Psychiatry 2000; 61(3):185–9.

Poster 88 **Saturday, October 28 10:00 a.m.-11:30 a.m.**

QUETIAPINE AS EFFECTIVE AS OTHER ATYPICALS

Supported by AstraZeneca Pharmaceuticals

Jeffrey M. Goldstein, Ph.D., *Global Scientific Advisor, AstraZeneca Pharmaceuticals, 2 Righter Parkway, Wilmington, DE 19803*; John Donoghue

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, participants should be able to learn that quetiapine is as effective as other antipsychotics when using clinically meaningful measurements.

SUMMARY:

Objective: The Number Needed to Treat (NNT) is a measure that has direct clinical utility by indicating the number of patients that need to be treated before a predefined treatment response is achieved. Thus, low NNT values are better than high ones. This study compares the NNT of quetiapine and other antipsychotic medications.

Method: Data were derived from three pivotal placebo-controlled, multiple-dose trials that included a haloperidol arm. The NNT to achieve 20% and 40% reductions in Brief Psychiatric Rating Scale (BPRS) scores were calculated for quetiapine, olanzapine, risperidone, and haloperidol.

Results: The NNT for a 40% reduction in BPRS scores for quetiapine was the lowest.

	Mean dose (mg/day)	NNT reduction in BPRS 20%	40%	Reference
Risperidone	6	3	–	Marder & Meilbach (1994)
	10	6	–	
Haloperidol	20	9	–	
Olanzapine	10	6	10	Beasley et al (1996)
	15	4	7	
Halopericol	16.4	4	8	
Quetiapine	300	4	5	Arvanitis et al(1997)
	600	3	5	
Haloperidol	12	5	7	

Conclusion: Although not directly comparable, these results suggest that, when using clinically meaningful measurements, quetiapine is as effective as olanzapine, risperidone, and haloperidol.

Funded by a grant from AstraZeneca.

REFERENCES:

1. Small JG, Hirsch SR, Arvanitis LA, Miller BG, Link CGG, and The Seroquel Study Group: Quetiapine in patients with schizophrenia: a high- and low-dose double-blind comparison with placebo. Arch Gen Psychiatry 1997; 54:549–557.
2. Arvanitis LA, Miller BG, and the Seroquel Trial 13 Study Group: Multiple fixed doses of "Seroquel" (quetiapine) in patients with acute exacerbation of schizophrenia: a comparison with haloperidol and placebo. Biol Psychiatry 1997; 42:233–246.

Poster 89 **Saturday, October 28 10:00 a.m.-11:30 a.m.**

EFFICACY OF QUETIAPINE IN TREATING DELIRIUM

Supported by AstraZeneca Pharmaceuticals

Thomas L. Schwartz, M.D., *159 Richfield Avenue, Syracuse, NY 13205-3116*; Prakash S. Masand, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to compare the efficacy of quetiapine and haloperidol in the treatment of delirium.

SUMMARY:

Objective: To assess the efficacy of quetiapine in the treatment of delirium.

Method: Charts were retrospectively reviewed of 11 consecutive patients with delirium who were given quetiapine as first-line treatment for their symptoms. A control group of 11 patients treated with haloperidol for delirium was evaluated during the same time period. The Delirium Rating Scale (DRS) was used to evaluate the efficacy of each treatment.

Results: Ten of 11 patients in both groups had ≥50% improvement in DRS scores. There was no difference in onset of symptom resolution, duration of treatment, and overall clinical improvement. Quetiapine was better tolerated in these medically ill patients.

Conclusion: Quetiapine appears to be an efficacious and well-tolerated treatment for delirium. Further prospective studies are warranted.

Funded by a grant from AstraZeneca.

REFERENCES:

1. Trzepaca PT, Teague GB, Lipowski ZJ: Delirium and other organic mental disorders in a general hospital. Gen Hosp Psychiatry 1985; 7101–106.
2. Lipowski ZJ: Delirium (acute confusional states). JAMA 1987; 258:1789–1792.

Poster 90 **Saturday, October 28 10:00 a.m.-11:30 a.m.**

ATYPICAL ANTIPSYCHOTICS DIFFER IN TERMS OF EPS

Supported by AstraZeneca Pharmaceuticals

Rajiv Tandon, M.D., *Professor of Psychiatry, and Director, Schizophrenia Program, University of Michigan Medical Center, 1500 East Medical Center Drive, UH 9C-9150, Ann Arbor, MI 48105-0120*; Michael D. Jibson, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand that while all atypical antipsychotics are less likely than conventional antipsychotics to cause EPS at clinically effective doses, there are important differences between different atypical agents in this regard and these differences are relevant in several clinical settings.

SUMMARY:

Previously, clinicians worked with antipsychotic drugs, which almost invariably caused EPS at the doses at which they were clinically effective. By definition, the atypical antipsychotic agents are significantly better than conventional agents with regard to EPS—i.e., they are clinically effective at doses at which they do not cause EPS. This EPS advantage of atypical antipsychotics translates into several important benefits, including better negative symptom efficacy, lesser dysphoria, less impaired cognition, and a lower risk of TD. However, there are important differences between the various atypical antipsychotics with regard to this EPS advantage. Pharmacologically, different atypical antipsychotics differ in the degree of separation between the dose response curves for their antipsychotic and EPS effects. Clinically, this pharmacological difference translates into different degrees of risk to cause EPS with increasing doses of the atypical antipsychotic. Dose-related EPS have been reported with risperidone and olanzapine, but not for quetiapine or clozapine. With risperidone, a clear dose-related increase in ESRS scores was noted as the dose increased from 2 mg/day to 16 mg/day; similar though less robust findings are noted with olanzapine. By contrast, in a randomized, dose-ranging, placebo-controlled study of quetiapine (75–750 mg/day), no dose-related increase in any measure of EPS was noted. Similarly, no increase in rate of EPS has been noted with increasing doses of clozapine. These differences among various atypicals with regard to EPS have been confirmed in compartive studies. Since the EPS advantage of the atypical agents is the basis of their several advantages over conventional neuroleptics, it is critical that they be used in such a manner that EPS is avoided.

REFERENCES:

1. Jibson MD, Tandon R: J Psychiatric Res 1998; 32:215–228.
2. Tandon R, et al: J Clin Psychiatry 1999; 60(Supplement 8): 21–28.

Poster 91 **Saturday, October 28 10:00 a.m.-11:30 a.m.**

TARDIVE DYSKINESIA LOWER WITH QUETIAPINE

Supported by AstraZeneca Pharmaceuticals

Ihor W. Rak, M.D., *Department of Research, AstraZeneca Pharmaceuticals, 1800 Concord Pike, Wilmington, DE 19850*; Joseph A. Pultz; Paul P. Yeung, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have a better understanding of why treatment with the atypical antipsychotic quetiapine is less likely to cause the early extrapyramidal symptoms that often portend future tardive dyskinesia symptoms.

SUMMARY:

Objective: To assess the incidence of tardive dyskinesia (TD) in patients with psychosis treated with quetiapine compared with that reported in the literature for conventional antipsychotics.

Methods: 1447 patients aged 18 to 65 years with acute exacerbation of schizophrenia or schizoaffective disorder were assessed for TD after receiving quetiapine therapy. TD was defined using the Abnormal Involuntary Movement Scale (AIMS) and both the Glazer-Morgenstern and the Schooler-Kane criteria.

Results: Analyses indicated the incidence of TD may be lower with quetiapine than with conventional antipsychotics.

Conclusion: Quetiapine, at all therapeutic doses, was less likely to cause TD than conventional antipsychotics, based on the incidence of TD reported with conventional antipsychotics in previous studies.

Funded by a grant from AstraZeneca

TARGET AUDIENCE:

Psychiatrists.

REFERENCES:

1. Kane JM: Tardive dyskinesia: epidemiological and clinical presentation, in: Bloom FE, Kupler DJ, eds. Psychopharmacology: The Fourth Generation of Progress. New York, Raven Press, 1995; 1485–1495.
2. Glazer WM, Morgenstern H, Doucette JT: Predicting the long-term risk of tardive dyskinesia in outpatients maintained on neuroleptic medications. Journal of Clinical Psychiatry 1993; 54(4):133–9.

Poster 92 **Saturday, October 28 10:00 a.m.-11:30 a.m.**

UNIFIED PSYCHODYNAMIC THEORY

Rodney E. Kingston, M.D., *Chief Resident, Department of Psychiatry, Vanderbilt University, 1500 21st Avenue, South, Suite 2200, Nashville, TN 37212*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the homeodynamic process model and its basis in homeostasis and evolution, integrate ego psychology, object relations theory, and self psychology into a unified psychodynamic theory, understand the role of learning theory (Piaget) in the unified theory, describe clinical uses of the unified theory.

SUMMARY:

Intended for an audience of psychiatrists, mental health professionals, and trainees, this presentation addresses the lack of a unifying theoretical framework for psychodynamics. The presentation will start with a review of literature regarding the perceived conflicts among the major psychodynamic theories. Next a linkage to natural science principles will be established by the construction of a homeodynamic process model, which is based on evolution and homeostasis and which explains the seemingly paradoxical variability and stability that characterize living systems. By application of the homeodynamic process model, the major psychodynamic frameworks, ego psychology, object relations theory, and self psychology, will be demonstrated to be interdependent components of a unified system rather than competing and contradictory theories. Conflict and deficit models of psychopathology will likewise be shown to be interdependent components of the system. Additionally, the developmental theory of Piaget will be explained from a homeodynamic systems perspective and will be shown to be an integral component of the unified psychodynamic model, thus promoting the convergence of psychodynamic theory with a widely accepted psychological theory of learning. Finally, the application of the unified theory to clinical practice issues, such as the establishment of therapeutic goals and the management of resistance will be explored.

REFERENCES:

1. Pine F: Drive, Ego, Object, and Self: A Synthesis for Clinical Work. New York, HarperCollins, 1990.
2. Greenberg JR, Mitchell SA. Object Relations in Psychoanalytic Theory. Cambridge, Harvard University Press, 1983.

Poster 93 **Saturday, October 28**
10:00 a.m.-11:30 a.m.

HALLUCINATIONS IN HOSPITALIZED CHILDREN WITH PSYCHIATRIC DISORDERS

Rinah C. Gutiérrez, M.D., *Child and Adolescent Psychiatry Resident, St. Vicents Hospital, 203 West 12th Street, New York, NY 10011*; A. Reese Abright, M.D., *Chief of Child and Adolescent Psychiatry, St. Vincents Hospital, 203 West 12th Street, Suite 606, New York, NY 10011–7762*; Kevin E. Robinson, M.D.; Jorge Otero, M.D.

EDUCATIONAL OBJECTIVES:

Participants will gain increased knowledge regarding current literature on hallucinations in children and prevalence, characteristics, and associated diagnoses in a sample of psychiatrically hospitalized children.

SUMMARY:

The purpose of the present pilot study is to ascertain the prevalence, characteristics, and diagnostic concomitants of hallucinations as a presenting symptom in a sample of psychiatrically hospitalized children.

Method: The study sample is drawn from a cohort of 92 children (age range 3 to 13 years) admitted to a psychiatric inpatient unit in an urban university hospital during a three-month period. Children who presented with hallucinations on admission were identified, and their medical records reviewed.

Results: 20 of the 92 children (22%) presented with hallucinations. Mean age of these 20 children was 8.84 (range 4.75 to 13 years); gender distribution was 15 males and five females (3:1). A total of 65% reported auditory hallucinations, 10% visual hallucinations, and 25% both auditory and visual hallucinations. Admitting diagnoses included disruptive behavior disorders (65%), mood disorders (25%), anxiety disorders (25%), substance-induced psychotic disorders (15%), and other psychotic disorders (30%).

Conclusion: Findings from this pilot study are consistent with the limited data in the literature regarding hallucinations in inpatient samples of children. Results confirm the need for systematic studies of hallucinations in this population.

REFERENCES:

1. Caplan R, Tanguay PE: Development of psychotic thinking in children, in Child and Adolescent Psychiatry: A Comprehensive Textbook, Second Edition. Edited by Lewis M. Baltimore, Williams & Wilkins, 1996, pp. 315–322.
2. Garralda ME: Hallucinations in children with conduct and emotional disorders: I: The clinical phenomena. Psychological Medicine 1984; 14: 589–596.

Poster 94 **Saturday, October 28**
10:00 a.m.-11:30 a.m.

USE OF CITALOPRAM IN PATIENTS WITH CARDIOVASCULAR DISEASE

Supported by Forest Laboratories, Inc.

William Heydorn, Ph.D., *Department of Medicine, Forest Laboratories, Inc., 909 Third Avenue, New York, NY 10022*

EDUCATIONAL OBJECTIVES:

To recognize that citalopram can be safely administered to patients with cardiovascular disease.

SUMMARY:

Patients with depression often have a number of comorbid conditions. As a result, antidepressants are often administered with other medications. Interactions among medications and disease states can pose a significant risk. Cardiovascular diseases and hypertension are two of the most common conditions coexisting with depression. Citalopram is a selective serotonin reuptake inhibitor marketed as an antidepressant for more than 10 years and prescribed to more than 20 million patients. It has both a low side-effect profile and low risk for drug interactions. This report reviews safety data from patients who received citalopram in clinical trials. Safety data were examined from 4,168 patients who received citalopram for depression, Alzheimer's disease, or panic disorder. Of this population, 193 patients (4.6%) reported a history of cardiovascular disease, and 138 patients (3.3%) reported a history of hypertension. To assess potential drug-disease interactions, adverse event rates in citalopram-treated patients with cardiovascular disease or hypertension were compared with corresponding rates in the remaining population.

The adverse-event profile during citalopram treatment of patients with cardiovascular disease or hypertension did not differ from that in the entire citalopram-treated study population. Similarly, the concomitant use of cardiovascular and antihypertensive medications with citalopram had no effect on adverse-event rates. These results suggest that citalopram can be safely administered to patients with concurrent cardiovascular diseases.

REFERENCES:

1. Rasmussen SL, Overo KF, Tanghoj P: Cardiac safety of citalopram: prospective trials and retrospective analyses. J Clin Psychopharmacol 1999; 19(5):407–15.
2. Glassman AH: Cardiovascular effects of antidepressant drugs: updated. J Clin Psychiatry 1998:59 Suppl 15:13–8.

Poster 95 **Saturday, October 28**
10:00 a.m.-11:30 a.m.

USE OF CLOZAPINE NONPSYCHOTIC PATIENTS WITH SUICIDAL BEHAVIORS

Panakkal David, M.D., *Psychiatrist, Saratoga County Mental Health Center, 211 Church Street, Saratoga Springs, NY 12866*; Dianne Waters, R.N., *Nurse, Community Mental Health Department, Saratoga County Mental Health Center, 211 Church Street, Saratoga Springs, NY 12866*; Ivan J. Engel, M.D.

EDUCATIONAL OBJECTIVES:

To consider clozapine for patients who have failed multiple drug trials for suicidal behaviors.

SUMMARY:

Five patients who failed multiple trials of various antipsychotics for suicidal behaviors were given an open trial of clozapine. All patients had a nonpsychotic diagnosis. Number of hospital days, emergency contacts, number of self-injurious behaviors, and suicidal attempts were measured for one year prior to start of clozapine and for one year after starting of clozapine. The results show that there are significant decreases in all areas measured. For example, the average number of hospital days decreased from 80 to four.

REFERENCES:

1. Johnson ME: Journal of Clinical Psychiatry 1999; 60:477–84.
2. McMillen RT, Grayson JD: Journal of Personality Disorders 1995; 9:76–82.

POSTER SESSION V

Posters 98–124

Poster 96 **Saturday, October 28**
10:00 a.m.-11:30 a.m.

RISPERIDONE IN CHILDREN WITH SIGNIFICANT CONDUCT PROBLEMS AND BELOW-AVERAGE INTELLECTUAL FUNCTIONING

Robert L. Findling, M.D., *Professor of Pediatrics and Adolescent Health, and Director, Division of Child and Adolescent Psychiatry, University of Cleveland Medical Center, 11100 Euclid Avenue, Cleveland, OH 44106-5080;* Michael G. Aman, M.D., *1581 Dodd Drive, Columbus, OH 43210*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to assess benefits of risperidone in treating children with severe conduct disorder.

SUMMARY:

The benefit of risperidone for severe conduct disorder in children with sub-average intellectual functioning was documented in a previous multicenter, randomized, placebo-controlled study of short duration (six weeks).

Objective: To assess the long-term safety and efficacy of risperidone for conduct disorders in children with sub-average intellectual functioning.

Methods: A 48-week-open-label study was conducted in 107 patients, between 5 and 12 years old, with sub-average intellectual functioning who had conduct disorder, oppositional defiant disorder, or disruptive behavior

disorder not otherwise specified, who had previously completed at least two-weeks of the six-week, double-blind placebo-controlled, randomized study.

Results: All patients received open-label risperidone at doses between 0.02 and 0.06 mg/kg/day. Statistically significant improvements over the double-blind randomized study baseline occurred on the primary efficacy variable—the conduct problem subscale of the Nisonger Child Behavior Rating Form (N-CBRF)—and in all other N-CBRF subscales as well after 48 weeks. The three most common adverse events were somnolence, headache, and rhinitus.

Conclusion: Risperidone has a good overall risk-benefit profile and is effective for the long-term treatment of conduct disorder, disruptive behavior disorder, and oppositional defiant disorder in children with subaverage intellectual functioning.

REFERENCES:

1. Findling RL, McNamara NK, Branicky LA, et al: A double-blind pilot study of risperidone in the treatment of conduct disorder. J Am Acad Adolesc Psychiatry 2000; 39:509–16.
2. Buttelaar JK: Open-label treatment with risperidone of 26 psychiatrically-hospitalized children and adolescents with mixed diagnoses and aggressive behavior. J Child Adolesc Psychopharmacol 2000; 10:19–26.

Poster 97 **Saturday, October 28**
10:00 a.m.-11:30 a.m.

RISPERIDONE AND OLANZAPINE: PATTERNS OF USE IN A VA SYSTEM

Supported by Janssen Pharmaceutica and Research Foundation

John C. Voris, Pharm.D., *Associate Professor, Department of Clinical Pharmacy, University of South Carolina, 1312 Country Squire Drive, Columbia, SC 29122*

EDUCATIONAL OBJECTIVES:

At the conclusion of this poster presentation, the participant should be able to discuss trends in dosing of risperidone and olanzapine in selected VA hospitals and trends in use of risperidone and olanzapine according to diagnosis.

SUMMARY:

This retrospective study compared risperidone and olanzapine use in seven VA systems during August 1996 (year 1) and August 1999 (year 3). From year 1 to year 3, total prescriptions rose from 8,913 to 19,980 for risperidone and from 3,824 to 20,682 for olanzapine. The average dose (risperidone: 3.62 and 3.33 mg/d; olanzapine 10.19 and 10.65 mg/d) and cost (risperidone: $3.82/day and $3.13/day; olanzapine $5.53/day and $5.61/day) were similar in year 1 and year 3. A random sample of 25% of patients (risperidone, n = 43, olanzapine, n = 48) was taken at the Dorn VA system, Columbia, S.C. In both years 1 and 3, the mean age of risperidone patients was significantly higher than that of olanzapine patients. Significant between-group differences emerged in diagnostic groups. For example, in both year 1 and year 3, the proportion of patients with psychosis treated with risperidone increased from 37% to 44% and those treated with olanzapine decreased from 68% to 46%. From year 1 to year 3, the average doses (all diagnoses) decreased from 3.01 mg/day to 2.06 mg/day for risperidone and increased from 8.36 to 9.29 mg/day for olanzapine. In patients with schizophrenia, concomitant use of a second neuroleptic was significantly greater with olanzapine (20%) than with risperidone (6%). The results indicate that risperidone and olanzapine use differed at this institution with respect to patient age, diagnosis, and concomitant medications.

REFERENCES:

1. Jibson MD, Tandon R: New atypical antipsychotic medications. J Psych Res 1998; 32:215–28.
2. Raleigh F: Use of novel antipsychotic drugs. Pharmacotherapy 1996; 16:160–165.

Poster 98 **Saturday, October 28**
3:30 p.m.-5:00 p.m.

TRENDS IN THE INDIVIDUAL PSYCHOANALYTICAL THERAPY OF BPD

Diego Cohen, M.D., *Department of Psychiatry, Hospital Y. T. Borda, Arenales 3504, Buenos Aires, Argentina 01425*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize the different technical approach, in accordance with theoretical viewpoints, regarding the etiology, and psychodynamics of borderline personality disorder; recognize the differences and indications between classical psychoanalysis, expressive psychotherapy, and supportive psychodynamic therapy in accordance with symptoms and course of the disorder.

SUMMARY:

Since borderline diagnosis became recognized in the late thirties (Stern, 1938) there have been great changes in the psychoanalytical treatment of BPD. These changes are the result of research and theoretical contributions by the object relation school, and in the fields of ego psychology, drive theory, self-psychology (the deficit model) and research into early mother-infant interaction,

i.e., separation-individuation processes by M. Mahler and from more accurate diagnosis instruments. The historical evolution begins with the non-analyzability and supportive approach posit by Zetzel and Zilboorg in the forties, culminating in the greater focus on psychodynamic therapy in the sixties and seventies. Despite differences in approach, most authors agree on these key issues: (1) establishment of a stable framework, (2) avoiding a passive therapeutic stance, (3) containing the patient's anger, (4) confronting self-destructive behavior, (5) making connections between feelings and actions, (6) monitoring countertransference feelings and maintaining the focus of the intervention on the here and now. The purpose of this presentation is to delineate the different technical approaches in the use of parameters such as transference interpretations, countertransference, the importance of interpretation and analytical setting in contemporary psychodynamic treatment of borderline personality disorder.

REFERENCES:

1. Waldinger RJ, Gunderson J: Effective Psychotherapy with Borderline Patients Case Studies. American Psychiatric Press, Washington DC, 1987.
2. Clarkin JF, Yeomans FE, Kernberg OF: Psychotherapy for Borderline Personality. John Wiley & Sons, New York, 1999.

Poster 99 **Saturday, October 28 3:30 p.m.-5:00 p.m.**

DEPRESSIVE MIXED STATES IN BIPOLAR II AND UNIPOLAR OUTPATIENTS

Franco Benazzi, M.D., *Senior Psychiatrist, Department of Psychiatry, National Health Services, Forli, Via Pozzetto 17, Cervia Ra, Italy*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand clinical features and treatment implications of depressive mixed states.

SUMMARY:

Objective: Depressive mixed state (DMS) (major depressive episode with some hypomanic symptoms) is understudied. The diagnosis of bipolar II disorder may be difficult, because the reliability of the history of hypomania may be low. The aim of the present study was to find the prevalence of DMS among bipolar II and unipolar depressed outpatients, and the sensitivity and the specificity of DMS for the diagnosis of bipolar II disorder.

Method: One hundred and ten consecutive DSM-IV bipolar II and unipolar depressed outpatients were interviewed by the author with the Structured Clinical Interview for DSM-IV. DMS was defined as an MDE with more than one (DMS2) or more than two (DMS3) concurrent hypomanic symptoms.

Results: DMS2 was present in 72.3% of bipolar II, and in 48.8% of unipolar patients (p 0.016). DMS3 was present in 46.1% of bipolar II, and in 8.8% of unipolar patients (p 0.000). DMS3 had the highest specificity for the diagnosis of bipolar II disorder (91.1%).

Conclusion: The high prevalence of DMS in bipolar II (and in unipolar) patients has important treatment implications, as antidepressants alone may worsen DMS, and mood stabilizers may be useful. DMS3 may be a marker of bipolar II disorder.

TARGET AUDIENCE:

Clinicians and researchers working on mood disorders.

REFERENCES:

1. Benazzi F: Major depressive episodes with hypomanic symptoms are common among depressed outpatients. Compr Psychiatry, in press.
2. Benazzi F: Prevalence of bipolar II disorder in outpatient depression: a 203-case study in private practice. J Affect Disord 1997; 43: 163–166.

Poster 100 **Saturday, October 28 3:30 p.m.-5:00 p.m.**

FACTOR ANALYSIS OF THE MONTGOMERY ASBERG DEPRESSION RATING SCALE IN BIPOLAR II AND UNIPOLAR OUTPATIENTS

Franco Benazzi, M.D., *Senior Psychiatrist, Department of Psychiatry, National Health Services, Forli, Via Pozzetto 17, Cervia Ra, Italy 48015*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand symptomatological differences between bipolar II and unipolar depression.

SUMMARY:

Objective: Bipolar II depression is understudied. Study aim was to compare symptomatological differences between bipolar II and unipolar depression by factor analysis of Montgomery Asberg Depression Rating Scale (MADRS).

Method: Five hundred and fifty seven consecutive major depressive and dysthymic (unipolar) and bipolar II disorder depressed outpatients were interviewed with

Structured Clinical Interview for DSM-IV and MADRS. Factor analysis (STATA 5) of MADRS in bipolar II and unipolar studied.

Results: Squared-multiple correlation coefficients factor analysis, with varimax rotation, found three factors in bipolar II depressed patients: factor 1, apparent sadness, reported sadness; factor 2, reduced sleep, reduced appetite; factor 3, concentration difficulties, lassitude, inability to feel, pessimistic thoughts, suicidal thoughts; and three factors in unipolar depressed patients: factor 1, apparent sadness, reported sadness, inability to feel, suicidal thoughts; factor 2, concentration difficulties, lassitude, inability to feel, pessimistic thoughts; factor 3, inner tension, reduced sleep.

Conclusion: Factor analysis of MADRS in bipolar II and unipolar found three different factors. Main difference was presence of a vegetative factor (sleep, appetite) in bipolar II depression. Result is in line with findings of more atypical features in bipolar II than in unipolar depression. Different factor structure suggests biology differences.

TARGET AUDIENCE:

Clinicians and researchers working on mood disorders.

REFERENCES:

1. Benazzi F: Prevalence and clinical features of atypical depression in depressed outpatients: a 467-case study. Psychiatry Res 1999; 86:259–265.
2. Benazzi F: Bipolar II depression in late life: prevalence and clinical features in 525 depressed outpatients. J Affect Disord, in press.

Poster 101 **Saturday, October 28 3:30 p.m.-5:00 p.m.**

AMYTAL INTERVIEW IS A TREATMENT FOR CONVERSION DISORDERS

Sadiq H. Al-Samarrai, M.D., *Department of Psychiatry, Cooper Hospital, 401 Haddon Avenue, E&R Building, #356, Camden, NJ 08103;* Thomas S. Newmark, M.D., *Cooper Hospital, 401 Haddon Avenue, E&R Building, #356, Camden, NJ 08103*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize when and how to utilize the technique of sodium amytal in the treatment of conversion disorder and hysterical amnesia.

SUMMARY:

Amytal interviews have a valid role in the assessment and initial management of catatonia, hysterical stupor, and unexplained muteness as well as in distinguishing between depressive, schizophrenic, and organic stuporous states. Valid therapeutic indications include the abreaction of traumatic neurosis, recovery of memory in amnesic and fugue states, and recovery of function in conversion disorders. Case studies confirm the serial amytal interview has utility in the clinical setting as a diagnostic and therapeutic tool. Assessment of the patient must be based on careful physical and psychiatric evaluation that will identify any underlying physical illness or concurrent psychopathology. The following cases responded dramatically to the amytal interview with rapid improvement in their symptoms. Patients need follow up after responding to amytal interview because the results are not absolutely conclusive. Amytal interview is a safe and simple technique that can make a difference in therapeutic management. The intended audience for this poster includes psychiatrists and other health care professionals including physicians from other disciplines, residents, medical students, nurses, therapists, and social workers.

REFERENCES:

1. Kent D, Timasson K, Coryell W: Course and outcome of conversion and somatization disorders: a four-year follow-up. Psychosomatics 1995; 36:138.
2. Martin RL: Diagnostic issues for conversion disorder. Hospital Community Psychiatry 1992; 43:771.

Poster 102 **Saturday, October 28 3:30 p.m.-5:00 p.m.**

COMBINED PHARMACOTHERAPY AND PSYCHOTHERAPY FOR PREVENTING ALCOHOL RELAPSE

Marcin Ziolkowski, M.D., *Director, Department of Psychiatric Nursing, University School of Medicine, Kurpinskiego 19, Bydgosqcq, Poland 85096;* Janusz K. Rybakowski, M.D., *Chair and Professor of Adult Psychiatry, University of Medical Sciences, Szpitalna 27/33, Poznan, Poland 60572*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to grasp the idea of combined pharmacotherapy and psychotherapy approach for relapse prevention in alcoholic patients and to identify relative value of each therapeutic element.

SUMMARY:

The study was performed on 200 male alcohol-dependent inpatients, randomly allocated to one of two methods of either pharmacotherapy or psychotherapy in 2 × 2 paradigm. Naltrexone (NAL), an opioid receptor antagonist, 50 mg/day, or tianeptine (TIA), a novel sero-

tonergic drug enhancing scrotonin reuptake and diminishing the activity of stress axis, 37.5 mg/day, were given for four months, one month on inpatient and three months on outpatient basis. Concomitantly, two psychotherapeutic methods were also applied: training to cope with alcohol craving (TC) and training to cope with emotions (TE). Psychotherapy sessions were held during the first month of treatment. During four months of observation, the effectiveness of NAL or TIA for prevention of alcohol relapse was found similar; alcohol relapse occurred in 36% subjects receiving NAL and in 32% subjects treated with TIA. Overall, better effects were observed in patients receiving TC than those trained with TE: among patients treated with TC, 26% had relapse and among those treated with TE, relapse occurred in 42% patients (p = 0.02). The advantage of TC over TE was evident in patients receiving either NAL or TIA. Compliance with treatment was a factor associated with better outcome irrespective of the kind of therapy.

REFERENCES:

1. O'Malley SS, Jaffe JA, Chang G, et al: Naltrexone and coping skills therapy for alcohol dependence: a controlled study. Arch Gen Psychiatry 1992; 49:881–887.
2. Malka R, Loo H, Ganry H, et al: Long-term administration of tianeptine in depressed patients after alcohol withdrawal. Br J Psychiatry 1992; 160:suppl 15, 66–71.

Poster 103 **Saturday, October 28 3:30 p.m.-5:00 p.m.**

ALCOHOL RELAPSE PREVENTION: PHARMACOECONOMICS OF NALTREXONE VERSUS TIANEPTINE

Marcin Ziolkowski, M.D., *Director, Department of Psychiatric Nursing, University School of Medicine, Kurpinskiego 19, Bydgosqcq, Poland 85096;* Janusz K. Rybakowski, M.D., *Chair and Professor of Adult Psychiatry, University of Medical Sciences, Szpitalna 27/33, Poznan, Poland 60572*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the main principles of pharmacoeconomic evaluation applied to pharmacotherapy of alcoholism and to understand the economic advantage of one drug over another.

SUMMARY:

The study was performed on 141 male alcohol-dependent inpatients, randomly allocated to one of two methods of pharmacotherapy in order to prevent drinking relapse: Naltrexone (NAL), an opioid receptor antagonist, 50 mg/day, (68 patients); or tianeptine (TIA) a novel serotonergic drug enhancing serotonin reuptake and diminishing the activity of stress axis, 37.5 mg/day, (73 patients), were given for four months, one month on inpatient and three months on outpatient basis. Alcohol relapse was observed in 20.5% of subjects from NAL group and in 17.8% subjects in TIA group. Direct medical costs per patient were 797 and 586 Polish zlotys (PLN), respectively (p = 0.001). Indirect costs were estimated to be 230 PLN and 217 PLN per patient, respectively. Total cost of treatment was 75.271 PLN and 62.457 PLN what means 1.107 PLN vs 856 PLN per patient, respectively (p = 0.0001). Eventually, the cost-effectiveness ratio in the NAL group was 1394 and in the TIA group 1042. It is concluded that the treatment regimen with TIA in comparison with NAL is equivalent as far as the prevention of relapse is concerned but significantly more economic in terms of direct medical and total costs as well as cost-effectiveness ratio.

REFERENCES:

1. Holder HD, Longabaugh R, Miller WR, Rubonis AV: The cost effectiveness of treatment for alcoholism: a first approximation. J Stud Alcohol 1991, 6, 517–540.
2. Finney WJ and Monahan CS: The cost-effectiveness of treatment for alcoholism: a second approximation. J Stud Alcohol 1996, 57, 229–243.

Poster 104 **WITHDRAWN**

Poster 105 **Saturday, October 28 3:30 p.m.-5:00 p.m.**

SOCIAL COGNITION AND OLANZAPINE

Kimberly H. Littrell, N.P., *Nurse Practitioner, Promedica Research, 3758 Lavista Road, Suite 100, Tucker, GA 30084;* Nicole M. Hilligoss, M.S., C.R.C., *Promedica Research, 3758 Lavista Road, Suite 100, Tucker, GA 30084;* Carol D. Peabody, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the effect olanzapine has on social cognition in patients with schizophrenia.

SUMMARY:

Objective: To determine interpersonal perception among patients with schizophrenia and to evaluate the effect of olanzapine on the interpretation of nonverbal

communication and social perception in patients with schizophrenia.

Method: Fifty-two (31 M, 21 W) patients meeting DSM-IV criteria for schizophrenia or schizoaffective disorder were evaluated for interpersonal perception. From this preliminary cohort, a subset of 22 (14 M, 8 W) were enrolled in a 12-month, open-trial of olanzapine. All patients were receiving conventional antipsychotic medications at entry, and the subset was cross-titrated to olanzapine. Patients' social cognition was evaluated at baseline and interim (12-weeks post-olanzapine treatment) using the Interpersonal Perception Task (IPT). The IPT contains 30 brief videotape scenes, each 30 to 60 seconds in length, with each scene paired to a question that has two or three possible answers. The viewer is asked to "decode" something important about the people he or she has just seen. Domains of kinship, intimacy, status, competition, and lying are assessed.

Results: Descriptive statistics were obtained on the preliminary cohort revealing areas of deficit. The subset data were analyzed using a T-test for non-independent samples and found statistically significant improvement ($p < .001$) on IPT scores between baseline and 12-weeks.

Conclusions: These preliminary data suggest that olanzapine has a positive effect on social cognition. However, continued study is needed to determine the effect of prolonged olanzapine treatment on social cognition. Additionally, larger, more controlled trials are needed to more fully understand the impact that atypical antipsychotics may have on improving this aspect of cognitive functioning.

TARGET AUDIENCE(S):

Psychiatrists, nurses, social workers, case managers.

REFERENCES:

1. Penn DL, Corrigan PW, Bentall RP, et al: Social cognition in schizophrenia. Psychological Bulletin 1997; 121 (1):114–132.
2. Ito M, Shiragata M, Kanno M, et al: Social cue perception in Japanese schizophrenic patients. Schizophrenia Research 1998; 34:113–119.

Poster 106 **Saturday, October 28 3:30 p.m.-5:00 p.m.**

OLANZAPINE TREATMENT FOR DUAL DIAGNOSIS PATIENTS

Kimberly H. Littrell, N.P., *Nurse Practitioner, Promedica Research, 3758 Lavista Road, Suite 100, Tucker, GA 30084;* Nicole M. Hilligoss, M.S., C.R.C., *Promedica Research, 3758 Lavista Road, Suite 100, Tucker, GA 30084;* Carol D. Peabody, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the efficacy of olanzapine in a dual diagnosis population.

SUMMARY:

Background: Research suggests that nearly half of all patients with schizophrenia concurrently abuse substances. However, despite the high prevalence rate, effective treatment for these comorbid conditions has eluded mental health professionals for decades. Clozapine has been reported to be effective in the treatment of patients dually diagnosed with schizophrenia and substance use disorders. Preliminary data from animal studies and case reports indicate that olanzapine may also be helpful in this difficult-to-treat population.

Objective: To evaluate the efficacy and safety of olanzapine in patients with schizophrenia and comorbid substance use disorders.

Method: Thirty patients with schizophrenia or schizoaffective disorder who met DSM-IV criteria for substance abuse or dependence (21 M, 9 F) were treated in a 12-month prospective, open-label olanzapine trial. All patients were receiving conventional antipsychotic medications at entry. Patients were evaluated with efficacy and safety measures at baseline and monthly thereafter including the PANSS, Schizophrenia/Substance Abuse Interview Schedule (SSAS), Herth Hope Index, AIMS, Barnes Akathisia Scale, Simpson Angus Scale, laboratory assays, vital signs, and weights.

Results: Improvements in all efficacy variables were observed. PANSS data were analyzed using ANOVA and t-test at baseline, six months, and 12 months. Statistically significant improvement ($p < .05$) in psychopathology from baseline to endpoints: PANSS Total (BL = 87, 32% mean decrease), PANSS Positive (BL = 29, 31% decrease), PANSS Negative (BL = 22, 41% mean decrease), and PANSS General (BL = 37, 33% mean decrease). T-test indicated statistically significant changes in PANSS scores occurred in the first six months of treatment. Patients' level of hope increased 54% from baseline to endpoint. Significant reductions in extrapyramidal symptoms were also noted. Twenty-one patients (14 M, 7 F) remained substance free during the study period. Nine patients (7 M, 2 F) used either alcohol or marijuana during the study period, but at significantly lower frequencies than prior to enrollment. Findings from the SSAS revealed that the effects of olanzapine on decreasing substance abuse fell into three main categories: (1) improvement in dysphoria and depression (88.9%), (2) improvement in negative symptoms (77.8%) and, (3) improvement in positive symptoms (55.5%).

Conclusion: Our results indicate that improvements in psychopathology and hopefulness associated with olanzapine treatment, along with reduced side effects,

may contribute to abstinence and sobriety among dually-diagnosed patients.

TARGET AUDIENCE(S):

Psychiatrics, nurses, social workers, case mangers.

REFERENCES:

1. Green AI, Zimmet SV, Strous RD, Schildkraut JJ: Clozapine for comorbid substance use disorder and schizophrenia: do patients with schizophrenia have a reward-deficiency syndrome that can be ameloriated with clozpine? Harvard Review of Psychiatry 1999; 6:287–296.
2. Meil WM, Schecter MD: Olanzapine attenuates the reinforcing effects of cocaine. Eu J Pharmacol 1997; (1):17–26.

Poster 107 **Saturday, October 28 3:30 p.m.-5:00 p.m.**

PATHOLOGICAL GAMBLING AMONG ADOLESCENT VIDEO POKER PLAYERS IN LOUISIANA

James R. Westphal, M.D., *Professor of Clinical Psychiatry, Louisiana State University Health Science Center, 1501 Kings Highway, Shreveport, LA 71130;* Lera J. Johnson, Ph.D., *Assistant Professor of Psychiatry, Centenary College, P.O. Box 41188, Shreveport, LA 71134-1188*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to list the symptoms of pathological gambling among adolescents who play video poker, and state the effects of illegal access to video gaming machines on adolescents.

SUMMARY:

Pathological gambling in adolescents has been associated with truancy, poor academic achievement, and functional disruptions.

Objectives: (1) to determine the extent of underage participation in video poker in Louisiana, and (2) to measure prevalence of pathological gambling among adolescents who play video poker.

Methods: A randomized stratified survey of students in public and private schools grades 6–12 (N = 11,736) was conducted in 57/64 Louisiana parishes in Spring 1997.

Results: Objective 1 Prevalence: Of 11,736 students (3% of total enrolled), 24.9% reported that they had played video poker at some time. Discarding data from 18-year olds, 22.46% of the total sample played video poker illegally.

Objective 2 Pathology: By DSM IV-J criteria, prevalence of video poker participation among pathological gamblers showed that 70% of pathological gamblers play video poker (255/363); 2.4% of the total sample played video poker and were pathological gamblers.

Discussion: Video poker is played illegally by more than one in five students in grades 6–12. A majority of adolescents with pathological gambling behavior play video poker. Video poker was found to be a significant predictor of pathological gambling behavior in this community sample. Findings especially useful for adolescent/child mental health and addiction/substance abuse practitioners.

REFERENCES:

1. Fisher S: Measuring pathological gambling in children: the case of fruit machines in the UK Journal of Gambling Studies 1992; 8(3):263–285.
2. Fisher S: Gambling and pathological gambling in adolescents. Journal of Gambling Studies 1993; 9(3):277–288.

Poster 108 **Saturday, October 28 3:30 p.m.-5:00 p.m.**

TEACHING PSYCHODYNAMIC PSYCHIATRY BY TELEMEDICINE

Supported by the American Academy of Psychoanalysis, Cincinnati Psychoanalytic Institute, and American Psychoanalytic Association

Debra A. Katz, M.D., *Assistant Professor of Psychiatry, University of Kentucky, 3470 Blazer Parkway, Lexington, KY 40509;* David A. Goldberg, M.D., *Department of Psychiatry, University of Connecticut, 10 Talcott Road, East Wing, MC-6410, Farmington, CT 06030;* Mary Grace, Ph.D.; Jacob D. Lindy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) understand the usefulness of telemedicine technology in teaching psychodynamic psychiatry; (2) demonstrate improvement in residents' clinical skills, knowledge, and interest in psychodynamic psychotherapy as a result of this course.

SUMMARY:

The ability to enhance residency training by utilizing expert teachers at distant sites is a developing area of telemedicine application. Low-cost telemedicine technology has been utilized to teach a two-year, weekly course in psychodynamic psychiatry following a structured curriculum. Psychoanalysts from Cincinnati and New York taught residents at the University of Kentucky

in a project designed to assess the acquisition of skills and interest in psychodynamic psychiatry. The technology uses standard telephone lines, provides interactive audio/video conferencing, is operated by a telephone keypad, and costs approximately $2500. Preliminary data from 16 residents (mean age 33 years, 63% male) at the end of the first year demonstrate (1) an increased perception of themselves as more psychologically oriented, (2) enhanced regard for psychotherapy in the practice of psychiatry, (3) improved abilities in psychodynamic psychotherapy and psychodynamic formulation, (4) increased importance assigned to the teaching of psychodynamic psychotherapy, (5) increased knowledge of psychoanalytic theory, and (6) a greater chance that they will practice psychotherapy themselves. Most residents had no prior videoconferencing experience and rated the technology as improved over their expectations. Formal assessments of knowledge and psychotherapeutic skill demonstrate improvement at the end of the course. In summary, effective telemedicine teaching may have strong implications for the ability of expert teachers at distant sites to influence developing psychiatrists at critical points during their training, to stimulate interest in psychodynamic psychotherapy and to reinvolve psychodynamically oriented psychiatrists in residency education.

REFERENCES:

1. Goldberg DA: Structuring training goals for psychodynamic psychotherapy. Journal of Psychotherapy Practice and Research 1998; 7:10–22.
2. Bear D, Jacobson G. Aaronson S, Hanson A: Telemedicine in psychiatry: making the dream reality. American Journal of Psychiatry 1997; 154:884–885.

Poster 109 **Saturday, October 28**
3:30 p.m.-5:00 p.m.

HYPNOSIS IN THE TREATMENT OF PANIC DISORDER WITH GENERALIZED ANXIETY: A CASE REPORT

Z. Benjamin Blanding, Psy.D., *Clinical Psychologist and Associate Professor of Psychiatry, Rowan University, 201 Mullica Hill Road, Glassboro, NJ 08028*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that clinical hypnosis may still be a vital efficacious adjunctive treatment intervention to psychodynamic psychotherapy.

SUMMARY:

A case study of a 45-year-old woman in treatment with simple phobias, frequent panic attacks, persistent generalized anxiety, and a chronic nicotine addiction. Hypnosis became the primary intervention in treatment of the panic disorder and the anxiety. The rationale for the treatment provided was the patient's refusal to work with other modalities, her inability to recall early experiences beyond the age of eleven, and her profound belief that her only chance for recovery would only come through some kind of emotional breakthrough. After 12 months in treatment, emotional abuse experiences and indications of early childhood sexual trauma surfaced. The panic attacks and anxiety subsided with the experiencing and resolution of repressed childhood events. The patient reported feeling better, improved job productivity, and a more gratifying quality of life. Ego-state therapy and other hypnotic interventions are discussed. Treatment was terminated with symptoms in remission. At one year follow-up, symptoms continued to be in remission, with the patient functioning at a level better than her premorbid condition.

REFERENCES:

1. Michelson L, Ascher LM: Panic disorder: a hyperventilation interpretation. Anxiety and Stress Disorders. New York, The Guilford Press, 1987.
2. Watkins, JG, Watkins HH: Ego-state therapy, in Innovative Therapies. Edited by Corsini R. New York, Wiley, 1981.

Poster 110 **Saturday, October 28**
3:30 p.m.-5:00 p.m.

CHILD FATALITIES RELATED TO MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

Joann H. Haggerty, M.S.W., *Institute for Public Health, University of North Carolina, 912 Kings Mill Road, Chapel Hill, NC 27514;* John J. Haggerty, Jr., M.D., *Associate Professor of Psychiatry, University of North Carolina School of Medicine, CB-7160, Chapel Hill, NC 27599;* Marcia Herman-Giddens, D.Phil.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize the use of childhood homicide records to measure public health consequences of undertreated mental illness; discuss characteristics of childhood fatalities secondary to mental illness

SUMMARY:

Community measures of mental health morbidity and mortality typically focus on the prevalence of mental illness (MI) and its impact on the afflicted individual. In this study, we demonstrate that secondary community impacts of MI can be measured by use of childhood

homicide data. The investigators reviewed NC Medical Examiners Office records of all childhood homicides aged 0–11 years reported from 1985–94. In 31/259 fatalities (11.9%) the adult perpetrators had evidence of psychiatric illness or substance use disorder according to medical examiners' report. In 17/259 (6.5%) cases, the perpetrator had evidence of mental illness. In 16 of these 17 cases (94.1%), the perpetrators' MI was reported to be known to the mental health system or to the family. Fourteen of 259 (5.4%) perpetrators had evidence of substance use disorder. Only half of these were known prior to the fatality. Death records provide a potentially useful way of tracking secondary consequences of untreated MI. Interagency review of relevant mortality data may serve as a means of identifying and repairing gaps in community services. Mental health workers need to be aware of potential risks to vulnerable children from adults with undertreated mental illness.

REFERENCES:

1. Herman-Giddens ME, Brown G, Verbiest S, et al: Underascertainment of child abuse mortality in the United States. JAMA 1999; 282(5):463–7.
2. DePanfilis D, Zuravin SJ: Predicting child maltreatment recurrences during treatment. Child Abuse & Neglect 1999; 23(8):729–43.

Poster 111 **Saturday, October 28**
3:30 p.m.-5:00 p.m.

SIDE EFFECTS ASSOCIATED WITH ATYPICAL NEUROLEPTIC USE IN CHILDREN AND ADOLESCENTS

Supported by AstraZeneca Pharmaceuticals

Stephen Grcevich, M.D., *Department of Psychiatry, Case Western Reserve School of Medicine, 8500 East Washington Street, Chagrin Falls, OH 44027;* Connie McBurney, R.N.C.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to: 1) explore differences in the side effect profile of atypical neuroleptics in children and adolescents, as compared to adults; 2) contrast the side effect profiles of available atypical neuroleptics in the pediatric population; and 3) review the impact that use of concomitant medication has on the magnitude of weight gain associated with atypical neuroleptic use in children and adolescents.

SUMMARY:

Objective: Atypical neuroleptics are currently used for a wide range of clinical indications in pediatric and adolescent psychiatry. Many published studies describing the effects of atypical neuroleptics in this population enrolled a limited number of patients for specific indications, including psychosis and aggression. This analysis compares weight gain and other side effects associated with use of risperidone, olanzapine, and quetiapine in children and adolescents in a larger clinical sample.

Methods: Medical records of 97 patients treated in an outpatient mental health clinic serving children and adolescents between January 1995 and June 1999 were reviewed. Patients were prescribed risperidone (n = 75), olanzapine (n = 16), or quetiapine (n = 25). Some patients were sequentially treated with more than one agent.

Results: Weight gain was the most common side effect observed. Patients receiving quetiapine were less likely to gain >10 lb during the first three months of treatment compared with those on olanzapine ($p < 0.05$, Kruskal-Wallace test). Extrapyramidal symptoms were observed in 14 patients receiving risperidone, one patient receiving olanzapine, and one patient receiving quetiapine.

Conclusions: Because weight gain and EPS may impair cognitive and emotional development of and pose long-term health risks to children or adolescents, atypical neuroleptics should be used cautiously in this population. This analysis suggests that quetiapine may provide clinical advantages in comparison with olanzapine and risperidone, but further clinical research is necessary.

Funding for this work was provided by a grant from AstraZeneca Pharmaceuticals.

REFERENCES:

1. Bilder RM: Neurocognitive impairment in schizophrenia and how it affects treatment options. Can J Psychiatry 1997; 42:255–264.
2. Fisman S, Steele M: Use of risperidone in pervasive developmental disorders: a case series. J Child Adolesc Psychopharmacol 1996; 6(3):177–190.

Poster 112 **Saturday, October 28**
3:30 p.m.-5:00 p.m.

AN INVESTIGATION OF THE EFFICACY OF MIRTAZAPINE IN CANCER PAIN PATIENTS

Supported by Organon Inc.

Dale E. Theobald, M.D., *Director of Clinical Services, Community Cancer Care, Inc., 115 West 19th Street, Indianapolis, IN 46202;* Steven D. Passik, Ph.D.; Kenneth L. Kirsh, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand the impact of two dose levels of Mirtazapine on self-report symptom distress, quality of life and mood in cancer patients.

SUMMARY:

Mirtazapine has potential to improve symptomatic management of pain for patients with cancer. This was a seven-week, open label, cross-over design (15 mgs/ 30 mgs) which provided an initial investigation of the analgesic and antiemetic effects of mirtazapine in a trial of 20 cancer patients on opioid therapy for cancer-related pain.

The average age of the patients was 60.15 years. The study group consisted of 13 men and seven women. Repeated measures ANOVAs were conducted to compare weeks 1, 4, and 7 to baseline. The Zung Self-Rating Depression Scale scores ($F = 8.20$, $p < .05$) and FACT-G (measuring quality of life) scores ($F = 5.73$, $p < .05$) were significantly improved at study end (week 7) and were not dependent on dosage. The patients' weight, independent of dosage, was significantly higher at both week 3 and 7. No significant differences were found for either the MPAC items on pain intensity, pain relief, or mood, or the VAS scales measuring nausea, anxiety, insomnia, and appetite. However, all mean responses indicated a trend in improvement of patient's symptoms.

These initial findings suggest that mirtazapine is effective for improving depression and quality of life in patients with cancer-related pain. Further research with a larger number of patients will be needed to clarify the most effective dose of mirtazapine with use in cancer patients with pain.

REFERENCES:

1. Conill C, Verger E, Salamero M: Performance status assessment of cancer patients. Cancer 1990; 65:1864–1866.
2. DeBoer T: The pharmacologic profile of mirtazapine. J Clin Psychiatry 1996; 57(supp 14):19–25.

Poster 113 **Saturday, October 28**
3:30 p.m.-5:00 p.m.

BEHAVIORAL DISTURBANCES IN THE ELDERLY: THE BEHAVIORAL INTENSIVE CARE UNIT MODEL

Dario F. Mirski, M.D., *Assistant Professor and Associate Director, Department of Psychiatry, Medical University of South Carolina, 67 President Street, Charleston, SC 29425;* Darshan B. Thakkar, M.D., *Department of Psychiatry, Medical University of South Carolina, 67 President Street, Charleston, SC 29425;* Jacobo E. Mintzer, M.D.; David Bachman, M.D.; Kathy Hoemik, B.A.; Paul Nietert

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand an innovative method of management of specific severe behavioral problems in elderly patients, understand the clinical outcomes of this method for different elderly patients' populations (e.g. demented vs. non-demented).

SUMMARY:

Objective: Geriatric Behavioral Intensive Care Unit (BICU) is a regional referral service at Medical University of South Carolina. BICU offers a multidisciplinary approach to treat psychiatric comorbidity in demented patients (Mintzer J et al, 1993). The objective of this study is to measure the efficacy of this model.

Methods: Retrospective study of medical records. The 29 Cohen-Mansfield Agitation Inventory items were recorded hourly by staff.

Results: Of 127 elderly patients admitted during this six-month period, 55 patients were admitted with an Axis 1 diagnosis of dementia. Female were 53% ($n = 29$) of the study group. Mean age was 78 (± 10), average MMSE was 15 (± 7) and average length of stay was 10 (± 5) days. Physically non-aggressive behaviors dropped from 60.0% on the first day to 43.6% on the last day (27% decrease, $p < 0.05$). Physically aggressive behaviors dropped from 16.4% on the first day to 12.7% on the last day (23% decrease). Verbally non-aggressive behaviors dropped from 32.7% on the first day to 16.4% on the last day (50% decrease, $p < 0.05$). A total of 38% of patients were discharged home, and remaining were discharged to referring facilities except that 2% were discharged to long-term care hospitals.

Conclusion: The BICU model, if replicated, can be of great impact in management of complex behaviors in the elderly demented patient and can have also a positive effect in the cost of elderly-long term care treatment.

TARGET AUDIENCE:

Mental health professionals interested in geriatric patients with behavioral problems.

REFERENCES:

1. Behavioral Intensive Care Unit (BICU): a new concept in the management of acute agitated behavior in elderly demented patients. Mintzer JE, Lewis L, Pennypaker L, Simpson W, Bachman D, Wohlreich G, Meeks A, Hunt S, Sampson R. Gerontologist 1993; 33(6):801–6.
2. Cohen-Mansfield J. Billig N: Agitated behaviors in the elderly. I. A conceptual review. J Am Geriatr Soc 1986; 34(10):711–21.

Poster 114 **Saturday, October 28 3:30 p.m.-5:00 p.m.**

SAFETY UPDATE WITH QUETIAPINE AND LENTICULAR OPACITIES: EXPERIENCE WITH 435,000 PATIENTS

Supported by AstraZeneca Pharmaceuticals

Henry A. Nasrallah, M.D., *Professor of Psychiatry and Neurology, University of Mississippi Medical Center, 1500 East Woodrow Wilson Drive, Jackson, MS 39216;* Vikram Dev; Joher Raniwalla; Ihor W. Rak, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to examine the prevalence of cataracts and lens opacities in patients with schizophrenia treated with quetiapine.

SUMMARY:

Objective: To assess the prevalence of lenticular opacities in psychotic patients treated with quetiapine.

Method: The package insert for quetiapine in Canada and the U.S. recommends periodic eye exams for cataract formation. All reports of lens opacities submitted between September 1997 (when quetiapine became available) and December 1999 were examined.

Results: As of December 31, 1999, after the exposure of approximately 435,000 patients in the U.S., 17 cases of lens opacities were reported. The mean age was 44 years; male:female ratio was 5:12. Most had risk factors for lens opacities such as heavy smoking, hypertension, diabetes, and ocular trauma. Five had cataracts at baseline. An independent ophthalmologist's evaluation concluded that the reported lens opacities are likely not related to quetiapine treatment.

Conclusion: The number of lens opacities reported in 435,000 patients in the U.S. who received quetiapine in the first 27 months (0.004%) were fewer than the general population rate of cataracts (0.2%) and the published rate in chronic schizophrenia (21.6%). These 17 reports revealed no evidence of direct linkage to quetiapine treatment. The lens changes reported were similar to those seen in individuals with the above risk factors. Prospective studies comparing ocular status in patients receiving quetiapine versus other antipsychotics are needed to confirm these findings.

Funded by a grant from AstraZeneca.

REFERENCES:

1. McCarty CA, Wood CA, Fu CL, et al: Schizophrenia, psychotropic medication, and cataract. Opthalmology 1999; 106:683–687.
2. Smith D, Pantelis C, McGrath J, et al: Ocular abnormalities in chronic schizophrenia: clinical implications. Aust NZJ Psychiatry 1997; 31:252–256.

Poster 115 **Saturday, October 28 3:30 p.m.-5:00 p.m.**

MEDICAL EMERGENCIES IN PSYCHIATRIC HOSPITAL PATIENTS

Patricia H. Bazemore, M.D., *Associate Professor of Psychiatry, University of Massachusetts Medical School, 305 Belmont Street, Worcester, MA 01604*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to name the three major categories of medical emergencies in psychiatric hospital patients and know the preferred treatment and medical follow-up of these conditions.

SUMMARY:

The purpose of this presentation is to classify the initial diagnoses of life-threatening medical emergencies in a public psychiatric hospital and to show the effectiveness of the BLS-Plus program in their management. BLS-Plus is a program requiring universal BLS training, frequent mock codes, and specialized emergency equipment including an automatic defibrillator, oxygen, pulse oximeter, IV fluids, and parenteral, oral, and inhaled medications.

A total of 175 life-threatening emergencies, occurring between 1989 and 1999 were studied retrospectively. All emergencies were handled effectively using the BLS-Plus protocol. The major presenting diagnoses were seizures (43%), syncope (24%), and trauma associated with suicide attempts (9%); 58% of patients who had codes required transport to a general hospital for further treatment and evaluation. The codes were spread uniformly throughout the hours of 6 a.m. through midnight, with many fewer occurring between midnight and 6 a.m. Specialty clinics in neuropsychiatry, cardiology, and psychopharmacology were used to provide follow-up after codes.

Life-threatening medical emergencies are extremely common in psychiatric hospitals and require training, equipment, coordination with EMS, and follow-up for comprehensive treatment and prevention. Monitoring and evaluation of all medical emergencies is an important step in improving emergency medical services.

REFERENCES:

1. Barren MR, Hill KR, Merikle E, et al: Serious mental illness and mortality rates. Hospital and Community Psychiatry 1994; 45:604–605.
2. Bazemore PH: Medical problems of the seriously and persistently mentally ill. In Handbook for the Treatment of the Seriously Mentally Ill. Edited by Stephen M. Soreff. Seattle, Hogrefe and Huber Publishers, 1996.

Poster 116 **Saturday, October 28**
3:30 p.m.-5:00 p.m.

LESSONS FROM THE PSYCHIATRIC EMERGENCY SERVICE: YOUTH'S UNMET MENTAL HEALTH NEEDS

Supported by the Albert Einstein Society

Gail A. Edelsohn, M.D., *Director, Division of Child and Adolescent Psychiatry, Thomas Jefferson University School of Medicine, 1201 Chestnut Street, Room 1501, Philadelphia, PA 19107-4123;* Harris Rabinovich, M.D., *Director of Child and Adolescent Research Education, Thomas Jefferson University School of Medicine, 1201 Chestnut Street, Suite 1512, Philadelphia, PA 19107;* Angelo Meléndez, M.S.W.; Patricia Sheves, M.S.N.; Michael J. Vergare, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the broader definitions of child and adolescent psychiatric emergencies, appreciate the epidemiology of crisis response center, learn about applying such data to service needs, and understand the benefits of utilizing a classification system of psychiatric emergencies in order to develop alternatives to hospitalization and partial programs.

SUMMARY:

The Crisis Response Center (CRC) of the Albert Einstein Medical Center is unique in that it is the only designated center by the country of Philadelphia to provide psychiatric emergency service to children and adolescents. All youth seen between July 1 and October 31, 1997 were included in the sample. Cases were categorized with respect to psychiatric emergency from Class I (potentially life threatening) to Class IV (pseudoemergencies). Forty percent of youth were in the nonurgent category. The nonurgent categories include presentation for the following reasons: frustration of mental health consumers (parent, school, community agency) with an inefficient, overburdened outpatient clinic; too long a wait to see the clinic psychiatrist; running out of medications; or interagency struggle. Youth with attention deficit hyperactivity disorder were fairly evenly distributed between the urgent and nonurgent classes.

By studying demographics, distribution of diagnoses, and disposition patterns in the CRC, we planned and designed a new outpatient mental health service. We developed a set of inclusion and exclusion criteria for CARAT that is undergoing evaluation. CARAT was designed to stabilize youth in their community environment, provide rapid symptom control, return them to premorbid functioning, and provide an alternative to hospitalization or partial hospital programs.

REFERENCES:

1. Hillard JR: The past and future of psychiatric emergency services in the U.S. Hospital and Community Psychiatry 1994; 45:541–543.
2. Sadka S: Psychiatric emergencies in children and adolescents. New Directions for Mental Health Services 1995; 67:65–74.

Poster 117 **Saturday, October 28**
3:30 p.m.-5:00 p.m.

THE EMOTIONAL EFFECTS OF INFERTILITY: A PROPOSAL FOR *DSM-V*

Lisa Sine, Ph.D., *Professor of Marriage and Family Therapy, Virginia Technical Institute, 802 South Arlington Mill Drive, Suite 201, Arlington, VA 22204;* Brennan D. Peterson, B.S., *Doctoral Candidate, Virginia Technical Institute, c/o American Psychiatric Association, 1400 K Street, N.W., Washington; DC 20005*

EDUCATIONAL OBJECTIVES:

This poster will inform participants of the prevalence, severity, and emotional effects of infertility in both men and women. At the conclusion of the presentation, it is hoped participants will recognize the need to explore the inclusion of a new diagnostic V-code for this problem in the upcoming *DSM-V.*

SUMMARY:

Infertility, or the inability to conceive or carry a pregnancy to live birth after a year or more of regular sexual relations, affects one in six couples of childbearing age (17%). An estimated 5.3 million couples are diagnosed with infertility, representing an increase of 10% over the last 30 years. Approximately 75% of couples will seek some type of infertility treatment. Studies have shown that infertility is correlated with depression, anxiety, sexual dysfunction, decreased self-esteem, guilt, and social isolation in both men and women. The severity of these conditions often leads infertile couples to seek mental health counseling. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) does not currently include infertility as a diagnostic category. This, coupled with the lack of clinical interventions and strategies in the literature, texts, and training programs, makes it difficult for infertile couples to find providers who can effectively treat their emotional difficulties. It is proposed that the negative emotional symptoms resulting from a medical diagnosis of infertility are severe enough to warrant the inclusion of a new diagnostic category in the upcoming DSM-V. Similarities between infertility and bereavement, a condition currently included in DSM-IV, will be presented. Gender issues, social norms,

and cultural traditions will also be discussed when examining male and female emotional responses to infertility.

REFERENCES:

1. Daniluk JC: Gender and infertility, in Infertility: Psychological Issues and Counseling Strategies. Edited by Leiblum SR. New York, John Wiley & Sons, 1997, pp. 103–129.
2. Greil AL: Infertility and psychological distress: a critical review of the literature. Social Science and Medicine 1997; 45:1679–1704.

Poster 118 **Saturday, October 28 3:30 p.m.-5:00 p.m.**

CALIFORNIA PSYCHOTHERAPY ALLIANCE SCALES (CALPAS-P) PV: TRANSLATION AND REALIBILITY OF THE PORTUGUESE VERSION

José A. Marcolino, M.D., *Senior Lecturer, Santa Casa Medical School of Sao Paulo, Brazil, Rua Monte Alegre 428, CJ-53, Sao Paulo, Brazil 05014-000;* Eduardo Iacoponi, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will gain knowledge about the Portuguese version of CALPAS-P and some of its psychometric characteristics, and have it may contribute to a more careful measuring of therapeutic alliance and its inclusion in future psychotherapy research.

SUMMARY:

The alliance corresponds to a key concept of the psychotherapy process. This study produced a Portuguese translation and reliability coefficients of the patient version of the California Psychotherapy Alliance Scales (CALPAS-P). Translation procedures followed the back-translation technique, by means of bilingual individuals. For the reliability study, a sample of mental health professionals currently attending individual psychotherapy sessions were invited to answer the Portuguese version of CALPAS-P. Eighty-three questionnaires were returned. Results showed mean scale scores to be, respectively, 5.66 for PC, 5.20 for PWC, 6.10 for TUI and 5.99 for WSC. The scales showed high correlation between them, with values ranging from .57 to .74. Reliability coefficients (Cronbach's alpha) for the CALPAS-P were also high: .90 for all items; .71 for PC, .56 for PWC, .71 for TUI and .84 for WSC. These coefficients were compared favorably to those of the original studies using the English version. The present investigation, by making available the Portuguese version of CALPAS-P and some of its psychometric characteristics, may contribute to a more careful measuring of therapeutic alliance and its inclusion in future psychotherapy research.

REFERENCES:

1. Marmar CR, Weiss DS, Gaston L: Toward validation of the California Therapeutic Alliance laying system. Psychological Assessment 1989; 1:46–52.
2. Marziali E, Alexander L: The power of the therapeutic relationship. American J Orthopychiat 1991; 61(3).

Poster 119 **Saturday, October 28 3:30 p.m.-5:00 p.m.**

THE ANALYSIS OF NEWSPAPER ARTICLES ON PSYCHOSIS IN KOREA

Sung-Wan Kim, M.D., *Psychiatry Resident, Chonnam University Hospital, 8 Hackdong Tongku, Kwang-Ju, Korea 501-757,* Jin-Sang Yoon, M.D., *Professor, Department of Psychiatry, Chonnam University Hospital, 8 Hackdong Tongku, Kwang-Ju, Korea 501-757;* Moo-Suk Lee, M.D.; Hyung-Yung Lee M.D.

EDUCATIONAL OBJECTIVES:

To realize that newspaper monitoring is important for appropriate information on psychosis. It might reduce social stigma and consequently help rehabilitation of psychotic patients.

SUMMARY:

The stigma against schizophrenia is enhanced by the mass media. This study investigated newspaper articles on psychosis, which strongly influence the public recognition of the illness. The newspaper articles of 'The Dong-a libo' and 'The Chosun libo', most popular daily newspapers in Korea, from March 1988 to February 2000 were reviewed through a news-searching program in Chollian. The search words, which were regarded as psychotic illness, were 'Schizophrenia', 'Psychosis', 'Mental illness', and 'Mental derangement'. A total of 326 articles were classified by category and analyzed quantitatively and qualitatively.

Of the 326 articles, the number with a negative description was 228 (69.9%), the number with a neutral or positive description was 43 (13.2%), and the number without specific viewpoint was 55 (16.9%). The most frequent negative theme was 'psychotic patients are dangerous or violent or may commit a crime' (n = 118). Other negative themes were these: 'psychotic patients are bizarre or grotesque (n = 27), 'psychotic patients can't function in society well' (n = 18). 'psychosis is incurable and families should bear great burden (n = 18), psychosis is shameful (n = 13), and 'psychotic patient should be institutionalized (n = 6). There were also

'prejudices against the cause of the illness (n = 18), 'the description of psychosis in degrading terms' (n = 22) and the negative description on psychiatric hospitalization (n = 18) to 'institutionalization', 'imprisonment' and 'put into' etc. In the articles using the terms 'mental derangement' or 'psychosis' compared with 'mental illness', 'schizophrenia', the frequency of negative articles was high. Within each type of article, news, politics, and culture articles more frequently had a negative description, but health articles less frequently had a negative description and most frequently had a neutral or positive description.

REFERENCES:

1. Kommana S, Mansfield M, Penn DI: Dispelling the stigma of schizophrenia. Psychiatric services 1997; 46:1393–1395.
2. Williams M, Taylor J: Mental illness: media perpetuation of stigma. Contemp Nurse 1995; 4:41–6.

Poster 120 **Saturday, October 28 3:30 p.m.-5:00 p.m.**

PANIC ATTACKS CAN ALERT PSYCHIATRISTS TO SUSPECT LYME ENCEPHALOPATHY

Virginia T. Sherr, M.D., *Private Practice in General Psychiatry, 47 Crescent Drive, Holland, PA 18966-2105*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should (a) have a higher index of suspicion for cryptic tick-borne diseases, (b) have increased awareness of panic attacks as indicators of previously unsuspected Lyme disease, (c) understand the usefulness of laboratory and SPECT scan tests in fully evaluating psychiatric symptoms, and (d) view persistent, chronic Lyme disease as a neuropsychiatric illness.

SUMMARY:

In a Pennsylvania psychiatric office within a mid-winter, 1999, 10-week span, three nurses presented with severe panic attacks. Previously ''nerveless'' they suddenly and separately experienced episodes of racing pulse, breathlessness, overwhelming anxiety, impending doom, sweating, unique pains, headaches, chills, and confusion. Family doctors eliminated other etiologies, reassuring them they had typical panic disorders. Subsequent evaluation by the psychiatrist included testing for tick-borne diseases (TBD). Results, utilizing sensitive tests via several reference laboratories, included no positive Lyme serologies but positive polymerase chain reactions of blood (two cases) or urine (one case) for DNA of Lyme spirochetes and positive SPECT brain scans indicating encephalopathies compatible with Lyme disease in all three cases. Currently, all three women are free of panic attacks while taking high oral doses of antimicrobial medications for their infections—primarily Lyme borreliosis. Anxiolytics became unnecessary in one case and were greatly reduced in the others. Two patients require pain medications for other symptoms of persistent Lyme disease. Since the RNs' diagnoses, others in the same geographic area also have been diagnosed as having Lyme encephalitis/vasculitis via SPECT scans including one seronegative man who experienced horrific rage/panics/headaches but who is recovering via antimicrobial treatment for previously unsuspected TBD.

REFERENCES:

1. Fallon BA: Psychiatric aspects of Lyme disease. Psychiatric Clinics of North America 1999; 154:1625–29.
2. Logigian EL, et al: Reversible cerebral hypoperfusion in Lyme encephalopathy. Neurology 1997; 49:1661–1670.

Poster 121 **Saturday, October 28 3:30 p.m.-5:00 p.m.**

THE IMPACT OF TERMINATING DISABILITY BENEFITS TO SUBSTANCE ABUSERS

Katherine E. Watkins, M.D., *Research Psychiatrist, RAND Corporation, 1700 Main Street, Santa Monica, CA 90407;* Deborah Podus, Ph.D.; Emilia Lombardi, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the impact of terminating disability benefits to substance abusers and their access to care.

SUMMARY

Introduction: In 1996 Congress terminated Supplemental Security Income (SSI) benefits to individuals disabled by substance abuse. Although most were expected to continue benefits under another disability category, 64% were not reclassified. Prior work suggests that many had independent psychiatric problems and that many who reported mental health problems lost benefits. We examine the impact of the legislation on mental health and access to care in Los Angeles County.

Methods: 253 randomly selected subjects were interviewed every six months for two years. We classified respondents into those continued on SSI (42%), those who depended on other forms of public income assist-

ance (27%), and those who relied on nonpublic sources of income (31%). We describe mental health status and utilization at baseline and two years later, by income source.

Results: Perceived emotional health status, current symptoms, and disability improved over the course of the study among all three groups. Rates of psychiatric hospitalization did not change, although the proportion reporting any mental health care decreased.

Discussion: Despite widespread concerns that the legislation would result in worsening mental health problems, our data suggest that mental health improved during the two years following the termination of disability benefits. We discuss policy implications.

REFERENCES:

1. McKay JR, McLellan AT, Durrel J, et al.: Characteristics of recipients of Supplemental Security Income (SSI) benefits for drug addicts and alcoholics. Journal of Nervous & Mental Disease 1998; 186:290–298.
2. Watkins KE, Wells KB, McLellan AT: Termination of social security benefits among Los Angeles recipients disabled by substance abuse. Psychiatric Services 1999; 50:914–925.

Poster 122 **Saturday, October 28**
3:30 p.m.-5:00 p.m.

RISPERIDONE VERSUS PLACEBO AS COMBINATION THERAPY TO MOOD STABILIZERS IN THE TREATMENT OF THE MANIC PHASE OF BIPOLAR DISORDER: FOCUS ON EFFICACY

Supported by Janssen Pharmaceutica and Research Foundation

Gary S. Sachs, M.D., *Director, Department of Psychiatry, Harvard Medical School, Massachusetts General Hospital, 50 Staniford Street, Fifth Floor, Boston, MA 02114;* Charles L. Bowden, M.D.; James C.Y. Chou, M.D.; David G. Daniel, M.D.; Frederick Petty, M.D.; C. Risch, M.D.; Dan L. Zimbroff, M.D.; D. Brown, M.D.; Charles B. Nemeroff, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to assess the effectiveness of risperidone in acute bipolar mania.

SUMMARY:

Background: Early open-label studies suggest the atypical antipsychotic agent risperidone is safe and effective as add-on therapy for acute mania in bipolar disorder.

Methods: A randomized, controlled, double-blind, multicenter, Phase III trial compared add-on risperidone (1–6 mg/day), haloperidol (2–12 mg/day), or placebo with open-label lithium or valproate for the management of acute mania. The initial double-blind treatment phase lasted for three weeks; in a subsequent extension phase, patients received open label risperidone (0–6 mg/day) along with a mood stabilizer (lithium and/or valproate and/or carbamazepine) for 10 weeks. A total of 158 patients were randomized into the three groups. Adverse events were noted; primary efficacy was change from baseline on YMRS at endpoint.

Results: Preliminary analysis indicates statistically significant change in favor of risperidone ($p = 0.009$) on YMRS at endpoint (three weeks) versus placebo; statistically significant change in favor of risperidone on CGI ($p = 0.002$) versus placebo. The overall incidence of adverse events was similar in the placebo and risperidone groups; patients receiving haloperidol had greater EPS than placebo or risperidone.

Conclusions: The preliminary results of this study indicate that risperidone (1–6 mg/day) is safe and effective as combination therapy to lithium or valproate for the treatment of acute bipolar mania.

Sponsored by an unrestricted educational grant from Janssen Pharmaceutica.

REFERENCES:

1. Ghaemi SN, Sachs GS, Baldassano CF, et al: Management of bipolar disorder with adjunctive risperidone: response to open treatment, in New Research Program of and Abstracts of the 148th Annual Meeting of the American Psychiatric Association. May 22, 1995; Miami, FL, Abstract N82:77.
2. Goodnick PJ: Risperidone treatment of refractory acute mania. J Clin Psychiatry 1995; 56:330.

Poster 123 **Saturday, October 28**
3:30 p.m.-5:00 p.m.

A DOUBLE-BLIND, PLACEBO-CONTROLLED STUDY OF MIRTAZAPINE AUGMENTATION FOR REFRACTORY MAJOR DEPRESSION: PRELIMINARY FINDINGS

Supported by Organon Inc.

Linda L. Carpenter, M.D., *Assistant Professor of Psychiatry, Brown University, 345 Blackstone Boulevard, Providence, RI 02906;* Sarah Yasmin, M.D.; Lawrence H. Price, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the utility of mirtazapine,

a novel antidepressant drug, in the role of augmentation for major depression that has not responded to standard pharmacotherapy.

SUMMARY:

Introduction: Pharmacotherapeutic strategies that target specific actions at multiple neuronal receptors or cellular components may offer a superior approach for treatment of refractory depression. Mirtazapine, a novel antidepressant whose mechanism involves the enhancement of noradrenergic and serotonergic neurotransmission via blockade of alpha-2-adrenergic auto- and heteroreceptors, without activity at the serotonin transporter, is a compelling candidate for antidepressant augmentation.

Methods: Adult outpatients with persistent major depressive disorder despite at least four weeks of standard antidepressant pharmacotherapy were randomized to four weeks augmentation with mirtazapine (15 to 30 mg po qhs) or placebo in a double-blind fashion. All patients continued their primary antidepressant regimen at stable dosage. Baseline and weekly clinician- and patient-rated assessments were obtained, along with weight, vitals, and plasma drug levels.

Results: To date, 25 individuals have completed the trial. Preliminary data analysis using CGI global improvement criteria or 50% reduction in HRSD-17 scores for categorical response indicate 6/10 (60%) responders to active mirtazapine and 3/15 (20%) responders to placebo, with a trend toward significant drug effect ($p = .087$). Other outcome measures (e.g., scores on self-report instruments for depression, anxiety, and quality of life) demonstrate significant clinical benefit for mirtazapine augmentation. Side effects did not differ across treatment groups in the preliminary analysis.

Conclusions: Preliminary results of this placebo-controlled, double-blind trial of mirtazapine augmentation of standard antidepressant therapy are in keeping with findings from our open-label trial, suggesting the drug has utility in the treatment of refractory depression.

REFERENCES:

1. Stahl S: Are two antidepressant mechanisms better than one? J Clin Psychiatry 1997; 58:339–340.
2. Carpenter LL, Jocic Z, Hall JM, et al: Mirtazapine augmentation in the treatment of refractory depression. J Clin Psychiatry 1999; 60:45–49.

Poster 124 **Saturday, October 28**
3:30 p.m.-5:00 p.m.

REMISSION OF ANXIETY DURING LONG-TERM TREATMENT OF VENLAFAXINE XR IN PATIENTS WITH GAD

Supported by Wyeth-Ayerst Laboratories

Eliseo Salinas, M.D., *Vice President of CNS Global Research, Wyeth-Ayerst Laboratories, 145 King of Prussia Road, Radnor, PA 19087;* Paolo Meoni; David Hackett, M.S., B.Sc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the significance of long-term treatment to achieve remission in GAD and the long-term efficacy of venlafaxine XR in the treatment of GAD.

SUMMARY:

Objective: To determine the characteristics of the long-term efficacy of venlafaxine XR in the treatment of generalized anxiety disorder (GAD).

Methods: Data from two comparable, placebo-controlled, six-month trials of venlafaxine XR in 767 patients were pooled. The effect of various venlafaxine XR doses (37.5 to 225 mg) on response and remission was compared with placebo using last observation carried forward (LOCF) analysis.

Results: Venlafaxine XR treatment was associated with significantly higher rates of response (≥50% improvement on baseline HAM-A score) and remission (absolute HAM-A total score 7) compared with placebo starting from the first and second weeks of treatment, respectively. A significantly higher proportion of venlafaxine XR-treated patients achieved remission after six months of treatment ($P < 0.001$) than after eight weeks. After long-term treatment with venlafaxine XR, equal percentages of moderately anxious (HAM-A score of 18 to 25 at baseline) and severely anxious (HAM-A score >25 at baseline) patients achieved remission. In contrast, placebo-treated, severely anxious patients showed a lower rate of remission than moderately anxious patients in the same treatment group.

Conclusions: Venlafaxine XR is effective in long-term as well as short-term treatment of GAD. Longer-term treatment is characterized by an increased rate of remission.

TARGET AUDIENCE:

Psychiatrists and primary care physicians.

REFERENCES:

1. Rickels K, Pollack M, Sheehan D, Haskins JT: Efficacy of extended-release venlafaxine in nondepressed outpatients with generalized anxiety disorder. Am J Psychiatry 2000; 157:968–974.
2. Mahe V, Balogh A: Long-term pharmacological treatment of generalized anxiety disorder. Int Clin Psychopharmacology 2000; 15:99–105.

Award Workshop 1 **Thursday, October 26**
8:30 a.m.-11:30 a.m.

AUTISM: SOLVING THE PUZZLE—ASSESSMENT INTERVENTION

Certificate of Significant Achievement

Jean Ruttenberg, M.A.S., *Director, Center for Autistic Children, 3965 Conshohocken Avenue, Philadelphia, PA 19131*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to gain an understanding of autism and assessment techniques used at the Center for Autistic Children.

SUMMARY:

Autism has long been considered one of the most perplexing disorders for families and clinicians. Recent research is contributing enormously to our understanding of why Autism is so difficult a disorder to understand. Practitioners are just beginning to appreciate the challenge of translating the research findings into program goals and objectives.

In this overview I will summarize what is known about Autism in children and adults. The Profile Assessment Model used at the Center for Autistic Children will be focused upon as a practical method for consolidating information. Lastly, utilizing the Profile Assessment, an explanation of the design of appropriate therapeutic supports and intervention will cover the function of visual supports, environmental considerations and crisis management.

REFERENCES:

1. Greenspan SI: The Child with Special Needs. A Merloyd Lawrence Book Addison-Wesley, 1998.
2. Koegel RI, Koegel LK: Teaching Children with Autism. Paul H. Brookes Publishing Co., 1995.

Award Workshop 2 **Thursday, October 26**
8:30 a.m.-11:30 a.m.

COMMUNITY LINKAGES FOR CONSUMERS ENTANGLED IN THE CRIMINAL JUSTICE SYSTEM

Certificate of Significant Achievement

Rocío E. Nell, M.D., C.P.E., *Chief Executive Officer and Medical Director, Montgomery County Emergency Services, 501 Beech Drive, Norristown, PA 19403;* Donald F. Kline, M.S., *Director of Criminal Justice, Montgomery County Emergency Services, 501 Beech Drive, Norristown, PA 19403*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) develop strategies for collaboration between criminal justice and mental health agencies; 2) obtain strategies for developing community-based supports/linkages; and 3) gain knowledge accent need for a Forensic Task Force.

SUMMARY:

The seminar will focus on the need for agency collaboration and community linkages for persons suffering from a mental illness or have a co-occurring disorder who have become entangled in the criminal justice system. The seminar will describe the Montgomery County Emergency Service (MCES) criminal justice and jail diversion programs (Forensic ICM—Diversion Team), agency collaboration, community-based treatment and follow-up. Developing alternatives to incarceration, support systems and aftercare planning for persons discharged from jail or have been diverted from the criminal justice system will also be discussed. This information was presented at the GAINS Center year 2000 national conference in Miami, Florida on April 26, 2000. The seminar was well received and had approximately 60 participants.

Topics include: 1) pre-booking verses post-booking diversion; 2) development of specific alternatives to jail; 3) strategies for developing a diversion program; 4) law enforcement training; 5) mobile crisis support; 6) forensic intensive case management services; 7) inception of a forensic social worker within the Montgomery County Correctional Facility (County Jail); and 8) how the Forensic Task Force impacts on the various systems.

REFERENCES:

1. Torrey EF, Sticher J, Ezekiel J, Wolfe S, Sharfstein, J, Noble J, and Flynn L: Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals. Washington, DC., Public Citizen's Research Group and National Alliance for the Mentally ill, 1992.
2. Draine J, Solomon P: Describing and evaluating jail diversion services for persons with serious mental illness. Psychiatric Services. 1999; 50(2), 56–61.

Award Workshop 3 **Thursday, October 26**
8:30 a.m.-11:30 a.m.

EASTERN STATE HOSPITAL PSYCHOSOCIAL REHABILITATION PROGRAM

Certificate of Significant Achievement

Gabriel Koz, M.D., *Medical Director, Eastern State Hospital, 306 Indian Springs Road, Williamsburg, VA 23185-3943;* Karen M. Marsh-Williams, O.T., *Rehabili-*

tation Director, Eastern State Hospital, 306 Indian Springs Road, Williamsburg, VA 23185-3943

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the value that the unique application of psychosocial rehabilitation principles and techniques has on the treatment of seriously mentally ill adults in a long-term setting, and recognize that individualized treatment planning can be accomplished with treatment team support committed to the model within a biopsychosocial framework and a unique scheduling and tracking system.

SUMMARY:

Eastern State Hospital, the nation's first psychiatric hospital (1773), is a 500-bed facility, on a 550-acre campus, that treats acute and long-term seriously and persistently mentally ill adults and geriatric citizens from the Eastern region of Virginia. Our service area encompasses 16 counties with 9 community service boards covering 5,000 square miles with a population of approximately 1.6 million. The Psychosocial Rehabilitation Program (PSR) at Eastern State Hospital has been the first in the state to incorporate psychosocial rehabilitation principles within a large institution. The goal is to increase the functioning of persons with psychiatric disabilities, so they can be successful and satisfied in their present and future environments with the least amount of professional intervention. The result has been a paradigm shift from custodial to active, patient-specific treatment. Each patient's uniquely structured, diverse treatment plan, based on a very large menu of offerings, renders this program so rare and acknowledged. To ensure that the individual treatment plan is carried out, requires a comprehensive well-planned tracking system utilizing computers to bring staff and patients together at the right time in the right place. This program demonstrates what can be achieved within a state hospital with an evermore difficult and complex group of psychiatric patients who are often medically compromised in addition.

REFERENCES:

1. Bopp JB, Ribble DJ, Cassidy JJ, Markoff RA: Reengineering the state hospital to promote rehabilitation and recovery. Psychiatric Services 1996; 47:697–701.
2. Smith, RC: Implementing psychosocial rehabilitation with long term patients in a public psychiatric hospital. Psychiatric Services 1998; 49:593–595.

Award Workshop 4 **Thursday, October 26**
8:30 a.m.-11:30 a.m.

EMERSON-DAVIS FAMILY DEVELOPMENT CENTER

Gold Award

Harvey Lieberman, Ph.D., *Executive Vice President. Institute for Community Living, Inc., 40 Rector Street, 8th Floor, New York, NY 1000;* Jeffrey Palmer, M.S.W., *Institute for Community Living, Inc., 40 Rector Street, 8th Floor, New York, NY 10006;* Linda Nagel, Ph.D., *Director of the Learning Center, Emerson-Davis Family Development Center, 8620 18th Avenue, Brooklyn, NY 11214*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be familiar with a community-based approach to family reunification for single parents who are separated from their children due to mental illness and homelessness and will understand the administrative and clinical program design issues involved in creating such a program.

SUMMARY:

This presentation describes how single-parent families separated by parental mental illness, homelessness, and substance abuse are reunited by the Emerson-Davis Family Development Center, a demonstration project of the Institute for Community Living, Inc in New York City. Emerson was created to provide an example for policy makers, community leaders, and mental health professionals working toward the recovery of people with serious mental illness of an approach that can contribute to the well-being both families served and yield beneficial effects for society. To accomplish this, ICL developed a growing continuum of housing and related support services currently consisting of a congregate residence with 38, one and two bedroom apartments and 24-hour/7-day support, and 8 scatter-site family apartments with case management services for families who no longer need the congregate setting. Experience with this project suggests that a well-designed residential program accompanied by a comprehensive array of family clinical, case management, educational, and preventive services are can provide a nurturing environment for the whole family. The project's methods are promising in both human and fiscal terms.

REFERENCES:

1. Lieberman HJ, Campanelli PC, Ades Y, Cruz T, Nagel L, Palmer: Reunifying single-parent families with special needs. Psychiatric Rehabilitation Journal 1999; 23(1)42–46.

2. Buckner J, Bassuk E, Zima B: Mental health issues affecting homeless women: Implications for intervention. American Journal of Orthopsychiatry 1993; 63(3), 385–399.

Award Workshop 5 **Thursday, October 26**
8:30 a.m.-11:30 a.m.

MHA VILLAGE

Gold Award

Martha N. Long, B.A., *Director, Village Integrated Service Agency, 456 Elm Avenue, Long Beach, CA 90802;* David A. Pilon, Ph.D., *Village Integrated Service Agency, 456 Elm Avenue, Long Beach, CA 90802*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand key concepts and critical elements of Village model and conceptualize capitated/ case rate models for comprehensive services.

SUMMARY:

A model of comprehensive services that has been functioning since 1990 within a public sector managed mental health care program will be outlined. The Village model offers consumer-driven services that are highly individualized and cover psychiatric, medication, employment, social, money management and dual diagnosis services. The design features of an integrated service model implemented in a state-funded initiatives will be discussed, along with principles of growth vs. maintenance, medication policies in support of goals vs. symptom reduction only.

This presentation will be of interest to those who are concerned with the impact of design on practice.

Ten years of financial and functional outcomes will be presented, including conclusions of an independent evaluator.

REFERENCES:

1. Hargreaves WA: A capitation model for providing mental health services in California. Hospital and community Psychiatry 1992; 43:275–277.
2. Chandler DW, Levin SJ, Barry P: The menu approach to employment. Psychiatric Rehabilitation Journal. 23(1).

Symposium 1 **Wednesday, October 25**
8:30 a.m.-11:30 a.m.

CURRENT TRENDS IN PUBLIC-SECTOR MANAGED CARE

American Association of Community Psychiatrists

Michael A. Hoge, Ph.D., *Associate Professor of Psychology, Yale University, 25 Park Street, 6th Floor, New Haven, CT 06519;* Kenneth Minkoff, M.D., *Medical Director, Arbour Choate Health Management, 12 Jefferson Drive, Acton, MA 01720*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the key dimensions, national trends, innovative models, and outcomes regarding public-sector managed behavioral health care.

SUMMARY:

Managed care has emerged as a major force in the public-sector, reshaping the financing and delivery of mental health and substance abuse services. All but four states now have implemented some form of managed behavioral health care. This symposium is designed to provide a broad overview of current trends and key issues in this area. The first of five presentations is designed to provide participants with a model for assessing and better understanding public-sector managed care initiatives. The second will focus on an innovative model of sector managed care in which the City of Philadelphia has assumed financial risk and management control for publicly funded behavioral health services. The third presentation involves a review of national trends in public-sector managed care and the available evidence regarding the outcomes of these initiatives. The fourth presentation, delivered by a representative of NAMI, will review family and consumer perspectives on public-sector managed care. The fifth presentation will review the experiences in Pennsylvania's Allegheny County with a provider-driven alternative to for-profit managed care for Medicaid-funded behavioral health services. Following these presentations, the discussant for the symposium will make some summary comments and then facilitate general discussion involving the panel and the audience.

No. 1A
TEN DIMENSIONS OF PUBLIC-SECTOR MANAGED CARE

Michael A. Hoge, Ph.D., *Associate Professor of Psychology, Yale University, 25 Park Street, 6th Floor, New Haven, CT 06519*

SUMMARY:

Managed care in public-sector mental health remains a poorly defined concept. It is currently understood largely through case examples, an approach of limited usefulness since each managed care initiative is shaped by local forces and is constantly changing. From a review of current public-sector managed care initiatives, 10 key dimensions on which such initiatives vary have been identified. In this segment of the symposium an assessment model focusing on these dimensions is proposed as a useful approach to establishing the essential characteristics and core differences of efforts to implement public-sector managed care. Each of the 10 dimensions will be reviewed and the common ways in which initiatives vary on these dimensions will be discussed. By way of conclusion, it will be suggested that the application of this assessment approach to a broad range of managed care projects yields the finding that most have focused on one principal dimension to the exclusion of other critical dimensions.

No. 1B
THE PHILADELPHIA MODEL OF PUBLIC-SECTOR MANAGED CARE

Estelle Richman, M.A., *Commissioner, Philadelphia Department of Public Health, 1101 Market Street, Suite 840, Philadelphia, PA 19107*

SUMMARY:

The City of Philadelphia is well known for its innovative model of managing mental health and substance abuse care for individuals who receive publicly funded health services. Estelle Richman, the commissioner of the Philadelphia Department of Public Health, will discuss three key elements of the model. The first element is the pooling of multiple funding streams, which fosters a more coordinated and efficient approach to managing care. The second element is the unique organizational structure, involving a city-controlled, private, nonprofit organization established to manage behavioral health care. The third element is the opportunity for reinvestment in services that this approach to managing care facilitates. Commissioner Richman will describe recent developments regarding Community Behavioral Health, the nonprofit organization that now manages behavioral health services for 370,000 covered lives in Philadelphia.

No. 1C
MEDICAID MANAGED CARE: FALSE PROMISES?

Trevor R. Hadley, Ph.D., *Professor of Psychiatry, University of Pennsylvania, 3600 Market Street, Philadelphia, PA 19104*

SUMMARY:

Privatization of health care and the diminishing role of government in administrating publicly funded mental health care programs are issues of great concern for consumers, providers, and policy makers alike in this era of health care reform. Most states today are contracting out health care services to non-governmental, private-sector entities such as HMOs in order to contain the costs of health care and reduce fiscal risk. The rapid and decentralized diffusion of managed care into public-sector systems has created great variance in the form that managed care plans take and the philosophies and structures under which they operate.

Managed care represents both opportunity and risk as it begins to reshape systems that serve our most vulnerable populations. How persons with severe mental illness (SMI) will fare under managed care is of particular policy concern. Due to the recurrent nature of their illnesses and the high service use, persons with SMI may not fare well under managed care programs.

This presentation will outline the major trends in managed care for the seriously mentally ill and review the current evaluation and research findings about its impact on care, quality, and satisfaction.

No. 1D
MANAGED CARE: PERSPECTIVES ON LESSONS LEARNED

E. Clarke Ross, D.P.A., *200 Glebe Road, Suite 1015, Arlington, VA 22203*

SUMMARY:

NAMI chapters and NAMI national have been actively involved in state and county effort to use managed care approaches to the organization and financing of public mental health services. Dr. Ross will provide perspectives on lessons learned; specifically:

(1) linkage between Medicaid and public mental health has failed
(2) appropriate payment and adequate services have not happened
(3) meaningful and authentic consumer, family, and enrollees participation has been rare
(4) publicly documented performance is rare.

No. 1E
MEDICAID MANAGED CARE: A NONPROFIT PROVIDER-SPONSORED ALTERNATIVE

Diane P. Holder, M.S., *President and CEO, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

Community Behavioral Health Organization is a not-for-profit, risk-bearing PPO that was created for the purpose of managing behavioral health risk contracts. The company was founded by Western Psychiatric Institute and Clinic of the UPMC Health System and St. Francis Health System and subsequently joined by a network of community-based providers to pursue Medicaid full-risk contract.

This presentation focuses on the rationale for establishing a risk-bearing organization, implementation requirements, as well as opportunities and consequences related to such a decision. Critical issues related to infrastructure, capitalization, performance targets, provider-payor conflicts, and public policy implications will be discussed.

REFERENCES:

1. Hoge MA, Jacobs S, Thakur NM, Griffith EEH: Ten dimensions of public-sector managed care. Psychiatric Services 1999; 50:51–55.
2. Minkoff K, Pollack D (eds): Managed Mental Health Care in the Public Sector. Amsterdam, Harwood Academic Publishers, 1997.
3. Hoge MA, Davidson L, Griffith EEH, et al.: Defining managed care in public-sector psychiatry. Hospital and Community Psychiatry 1994; 45:1085–1089.
4. Stroup TS, Dorwart R: Overview of public-sector managed mental health care, in Managed Mental Health Care in the Public Sector. Edited by Minkoff K, Pollack D. Amsterdam, Harwood Academic Publishers, 1997.
5. Hadley TR: Financing changes and their impact on the organization of the public mental health system: Administration and Policy in Mental Health 1996; (5).
6. Goldman W, McCulloch J, Sturm R: Costs and use of mental health services before and after managed care. Health Affairs 1998; 17(2): 40–52.

Symposium 2 **Wednesday, October 25**
8:30 a.m.-11:30 a.m.

DEVELOPING A CONTINUUM OF CRISIS SERVICES IN COMMUNITY MENTAL HEALTH

Peter L. Forster, M.D., *Associate Clinical Professor of Psychiatry, University of California, San Francisco, 211 Gough Street, Suite 211, San Francisco, CA 94102*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: demonstrate an understanding of the key components of an effective crisis service system

and discuss the benefits of developing flexible and responsive regional crisis systems.

SUMMARY:

Over the last 30 years, social changes such as deinstitutionalization and managed care have contributed to a substantial reduction in inpatient days and lengths-of-stay. Within the same time frame, there has been a large increase in the number of inpatient episodes and crisis visits. From 1970–1994, the inpatient bed rate per 100,000 civilian population declined by more than half, from 264 to 112. In 1955, there were 1.7 million episodes of psychiatric care of which 77%, or 1.3 million, were inpatient. In 1994, there were 10 million, but 26%, or 2.6 million, were inpatient. Furthermore, during this time, more forms of crisis service have developed, including mobile crisis, comprehensive emergency programs, etc. This presentation will describe key components of an effective crisis service system for mental health and will provide data to support the claim that the development of such a system results in improved outcomes, reduced inpatient costs, and greater client satisfaction.

We will discuss how each of these components fit into a regional crisis system and what the benefits of such a system are.

We will discuss the current role and future directions for the PES within the context of the interlinked network of community and hospital systems.

We will present data on the effectiveness of Emergency Department case management from the San Francisco public mental health system.

We will describe the Crisis Resolution Team (CRT), a brief intensive crisis case management program in the San Francisco public mental health system.

We will present data on the Mobile Crisis Program in San Francisco.

The target audience is clinicians, case managers, administrators, and researchers in the field of emergency psychiatry, community mental health, primary care, emergency medicine.

No. 2A
THE FUTURE OF PSYCHIATRIC EMERGENCY SERVICES: BUILDING LEVEL I SERVICES

Michael H. Allen, M.D., *Assistant Professor of Psychiatry, University of Colorado, Denver Health Medical Center, 777 Bannock Street, Denver, CO 80204*

SUMMARY:

Psychiatric emergency or crisis services have become an increasingly important element in the mental health system. Many approaches to delivering these services have been described but no unifying constructs have emerged. Most PESs around the country still operate in a consultation model. Others deliver comprehensive assessment, crisis stabilization, and initial definitive treatment. This presentation reviews the range of psychiatric emergency settings including their structure and functions, the evidence of their benefits to the system, and the controversies surrounding their utilization. Various existing systems including integrated delivery systems will be described. Categorization by capability will be presented as a means of improving the quality and consistency of assessment and treatment. Key ingredients of services at various levels will be enumerated with a view to fostering the development of flexible and responsive regional systems that meet the needs of both urban and rural environments.

No. 2B
THE ROLE OF THE MOBILE CRISIS TEAM IN SERVICE LINKAGE

Carolyn A. Kaufman, M.A., *Program Director, Mobile Crisis, 1380 Howard Street, San Francisco, CA 94103;* Karyn Dresser, Ph.D.

SUMMARY:

The city and county of San Francisco through Community Mental Health Services provide field crisis services through a Mobile Crisis Treatment Team. The team consists of multidisciplinary, multicultural, and multilingual staff who reflect the ethnic and cultural diversity of San Francisco. Whenever possible, all field assessments are conducted in the client's primary language with an emphasis on relevant cultural and spiritual factors that impact the current crisis on the client and the support system. Nearly 10% of the clients served are gay, lesbian, bisexual, or transgender. Half of the clients assessed are challenged with schizophrenia or other psychotic disorders and most have a substance abuse disorder. Half of the interventions result in an involuntary psychiatric admission. An analysis of paired samples revealed a decrease in the use of psychiatric emergency services and inpatient episodes following a Mobile Crisis intervention. The ability to medicate clients in the field and to bolster existing plans of care directly impacts hospitalization rates and the use of psychiatric emergency services.

No. 2C
CRISIS RESOLUTION CASE MANAGEMENT IN PSYCHIATRIC EMERGENCY SERVICES

Grad C. Green, C.N.S., *C.N.S. Team Leader, San Francisco General Hospital, 1001 Potrero Avenue, Room 1B-20, San Francisco, CA 94210*

SUMMARY:

The Crisis Resolution Team (CRT) is a short-term (30 to 60 day) case management service based at the Psychiatric Emergency Service of San Francisco General Hospital (SFGH). The team was developed in 1990 to address an increase in PES patient contacts resulting from the restructuring of a community crisis service. The purpose of the team is to decrease the patients' acute crisis contacts with PES and assist them in maintaining connections with service providers and support systems in the community. Referrals to the Crisis Resolution Team service are from both PES and the inpatient units at SFGH. The patients are given one option to voluntarily participate in the CRT program. This is an important aspect for patients who are usually introduced to these acute services involuntarily. They are then given the opportunity to decide on how their continuation of treatment will be tailored. The usual response is "you mean I get to tell you what I want?" The case management service incorporates principles of harm reduction and initiates definitive treatment while transitioning the client's care to community-based service providers. This presentation will describe this process.

No. 2D
A PILOT STUDY OF CLINICAL CASE MANAGEMENT WITH MEDICAL EMERGENCY DEPARTMENT HIGH USERS

Robert L. Okin, M.D., *Professor of Clinical Psychiatry, University of California, San Francisco General Hospital, 1001 Potrero Avenue, 7M-16, San Francisco, CA 94110;* Alicia Boccellari, Ph.D.; Francisca Azooar, Ph.D.; Martha Shumway, Ph.D.; Kathy O'Brien, L.C.S.W.; Alan Gelb, M.D.; Michael Kohn, M.D.; Phyllis Harding, R.N., M.S.; Christine Wachsmuth, R.N., M.S.

SUMMARY:

This study examined the impact of case management on hospital service utilization, hospital costs, homelessness, substance abuse, and psychosocial problems in frequent users of a public urban emergency department (ED). Subjects were 53 patients who used the ED five times or more in 12 months. Utilization, cost, and psychosocial variables were compared 12 months before and after the intervention. The median number of ED visits decreased from 15 to 9 ($p < .01$), median ED costs decreased from $4,124 to $2,195 ($p < .01$), and median medical inpatient costs decreased from $8,330 to $2,786 ($p < .01$). Homelessness decreased by −57% ($p < .01$), alcohol use by −22% ($p = .05$), and drug use by −26% ($p = .05$). Linkage to primary care increased 74% ($p < .01$). Fifty-four percent of medically indigent subjects obtained Medicaid ($p < .01$). There was a net cost savings, with each dollar invested in the program yielding a $1.44 reduction in hospital costs. Thus, case management appears to be a cost-effective means of decreasing acute hospital service use and psychosocial problems among frequent ED users.

REFERENCES:

1. Witkin MJ, Atay JE, Mandersheid RW, et al.: Highlights of Organized Mental Health Services in 1994 and Major National and State Trends. Center for Mental Health Services, 1998.
2. Allen MH: 'Level I' psychiatric emergency services: the tools of the crisis sector. Psychiatric Clinics of North America 1999 (in press).
3. Kates N, Eaman S, Santone J, et al: An integrated regional emergency psychiatry service. General Hospital Psychiatry 1996; 18:251.
4. Oldham JM, De Masi ME: An integrated approach to emergency psychiatric care. Growth and Specialization of Emergency Psychiatry 1995;67:124.
5. Zealberg JJ, Santos A: Comprehensive Emergency Mental Health Care. New York, W.W. Norton & Company, Inc, 1996.
6. Merson S, et al: Early intervention in psychiatric emergencies: a controlled clinical trial. Lancet 1992; 339:1311–4.
7. Baker D, Stevens C, Brook R: Regular source of ambulatory care utilization by patients presenting to a public hospital emergency department. JAMA 1994;271:1909–1912.
8. Kne T, Young R, Spillane L: Frequent ED users: patterns of use over time. AMJ Emerg Med 1998;16:648–652.

Symposium 3 **Wednesday, October 25**
2:00 p.m.-5:00 p.m.

FILLING IN THE GAPS: CONSUMER-RUN SERVICES AND THEIR PLACE IN THE CONTINUUM OF CARE

Michael J. Vergare, M.D., *Consultant, APA Institute Scientific Program Committee, Professor and Chair, Department of Psychiatry and Human Behavior, Jefferson Medical School, and Professor and Chair, Department of Psychiatry, Albert Einstein Medical Center, 841 Chestnut Street, Suite 1001, Philadelphia, PA 19107;* Joseph A. Rogers, *Executive Director, Mental Health Association of Southeastern Pennsylvania, 1211 Chestnut Street, Suite 1100, Philadelphia, PA 19107*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the principles and values

of the consumer-run services model and its important place in the continuum of care, and should also have a grasp of specific kinds of consumer-run services.

SUMMARY:

Even the most comprehensive system of traditional mental health services cannot meet all the needs of people with serious mental illness living in the community. Ironically, although no one should live in an institution, such places did provide patients with food, shelter, and contact with their peers. On the outside, however, people may find themselves isolated, unable to access professional services when they may feel the most need (such as holidays and weekends), and unable to advocate for themselves to get the services and supports they want.

Such gaps can be well filled by consumer-run services. The services that operate under the auspices of the Mental Health Association of Southeastern Pennsylvania include drop-in centers, vocational services, intensive case management, advocacy, residential services, and outreach and other services to people who are homeless and have mental illness. The philosophy behind such services, which minimize distinctions between staff and clients, is that some of the best helpers are those who have "been there." Consumer-run services are also characterized by freedom of choice.

This presentation will be of interest to a broad audience (professionals, consumers, family members), who will gain a better understanding of the philosophy, methods, and importance of consumer-run services.

No. 3A
COMMUNITY COMPANION

Jo Halberstadter, *Director, Division of Adult Advocacy and Support Programs, Mental Health Association of Southeastern Pennsylvania, 1211 Chestnut Street, Suite 1100, Philadelphia, PA 19107*

SUMMARY:

Jo Halberstadter, who was previously an external patient advocate employed by the Mental Health Association at Haverford State Hospital before it closed, will discuss Community Companion, a program that helps people with serious and persistent mental illness reintegrate into the community by linking them with volunteer friends. Community Companion, which the presenter supervises, is based on the Compeer model developed in Rochester, N.Y., but it is distinguished by the fact that the majority of its matches involve people with mental illness both as volunteers and clients. The double-consumer matches have the advantage of a level of empathy that can't be taught.

Compeer volunteers are carefully screened and trained to give support, not medical advice or psychological counsel. Their job is to simply be a friend.

The program is based on the principle that mitigating the loneliness and isolation that accompany mental illness will decrease the effects and frequency of symptoms. Data from the International Affiliation of Compeer Programs showed that during 1996 in New York state, where 40 percent of all those discharged from the hospital return within one year, only eight percent of those in the Compeer program were rehospitalized. Internationally, 40 percent of Compeer clients showed a decline in hospitalizations.

No. 3B
THE MENTAL HEALTH ASSOCIATION'S INTENSIVE CASE MANAGEMENT PROGRAM

Warren Rodgers, *Director, Targeted Case Management/ SHARE, Mental Health Association of Southeastern Pennsylvania, 1211 Chestnut Street, Suite 1100, Philadelphia, PA 19107*

SUMMARY:

Warner Rodgers will present on the Mental Health Association's Intensive Case Management program, which employs consumers as intensive case managers. The program was initially developed as a federally funded research demonstration project. The presenter will discuss the strategies employed to become financially self-sufficient after the grant ended.

The project was designed to assess the efficacy of consumer-delivered compared with non-consumer-delivered case management services. The MHASP team provided services in an assertive community treatment model, seeing clients in vivo, rarely in the office. Case management activities included housing, rehabilitation, and social activities for the clients. Case managers performed brokering and support functions as opposed to clinical management and treatment.

After two years, the two teams—consumer and non-consumer—were found to be equally effective. In addition, the consumer-delivered services were found unique in that they focused more personally on the clients' lives.

Winning financial independence involved key changes. For example, when the director's post was vacant in the grant's final year, the presenter was hired with the charge to achieve independence by acquiring Medicaid reimbursement. The project is now funded through Medicaid, with some funding from county resources.

The presenter will outline the tasks necessary to achieve independence, the barriers that needed to be overcome, and the future plans for expansion.

No. 3C
ACCESS: WEST PHILLY

Chris Simiriglia, *Director, Residential and Treatment Services, Mental Health Association of Southeastern Pennsylvania, 1211 Chestnut Street, Suite 1100, Philadelphia, PA 19107*

SUMMARY:

Christine Simiriglia will present on ACCESS-West Philly, a "one-stop shopping" center for people who are chronically homeless and have co-occurring disorders. ACCESS, funded by the federal Substance Abuse and Mental Health Services Administration, provides outreach, engagement, targeted case management, supportive housing, and other services to help homeless people with mental illness and, typically, substance abuse issues improve their lives.

Under one roof, ACCESS offers a general physician, psychiatrist, nurse, D&A specialist, and psychologist; a place to shower, get mail, get a meal, make a phone call; and Office of Vocational Rehabilitation Services—all in a "no-demand" environment.

Key to the project's success is that many of the staff themselves have psychiatric histories and/or are in recovery from substance abuse and/or are formerly homeless. Another factor is that, while traditional services are only reimbursed for registered clients, ACCESS is funded for a long engagement process, so that staff have time to win people's trust. In addition, while traditional services close cases if clients say they don't want services anymore, ACCESS doesn't. Its record speaks for itself: ACCESS has seen people who have been on the streets 10 to 15 years get into treatment, stabilize in housing, reconnect with family members, get their children back, and reclaim their lives.

No. 3D
THE FRIENDS CONNECTION

Jeannie Whitecraft, *Program Manager, Friends Connection, 520 North Delaware Avenue, Suite 200, Philadelphia, PA 19122*

SUMMARY:

Jeanie Whitecraft will discuss the Friends Connection, a program "without walls." To counteract the loneliness and alienation that drive many people who have mental illness to street drugs and alcohol, Friends Connection provides friendship, peer counseling, and meaningful leisure activities. The staff, all in recovery from substance abuse themselves, work one-to-one with clients. Staff and clients attend 12-step meetings together and also participate in informal activities. They teach principles of recovery in action—avoiding temptation and finding clean and sober activities.

The presenter will also describe a pilot study comparing Friends Connection clients with non-clients who had been in community care for at least a year. The research was designed to see if something could be added to intensive case management—already shown to improve the recipient's quality of life—that would lead to even better outcomes. The findings indicated that adding peer support to intensive case management dramatically decreased clients' hospitalizations and crisis events. In addition, the clients who had received peer support assessed their own lives as improved.

Friends Connection, collaborating with the University of Pennsylvania, is also involved in a federally funded national research project to assess the outcomes of consumer-operated services and see if such services, in tandem with traditional services, provide a significantly increased quality of life and reduce hospitalizations.

REFERENCES:

1. Borkman TJ: Understanding Self-Help/Mutual Aid: Experiential Learning in the Commons. Piscataway, NJ, Rutgers University Press, 1999.
2. Estroff SE: Making It Crazy: An Ethnography of Psychiatric Clients in an American Community. Berkeley, CA, Los Angeles, London, University of California Press, 1981.
3. Katz AH, Hedrick HL, Isenberg DH, Thompson LM, et al (eds): Self-Help: Concepts and Applications. Philadelphia, The Charles Press, 1992.
4. Mowbray CT, Moxley DP, Jasper CA, Howell LL: Consumers as Providers in Psychiatric Rehabilitation. Columbia, MD, International Association of Psychosocial Rehabilitation Services, 1997.

Symposium 4 **Wednesday, October 25**
2:00 p.m.-5:00 p.m.

MICROBES AND MENTAL ILLNESS

Robert C. Bransfield, M.D., *Private Psychiatry Practice, 225 Highway #35, Red Bank, NJ 07701*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to assist mental health clinicians toward incorporating infectious disease concepts in their theoretical approach and in their assessment and treatment of their patients. These insights can help explain the cause of many mental disorders and also expand our effectiveness to treat challenging patients.

SUMMARY:

Appreciating the link between infectious disease and mental illness is significant to the future of psychiatry. This symposium is targeted towards mental health professionals. It will integrate current theories, recent re-

search, and clinical observations. Microbes shape our evolution and impact our genetic content. Although infectious diseases may cause mental symptoms at any age, the effects are greater in critical prenatal and early neurodevelopmental stages.

Pathology may be from parasite genetic sequences incorporated into the human genome, hit and run infections with later consequences, and from chronic-relapsing or low-grade infections. Some trauma is a direct effect of microbes upon the brain, immune systems, and soma; while some trauma is a result of the body's response to infection that lacks adaptive specificity. These effects cause a cascade of events resulting in neuronal dysfunction from altered gene expression and changes in neurochemistry and neural architecture. A number of different infections, noninfectious agents and effects from chronic stress, in combination with susceptibility and resistance factors, result in the manifestation of different mental and somatic syndromes. The link between endogenous retroviruses and schizophrenia, lyme disease, viral infections, PANDAS, neuroimmunology, and the impact of infectious disease upon gene expression in the CNS will be presented to demonstrate these points.

No. 4A
THE IMPACT OF INFECTIOUS DISEASE UPON MENTAL FUNCTIONING

Robert C. Bransfield, M.D., *Private Psychiatry Practice, 225 Highway #35, Red Bank, NJ 07701*

SUMMARY:

The impact of infectious disease upon mental functioning is increasingly apparent when we integrate evolutionary concepts with psychiatry. Disease can be from an interaction of a vulnerability and a life situation. Although the link is sometimes cryptic, there is increasing evidence that microbes contribute to many of the common mental and physical diseases. Viral, vector-borne, and venereal infections may evade host defenses and are of particular concern.

Trauma to the body may be from the direct effects of microbes, such as toxins and the incorporation of parasite genetic sequences into the host genome or from host responses, such as autoimmune reactions, neuroimmune mechanisms, inflammation, gliosis, and the effects of cytokines. This injury results in neural dysfunction causing the spectrum of pathology associated with cognitive, psychiatric, and neurological syndromes.

Understanding these concepts changes the assessment of our patients and expands our treatment options now and in the future.

No. 4B
NEUROPSYCHIATRIC FEATURES OF LYME DISEASE

Brian A. Fallon, M.D., *Associate Professor of Psychiatry, Columbia University, 1051 Riverside Drive, #69, New York, NY 10032*

SUMMARY:

Lyme disease, a neuropsychiatric illness caused by the spirochete Borrelia Burgdorferi, may first be detected by the psychiatrist. This presentation will review the neurologic and psychiatric manifestations; provide diagnostic guides with a critical appraisal of laboratory assays, neuropsychological testing, and structural and functional neuroimaging; and discuss recent pathophysiological findings. Neuropsychiatric manifestations most commonly include cognitive disturbances (short-term retrieval, verbal fluency, attention, processing speed) and disturbances of anxiety and mood (panic attacks, irritability, mood swings). Less commonly, patients may develop new-onset obsessive-compulsive disorder, tics, autistic-like behaviors, mania, hallucinations, or paranoid delusions. Specific diagnostic and treatment controversies will be addressed from the perspective of how they impact upon the patient, the treating internist, the treating psychiatrist, the medical community, and the patient's access to care. The possible influence of other tick-borne organisms on the course of Lyme disease will be discussed as well, such as babesiosis and ehrlichiosis. This presentation would be most useful to mental health professionals who work in Lyme-endemic areas. No background is needed.

No. 4C
ENDOGENOUS RETROVIRUSES: A WAY OUT OF THE NATURE-NURTURE DILEMMA

Robert H. Yolken, M.D., *Department of Pediatrics, Johns Hopkins University, 600 North Wolf Street, Baltimore, MD 21210*

SUMMARY:

Family studies have indicated that schizophrenia and other neuropsychiatric diseases have strong genetic components. However, genes of major effect have not as yet been discovered for these diseases. In addition, epidemiological studies indicate that environmental factors such as perinatal infection and anoxia may contribute to the etiology of some cases of schizophrenia. The relative contributions of genetic and environmental risk factors for schizophrenia have been the subject of debate. Endogenous retroviruses are inherited components of the human genome that display high degrees of homology to

infectious retroviruses. These genetic elements probably arose from retrotransposition into the human germ line following active retrovirus infection. We have found evidence of the transcription of the endogenous retrovirus Herv-W in the cerebrospinal fluids of approximately 30% of individuals with recent-onset schizophrenia. This rate is significantly higher than that found in corresponding control groups ($p < .005$). We have also found evidence of increased transcription of Herv-W in the frontal cortex regions of post-mortem brains obtained from individuals with schizophrenia as compared with control individuals. These studies indicate that the activation of endogenous retroviruses may play a role in the etiopathogenesis of schizophrenia in some individuals and may contribute to both the genetic and environmental components of the disease process.

REFERENCES:

1. Nesse M, Williams GC: Evolution and the origins of disease. Scientific American 1998; 11.
2. Fallon BA, Nields JA: Lyme disease: a neuropsychiatric illness. American Journal of Psychiatry 1994; 141:1571–1583.
3. Fallon BA, Das S, Plutchok J, Tager F, et al: Functional imaging and neuropsychological testing in lyme disease. Clinical Infectious Diseases. 1997; 25:S57–63.
4. Yolken RH, Karlsson H, Yee F, Wilson NL et al: Retroviruses and Schizophrenia, Presented at Nobel Foundation Symposium on Schizophrenia Stockholm, Sweden, October 2, 1998.
5. Colantuoni C, Purcell AE, Bouton CML, Pevsner J: High throughout analysis of gene expression in the human brain. J Neurosci Res, in press, 2000.

No. 4D
ANALYSIS OF GENE EXPRESSION IN HUMAN BRAIN DISEASES USING HIGH-DENSITY MICROARRAYS

Jonathan Pevsner, Ph.D., *Department of Neurology, Kennedy Krieger Hospital, 707 North Broadway, Baltimore, MD 21205*

SUMMARY:

For many neurological disorders such as autism and schizophrenia, the primary genetic defects are not known. Additionally, secondary changes in gene expression may occur in these diseases as the brain compensates for the disruption of some pathway perturbed by the primary gene defect(s). We have studied gene expression in post-mortem brains of patients with two pervasive developmental disorders, Rett Syndrome (RS) and autism. RS is caused by mutations in the gene encoding a transcriptional repressor, methyl-CpG binding protein 2 (MeCP2). Patients with RS may exhibit changes in gene expression as a consequence of loss of transcriptional repression. We measured the expression levels of up to 20,000 genes using the Atlas (CLONTECH), GeneFilters (Research Genetics), MICROMAX (NEN Life Sciences), and UniGEM V (Incyle) cDNA microarrays. We performed control experiments in normal human brain samples to measure differences in expression profiles based upon factors such as age at death, gender, brain region, and post-mortem interval. In RS, we found a consistent up-regulation of a group of glial genes using several array techniques. These changes in gene expression were confirmed by PCR and Western blotting. These studies provide validation for the analysis of post-mortem human brains in the study of neurological disorders.

Symposium 5 **Thursday, October 26**
8:30 a.m.-11:30 a.m.

CULTURAL ASPECTS OF TRAUMA AND TORTURE: ASSESSMENT AND TREATMENT

Russell F. Lim, M.D., *Clinical Assistant Professor of Psychiatry, University of California, Davis, 601 W. North Market Boulevard, #100, Sacramento, CA 95834;* Stevan M. Weine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will be able to: (1) identify possible traumatic experiences for Southeast Asian and Cuban immigrants, (2) describe how culture and gender affect the client's experience of trauma, and (3) describe approaches in treatment for culturally different individuals who experience trauma.

SUMMARY:

Each year, refugees from many countries come to the United States, and many experience trauma or torture. Torture is a common experience among refugees, with estimates from 30% to 60% of the world's 15 million refugees has been tortured. Women in particular have been designated as a vulnerable population by the United Nations High Commissioner for Refugees, being particularly susceptible to sexual traumas such as rape and other forced sexual acts, and sexual torture. Psychological sequelae of such traumas include symptoms of post traumatic stress disorder, such as flashbacks, emotional numbing, intense emotional distress when exposed to cues that remind the individual of the traumatic event, and avoidance of any stimuli associated with the event. There is a high co-morbidity with major affective disor-

ders, anxiety disorders, and personality disorders, as well as many physical disorders. Treatment is often complicated by linguistic and cultural differences between caregivers and clients, but appropriate cultural consultation and sensitivity to cultural issues typically can overcome these. The symposium will present various examples of trauma that ethnic minorities have experienced, such as Southeast Asians, Cubans, among other immigrant groups, and women. Aspects of treatment will be addressed, including the re-working of the trauma through oral testimonies.

No. 5A
THE ALTON SCHOOL BUS TRAGEDY: IMPACT ON THE FAMILIES

Fructuoso R. Irigoyen-Rascón, M.D., P.A., *Private Psychiatric Practice, P.O. Box 1599, McAllen, TX 78505-1599*

SUMMARY:

On September 21, 1989, in the back-road community of Alton, Texas, a soft-drink delivery truck collided with a school bus transporting junior high school students forcing it into a gravel pit filled with water. Twenty-one children were killed, while 60 more suffered physical and/or emotional injuries as a result of the accident.

The tragedy mobilized intensive medical and psychological attention for the survivors and relatives of victims and survivors. The presenter and his team were involved in supplying psychiatric services including psychiatric evaluations, psychotherapy, pharmacotherapy, consultation and liaison, and, especially, family therapy to approximately 250 persons who had a direct relationship with the tragedy. Analysis of our cumulative experience allows us to visualize etiological factors that may contribute to either development of posttraumatic stress disorder or its prevention. Emphasis is placed on several cross-cultural elements thought to be meaningful in the development of PTSD among survivors and relatives as well as the role of the family as a unit that presents symptoms, distributes them, and may even prevent or abort these. Collaterally, the paper discusses the role of litigation in this case. The paper also includes a pertinent review of the literature on PTSD in civilian populations.

No. 5B
CLINICAL ISSUES IN THE TREATMENT OF TRAUMATIZED REFUGEES

J. David Kinzie, M.D., *Department of Psychiatry, Oregon Health Sciences University, Portland, OR 99201*

SUMMARY:

It is estimated that there are 20 million refugees in the world. Many of these have experienced psychological and physical trauma in addition to being dislocated from their country of original. Estimates of the amount of PTSD in the population range from 30% to 50%. Much of the clinical experience indicates that in traumatized refugees PTSD is chronic, quite debilitating, and relapsing. The focus of this paper is to discuss culturally specific ways of handling this trauma, dealing with the major effects of depression, intrusive thoughts, hyperarousal, and numbness and avoidance. A long-term relationship that provides symptom relief, safety, and re-education to the country is emphasized. A complicating issue is the counter-transference in working with traumatized refugees. Practical approaches will be emphasized.

No. 5C
POST-TRAUMATIC SYMPTOMATOLOGY IN CUBAN BOAT CHILDREN

Eugenio M. Rothe, M.D., *Department of Psychiatry, University of Miami School of Medicine, 275 Glenridge Road, Key Biscayne, FL 33149*

SUMMARY:

Introduction: Mental health problems, particularly posttraumatic stress disorder (PTSD), have been found to be prevalent in adult refugee populations. The present study reports on stress exposure and posttraumatic symptomatology in a group of children and adolescents presenting for psychological help inside the camps and a separate group, not identified as treatment seeking, evaluated after release to United States.

Method: (1) Approximately 20% of the refugees ages 3 to 19 presented to the infirmary for psychological help of whom 285 (11% of all children/adolescents) were administered the Post-Traumatic Stress Disorder Reactive Index (PTSDRI), a checklist of eight PTSD-DSM-IV symptoms and a list of stressors. (2) A separate group of children and adolescents ages 6 to 17 years old (N = 89) were administered the PTSDRI and were also rated by their school teachers with the Child Behavioral Checklist-Teacher Report form (CBCL-TRF). Within each group relationships of findings to gender and age groups were explored.

Results: Specific stressors included overcrowded unhygienic living conditions, surprise raids and searches by military personnel, riots, violent acts, witnessing overt sexual activity and a severe tropical storm, which blew away tents. Boys 6 to 12 years old identified stressors in relation to the ocean crossing as most difficult whereas girls 13 to 19 identified stressors related to life in the camps. Ninety-one percent of the help-seeking group seen inside the camps received ratings in the range of

a very severe PTSD as measured by the PTSDRI. Girls and younger-age children were the most severely affected.

Conclusion: Children and adolescent refugees can be subject to severe and multiple stressors and appear to have high prevalence rates of posttraumatic symptomatology. After release and immigration significant symptomatology may continue, but not necessarily in association with overt behavioral manifestations. Implications for intervention will be discussed.

4. Beigel A, Berren MR: Human induced disasters. Psychiatr Annals 1985:15:1145–150.
5. Boehnlein JK, Kinzie JD: Refugee trauma. Transcultural Psychiatric Review 1995; 32:223–252.
6. Rothe E, et. al: Simtomatologia post-traumática en niños y adolescentes balseros cubanos: una sinopsis de tres estudios. Psiquiatria. Añox. Numero 1 Spain. enero-febrero, 1998.
7. Ackerman H, Clark J: The Cuban Balseros: Voyage of uncertainty (Monograph). The policy centre of the Cuban American National Council Inc. Miami, 1995.

No. 5D
COMMUNITY-ORIENTED INTERVENTIONS WITH SURVIVORS OF POLITICAL VIOLENCE

Jack Saul, Ph.D., *Clinical Professor and Director, International Studies Center, New York University, 114 East 32nd Street, Suite 505, New York, NY 10016*

SUMMARY:

In our work with refugee survivors of torture and ethnopolitical violence from various cultures, the process of healing and renewal is embedded in a tapestry of communal relationships, shared meanings, and cultural forms that reestablish social integration and weave the personal stories of suffering into broader political and/or cultural narratives. The challenge for the therapist lies in helping to recreate social contexts in which such healing might take shape, evoking the family's internal and external resources, prior emotional connections, and cultural/communal/spiritual foundations. This presentation will review a variety of psychosocial interventions that address the traumatic consequences of political violence from individual to family to community. This includes recent work with a refugee theater project in New York to create a safe, empowering context for individual and collective testimony and artistic representation. Among the refugee groups presented will be West Africans, Tibetans, and Chileans.

REFERENCES:

1. Marsella AJ, Friedman MJ, Spain EH: A selective review of the literature on ethnocultural aspects of PTSD. PTSD Research Quarterly 1992; 3(2):1–7.
2. Young M: Psychological consequences of torture: clinical needs of refugee women, in Clinical Methods in Transcultural Psychiatry. Edited by Okpaku SO. Washington, DC, American Psychiatric Press, Inc., pp. 391–411, 1998.
3. Pynoos RS: Violence, personality and post-traumatic stress disorder, in The Mosaic of Contemporary Psychiatry. Edited by Kales, Pierce, Greenblat. New York, Springer-Verlag, 1992.

Symposium 6 **Thursday, October 26**
8:30 a.m.-11:30 a.m.

THE CASE MANAGEMENT RELATIONSHIP: CLINICAL AND RESEARCH PERSPECTIVES

Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute, Assistant Professor of Psychiatry, University of Pittsburgh Medical Center, and Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Room E-516, Pittsburgh, PA 15213;* Joel Kanter, M.S.W., *Senior Case Manager, Fairfax City Health Services, 7113 Poplar Avenue, Takoma Park, MD 20912;* Charles R. Goldman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will be able to identify essential dimensions of successful case management relationships.

SUMMARY:

Although often delivered by poorly trained and inexperienced staff, case management with severely mentally persons requires a high level of clinical skill and professional committment. Often involving reluctant and psychotic patients, case managers must establish relationships with patients and significant others in the midst of unpredictable community milieus. This symposium will examine the case management relationship from a variety of perspectives. These include a discussion of countertransference and boundary issues, the application of self-psychological and developmental theories, and a presentation of empirical research on the early phases of the case management alliance and its relationship to outcome.

No. 6A
DEVELOPMENTAL ISSUES IN CASE MANAGEMENT

Joel Kanter, M.S.W., *Senior Case Manager, Fairfax City Health Services, 7113 Poplar Avenue, Takoma Park, MD 20912*

SUMMARY:

Although case management has often been conceptualized as merely facilitating the provision of material necessities, case managers play a critical role in promoting stabilization and recovery from severe mental illness. However, as this recovery process ensues, case managers often become catalysts for their clients' renewed developmental processes—processes that were often arrested during years of mental illness and prodromal states. These developmental processes frequently involve the acquisition of new social and vocational skills, and may involve such fundamental skills as making "small talk", building friendships, experimenting with romantic relationships, and exploring career options. While skills training programs may address some of these deficits, case managers are often involved in engaging clients in activities that offer more naturalistic developmental experiences. These may include a church singles group, a class at a community college, or a part-time job.

Such new initiatives are fraught with opportunities for disappointment and frustration. In considering the appropriateness of these initiatives, case managers assist clients in modulating between dramatic swings of excitement and hope on one hand, and despair and hopelessness on the other. In such highly emotional situations, transferential patterns are often reenacted. Useful cautions can be viewed as discouragement or encouragement may be viewed as imposing unrealistic expectations.

In this presentation, the dynamics of these issues will be discussed and illustrated with vignettes from case management practice.

No. 6B
DO EARLY CLIENT/CASE MANAGER ALLIANCES MATTER?

Leslie B. Alexander, Ph.D., *Professor of Social Work, Bryn Mawr College, 300 Airdale Road, Bryn Mawr, PA 19010;* Darla S. Coffey

SUMMARY:

Findings are reported from an empirical study of the impact of the case management alliance on an array of outcome variables. Although much anecdotal evidence exists about the importance of a positive alliance between adult clients with SMI and their case managers, there are only a few published studies about this relationship. The two most widely cited (Neale & Rosenheck, 1995; Solomon, Draine, & Delaney, 1995) were cross-sectional and retrospective, with clients and workers rating their relationship after two years in the service. In both studies, the alliance predicted some client outcomes.

We explored the case management alliance and its relationship to client outcomes during the first nine months of clients' participation in intensive case management programs (ICMs). The worker/client alliance was assessed at three, six and nine months for 67 clients and 49 case managers after client entry into ICM. The relationship between two standardized alliance measures (the Working Alliance Inventory and the Helping Alliance Questionnaire II) and service satisfaction, attitudes about medication compliance, hospitalizations, treatment participation, and subjective and objective quality of life were assessed. Positive alliance formation could be identified after three months in ICM and this alliance predicted positive client outcomes on several measures at nine months.

No. 6C
COUNTERTRANSFERENCE AND BOUNDARY ISSUES IN CLINICAL CASE MANAGEMENT

Joseph F. Walsh, Ph.D., *Associate Professor of Social Work, Virginia Commonwealth University, 1001 West Franklin Street, Richmond, VA 23282*

SUMMARY:

Most of the psychodynamic literature on the recognition and management of countertransference and worker-client boundaries in clinical practice is based on assumptions that the relationship between the two parties is structured, formal, and occurs within one site. None of these assumptions is true in community-based case management models of intervention, where the worker and client may interact in a wide variety of settings and circumstances. Additionally, the complex problems and interpersonal deficits of clients who have serious mental illnesses may evoke a range of conscious and unconscious reactions from workers that must be acknowledged so that the worker can maintain a focus on goals that are client centered, rather than focusing (perhaps unconsciously) on his or her own wishes for the client. A shortcoming of case management intervention models with regard to the skill development of professionals is that little attention is given to these interpersonal dynamics and their effects on treatment outcome. In this paper the author presents some key principles for recognizing and managing countertransference and boundary issues based on a literature review and his own practice and supervisory experiences. The presentation is intended for supervisors as well as all practitioners in case management programs.

No. 6D
SCAFFOLDING THE SELF: A SELF-PSYCHOLOGICAL PERSPECTIVE ON CASE MANAGEMENT

George A. Hagman, M.S.W., *Southwest Connecticut Mental Health System, 1635 Central Avenue, Bridgeport, CT 06610*

SUMMARY:

Self psychology was developed as psychotherapy for narcissistic character disorders. Although Heinz Kohut suggested that a more active approach was necessary for more severe disorders, he never elaborated on this idea. This presentation presents a self-psychological perspective on the case management of persons with severe and debilitating mental illness. Patients who require case management suffer from the persistent or periodic experience of self-disintegration. Multiple areas of self-experience may be affected: cognition, affectivity, physiology, self-image, social involvement, and numerous areas of living. From a self-psychological perspective, the case manager assumes pervasive self-object functions for the patient, which involves concrete helping activities to construct and regulate the most fundamental components of the patient's selfhood. These activities may include entitlement procurement, psychopharmacology, and obtaining food, clothing and health care. The case manager's primary clinical focus is the restoration of an optimal level of self-stability, psychological organization, and psycho/physiological regulation. Unlike with psychotherapy, which aims toward the development of internal psychological structure, the self psychologically informed case manager contructs a supportive scaffolding within which the patient's psychological experience of self-hood can be restored, protected and maintained. The case manager's use of empathy is expanded to include not only the patient's inner life, but also his or her complex experience of living. A case example of the case management of a young dually diagnosed man is presented using a self-psychological perspective.

REFERENCES:

1. Kanter J: Community-based management of psychotic clients: the contributions of DW and Clare Winnicott. Clinical Social Work Journal 1989; 18(1):23–41.
2. Kanter J: Clinical case management: definition, principles, components. Hospital and Community Psychiatry 1989; 40:361–368.
3. Neale MS, Rosenbeck RA: Therapeutic alliance and outcome in VA intensive case management program. Psychiatric Services 1995; 46:719–721.
4. Solomon P, Draine J, Delaney MA: The working alliance and consumer case management. Journal of Mental Health Administration. 1995; 22:126–134.
5. Walsh J: Clinical Case Management With Persons Having Mental Illness: A Relationship-Based Perspective. Pacific Grove, CA, Wadsworth-Brooks/Cole, 2000.
6. Kanter J (Ed.) Clinical Issues in Case Management San Francisco, Jossey Bass, 1995.
7. Kohut H: The Analysis of the Self. Madison, CT, International Universities Press, 1991.
8. Kohut H. The Restoration of the Self. International Universities Press: Madison, CT., 1977.

Symposium 7 **Thursday, October 26**
2:00 p.m.-5:00 p.m.

OUT OF PSYCHOSIS AND INTO LIFE: PSYCHOTHERAPY IN THE FIELD

David A. Garfield, M.D., *Professor of Psychiatry, Finch University of Health Sciences, Chicago Medical School, 3333 Greenbay Road, North Chicago, IL 60064;* Brian Koehler, Ph.D., *41 Main Street, Yonkers, NY 10701;* Wayne S. Fenton, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will acquire knowledge about the special characteristic of "connectedness" or "relatedness," which is so often disturbed in psychotic illness. A cross-disciplinary national group of speakers will address this focus from a variety of different perspectives as the symposium moves from individual psychotherapy with the psychotic patient into day hospital and community settings. The establishment of "connections" via a variety of psychotherapeutic interventions in wider and wider settings sets the stage for the way out of psychosis and back into life.

SUMMARY:

This symposium will address the path of the schizophrenic patient as he or she moves out of psychosis and into life. Once symptom reduction has been achieved, the chronic mental patient who suffers from psychosis faces the same overwhelming task as that of a chronically war-torn nation. Few elements of normality are left. Perhaps by focusing on the key element of "relatedness" or "connectedness" which is so often altered in schizophrenia, we can trace the crucial progress one must make in reestablishing the crucial links that make for a life.

The International Society For The Psychological Treatments of Schizophrenia and the Other Psychoses (ISPS) is a group of mental health professionals who have been meeting on a regular basis since the 1950's. Through the years, psychoanalysts, psychiatrists, psychologists and social workers from The Austin Riggs Center, Chestnut Lodge, The Massachusetts Mental Health Center, The Shepherd Pratt Hospital and from analytic institutes and state mental hospitals across the

country have routinely presented at ISPS international conferences. Now the United States has officially organized its own chapter (ISPS-US) and this symposium illustrates the multifaceted work and programs of many of its members.

Dr. Michael Robbins will first present a paper on "Speaking in Tongues" in which he will explore the many ways schizophrenic speech patterns are communicative—not simple deficits. Next, Joel Kanter, MSW, will discuss Winnicott's concept of transitional phenomena in his look at the therapist as a "transitional participant" in the real life of the psychotic patient. Again, relatedness is at the heart of the endeavor. Julie Kipp, MSW, will then describe the crucial elements of interpersonal skill that are developed in her day program in the Bronx. Here, the patient is achieving "readiness" to connect to the larger outside world. Finally, Mary Moller, MSN, of Spokane, Washington, will detail the nurse-practitioner-based, community mental action model that links psychotic patients to jobs, friends, medication, family and religious institutions. Here, "relatedness" illustrates the end of the path "out of psychosis and into life." Wayne Fenton, M.D. of the National Institute of Mental Health will be the symposium's primary discussant.

Dr. David Garfield of Chicago Medical School and The Institute For Psychoanalysis, Chicago, along with Dr. Brian Koehler of Rockland Mental Health Center and the NYU postgraduate program in psychoanalysis are the chair and co-chair of this symposium, respectively.

No. 7A
SPEAKING IN TONGUES: LANGUAGE AND COMMUNICATION IN SCHIZOPHRENIA

Michael Robbins, M.D., *Associate Clinical Professor of Psychiatry, University of California at San Francisco, 14 Seventh Avenue, San Francisco, CA 94118*

SUMMARY:

The strangeness of schizophrenic speech and writing makes it seem logical to conclude that it is a meaningless breakdown product of a neurobiological disorder. My experience conducting intensive psychotherapy has convinced me that this is not so, and that it is a language (I call it schizophrenese) that conforms to lawful principles related to ordinary language. Verbatim vignettes are presented from my therapeutic work to illustrate some of its characteristics:

1. Primitive representation of self and subjectivity and related animation of the external world of things.

2. Collapse of the ordinary distinction between words, things, body states, and actions leading to a fusion of these ordinarily separable entities. Instead of being a vehicle of thought, the word is a thing of action. Schizophrenese is an action language without provision for time, space, or reflection.

3. As a consequence of (2) schizophrenese creates omnipotent delusions of control over a psyche that has become indistinguishable from the world, that eliminate the necessity to think about an emotionally unbearable reality.

Implications for psychotherapy are explored, including that it is impossible to make intelligible psychological interpretations without first translating schizophrenese into ordinary language.

No. 7B
BEING THERE: THE TRANSITIONAL PARTICIPANT IN COMMUNITY CARE

Joel Kanter, M.S.W., *Senior Case Manager, Fairfax City Health Services, 7113 Poplar Avenue, Takoma Park, MD 20912*

SUMMARY:

Although psychotherapy practice has traditionally been office based, the care and treatment of severely mentally ill persons has increasingly occurred in the home and community. Seen as a useful approach for engaging reluctant patients, such community interventions also offer new psychotherapeutic possibilities for facilitating recovery and psychic integration. Instead of merely listening to reports of patients' lives, mental health professionals actually witness important events and significant others in their patients' unfolding lives. Such events may include the illnesses and deaths of relatives, rehospitalizations and graduations, or more commonplace interactions with network members in a McDonalds or day program parking lot. Drawing on the work of Clare and Donald Winnicott, the therapist, psychiatrist, or case manager becomes a "transitional participant" in these lives, helping cognitively impaired patients integrate and appropriately respond to a variety of life experiences in ways that are more difficult to achieve when treatment occurs apart from patients' daily lives. In this presentation, this concept will be illustrated with case vignettes. Besides exploring the clinical implications of this concept, programmatic issues affecting interpersonal continuity will also be discussed.

No. 7C
PRE-LAUNCH: A DAY PROGRAM IN NEW YORK CITY

Julie Kipp, M.S.W., *Member, The International Society for the Psychological Treatment of Schizophrenia and*

the Other Psychoses, U.S. Chapter, 55 Westchester Square, Bronx, NY 10461

SUMMARY:

Treatment settings for people with serious mental illness have gone through dramatic changes since the early days of deinstitutionalization. Patients who used to be treated in long-term hospitalizations now receive care in various outpatient settings during their recovery phases, with some of the most ill of these clients coming to continuing day treatment programs. This paper will describe how one such program provides a place for clients who need a period of extended regression until they can "get a life." Being in a safe place where the vicissitudes of their illness will be tolerated may be enough in the beginning, and may in fact be as much as a very ill client can tolerate. Gunderson's (1979) first three milieu functions of containment, structure, and support describe treatment in the early stages. After that the client may be able to make use of the fourth function, involvement although initially only being involved in the insular community of the day program. In this protected milieu, clients may begin to risk small excursions into relationships and responsibilities, with titrated support and spurs to further growth. The fifth function, validation, can occur when clients are able to use treatment to understand themselves and perhaps begin to overcome limitations imposed on them by their disorder.

This paper will explore the question of regression in the day treatment setting. Although regression is a neglected concept in contemporary theory on treatment of seriously mentally ill people, issues regarding regression continue to hold a prominent place in the daily life of day treatment milieus. What level of regression is optimal? What guidelines can the treatment team make use of in order to challenge regressed clients enough, and to tolerate clients' potentially healing but extended periods of low functioning? In this regard, Winnicott's distinction between withdrawal and regression may be helpful: in the withdrawn state the self holds itself, with little opportunity for healing, whereas Winnicott's regression involves some trust in the caretaking environment and potential for reorganization at a higher level of personality functioning.

No. 7D
THE THREE R'S PSYCHIATRIC REHABILITATION PROGRAM: A WELLNESS MODEL

Mary D. Moller, M.S.N., A.R.N.P, *Member, The International Society for the Psychological Treatment of Schizophrenia and the Other Psychoses, U.S. Chapter, 5998 North Highway 291, Nine Mile Falls, WA 99206*

SUMMARY:

Schizophrenia presents a health challenge that can interfere with a person's level of wellness. It is important that people with schizophrenia establish a level of wellness that enables them to live in the environment of their choosing and to accomplish life tasks. The stigma and discouragement associated with schizophrenia often interfere with the ability to achieve a satisfactory level of wellness. Focusing on what can be done to achieve wellness rather than focusing on severity of illness will result in better overall health and a higher level of wellness. The Three R's Program: Relapse, Recovery, and Rehabilitation, a wellness approach to psychiatric rehabilitation, based on the Murphy-Moller Wellness Model, provides cost-effective treatment that assists individuals with schizophrenia to achieve a level of wellness that promotes symptom management and relapse prevention in a manner that can eliminate hospitalization and facilitate integration into community life. This presentation will present the three levels of wellness described in the Murphy-Moller Wellness Model as unstable, stable, and actualized that reflect levels of symptom intensity. These levels of wellness are then correlated with levels of functioning described as relapse, recovery, and rehabilitation. Discussion will focus on therapeutic interventions appropriate to each level of wellness.

REFERENCES:

1. Kanter J: Community-based management of psychotic clients: the contributions of DW and Clare Winnicott, Clinical Social Work Journal 18:23–41.
2. Kanter J: Clinical issues in delivering home-based psychiatric services, in Psychiatric Home Care. Edited by Menikoff A. New York, Academic Press, 1999.
3. Gunderson JG: Functions of milieu therapy, in C. Müller (Ed.) Psychotherapy of Schizophrenia: Proceedings of the Sixth International Symposium for the Psychotherapy of Schizophrenia, pp. 109–119. Amsterdam-Oxford: Excerpta Medica, 1979.
4. Winnicott DW: From dependence towards independence in the development of the individual, in D.W. Winnicott, The Maturational Processes and the Facilitating Environment Madison: International Universities Press, 1963, pp. 83–92.
5. Winnicott DW: Withdrawal and regression in Holding and interpretation: Fragment of an analysis New York, Grove Press, 1954/1986, pp. 187–192.
6. Moller MD, Murphy MF: The three r's rehabilitation program: a prevention approach for the management of relapse symptoms associated with psychiatric diagnoses. Journal of Psychiatric Rehabilitation 1997; 20:42–48.
7. Moller MD, Murphy MF: Reintegration and schizophrenia: the three R's approach. Continuum: Devel-

opments in Ambulatory Mental Health 1997; 4:17–35.

Symposium 8 **Thursday, October 26**
2:00 p.m.-5:00 p.m.

PSYCHIATRIC SERVICES ACROSS THE MILLENNIUM: A CELEBRATION OF 50 YEARS OF THE PSYCHIATRIC SERVICES JOURNAL

John A. Talbott, M.D., *Liaison, APA Institute Scientific Program Committee, Past President, American Psychiatric Association, and Professor of Psychiatry, University of Maryland School of Medicine, 701 West Pratt Street, Room 354, Baltimore, MD 21201-1596;* Jeffrey L. Geller, M.D., M.P.H., *Professor of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655-0002*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify and describe the six major themes published in the 50-year history of the APA journal Psychiatric Services and its predecessors, Mental Hospitals and Hospital & Community Psychiatry.

SUMMARY:

This symposium will celebrate the 50-year anniversary of the APA journal Psychiatric Services. The Editor, John A. Talbott, M.D., introduces the symposium by giving some historical context to the subject: presenting the reasons for founding its predecessor, Mental Hospitals, by Daniel Blain, M.D., in 1950; its evolutions under Donald Hammersley, M.D. to Hospital & Community Psychiatry; and recent life as Psychiatric Services. Then six of the most prominent members or former members of the journal's editorial board will present the evolution of six of the most important themes that have been featured from 1950–2000. They are:

Jeffrey Geller, M.D.: An Overview of 50 years of Psychiatric Services; Paul Appelbaum, M.D.: Patients' Rights and Legal Issues; Richard Lamb, M.D.: Deinstitutionalization and the Chronic Mentally Ill; Steven Sharfstein, M.D.: Financing Psychiatric Services; Howard Goldman M.D.: Organizing Psychiatric Services; and Carl Bell, M.D.: Special populations (children, the violent mentally ill, ethnic groups).

No. 8A
AN OVERVIEW OF 50 YEARS OF PSYCHIATRIC SERVICES

Jeffrey L. Geller, M.D., M.P.H., *Professor of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655-0002*

SUMMARY:

The last half-century of psychiatric services in the United States is examined through developments and trends organized largely around the locus of care and treatment because the location of treatment—institution versus community—has been the battleground for the ideology of care and for the crystallization of policy and legal reform. Deinstitutionalization is used to describe the movement of patients out of state hospitals, thus rejecting the widely used term "deinstitutionalization" as inappropriate. One reason is that the term wrongly implies that many settings where patients ended up were not institutional. Briefly reviewed are community care and treatment, economics, patient empowerment, outpatient commitment, and psychosocial rehabilitation. Outpatient commitment and patient empowerment, emerged earlier than now assumed, while psychosocial rehabilitation has recurred in slightly different forms over time. After 50 years of moving patients out of state hospitals and placing them somewhere else, mental health policymakers and practitioners remain far too focused on the locus of care and treatment instead of on the broadly defined quality of care.

No. 8B
PATIENT'S RIGHTS AND LEGAL ISSUES

Paul S. Appelbaum, M.D., *Vice President, APA Board of Trustees, and A. F. Zeleznik Professor of Psychiatry, Chairman, Department of Psychiatry, and Director, Law and Psychiatry Program, University of Massachusetts Medical School, 55 Lake Avenue, North, Room S7-866, Worcester MA 01655*

SUMMARY:

The past 50 years have seen a dramatic reorientation in our attitudes and practices regarding the legal rights of persons with mental disorders. At the mid-point of the 20th century, little had changed for a hundred years. Paternalism dominated the scene, with patients hospitalized and treated when physicians determined that they were in need of treatment; the exercise of their rights in institutions was largely dependent on their physicians' acquiescence. An era of rapid change began in the late 1950s, as the legitimacy of the dominant paradigm was called into question. Commitment laws were altered to reflect dangerousness-based criteria, and procedures for involuntary hospitalization moved closer to the model for criminal prosecution. Rights of hospitalized patients came more to resemble those of their fellow citizens in the community. The results of this radical reform have been controversial, with many mental health professionals seeing the new attention to patients' rights as obstructing their ability to provide needed care. But the empirical data are more equivocal, suggesting that a

reduction in funding for and availability of mental health services, not the provision of greater rights to patients, has been primarily responsible for the difficulties in providing treatment to persons with serious mental illness.

No. 8C
DEINSTITUTIONALIZATION AND THE SEVERELY MENTALLY ILL

H. Richard Lamb, M.D., *Professor of Psychiatry, University of Southern California School of Medicine, 1934 Hospital Place, Los Angeles, CA 90033-1071*

SUMMARY:

Deinstitutionalization, which began in the mid-1950s, has been dramatic. It has resulted in a decrease in the number of occupied state hospital beds from 339 to 22 per 100,000 population. The plight of the new generation of chronically and severely mentally ill persons has posed the most serious problems. These persons no longer receive life-long hospital admission and thus permanent asylum from the demands of the world. Resistance to treatment and substance abuse are problems. A comprehensive, integrated, and adequately funded community system of care for the chronically and severely mentally ill needs to be established. Where such systems exist, they can lead to higher levels of functioning and a higher quality of life. Unfortunately, there are insufficient treatment, housing, and rehabilitation resources to serve the very large numbers of mentally ill in the community. Moreover, some patients who have been deinstitutionalized cannot be effectively treated without highly structured 24-hour care. The way deinstitutionalization has been implemented has probably contributed to the large numbers of severely mentally ill persons on the streets and in the jails. Deinstitutionalization can result in a much richer life experience in the community; much more needs to be done to make that occur.

No. 8D
FINANCING PSYCHIATRIC SERVICES

Steven S. Sharfstein, M.D., *Chief Executive Officer, President and Medical Director, Sheppard-Pratt Hospital, 6501 North Charles Street, Baltimore, MD 21204-6819*

SUMMARY:

Over the past half century, mental health policy as expressed through changing methods for paying for care has determined treatment opportunities for persons with mental disorders. It's not the science, the new medications, breakthroughs in psychosocial interventions such as assertive community treatment, or innovative psychotherapy that have determined what we should and do pay for. That would be a more rational world. Instead treatment follows funding. When the shift from state-funded tax dollars of large, mostly custodial institutions to federal "seed money" for community mental health centers was made in the 1960s, and major federal financing programs such as Medicare, Medicaid, Social Security Disability, and Social Services were passed in the 1960s and 1970s, we developed opportunities for treatment called community mental health. When private tax-subsidized health insurance became more and more available to the employed and their dependents, a large psychotherapy practice emerged in a new marketplace with many nonphysician therapists thriving in private practice. The emergence of for-profit psychiatric hospitals, ("the chains") with their emphasis on care for children and adolescents and 28-day substance abuse treatment came about because of generous insurance with little accountability throughout the 1980s. Then in the 1990s, managed care found a powerful niche in rationing a range of opportunities for treatment and support. This paper will review in-depth these amazing changes for the past 50 years.

No. 8E
ORGANIZING PSYCHIATRIC SERVICES

Howard H. Goldman, M.D., Ph.D., *Professor of Psychiatry, University of Maryland School of Medicine, 10600 Trotters Trail, Potomac, MD 20854-4241*

SUMMARY:

This presentation will review the evolution of the different mental health services systems since World War II. It will discuss the growth of outpatient services, changes in hospital services, the growth of alternatives to the hospital, the development of specialized mental health services, and the emergence of primary care as a locus of mental health services. Developments in the public and private sectors, including the introduction of managed care, will be described.

No. 8F
FIFTY YEARS OF HOSPITAL AND COMMUNITY PSYCHIATRY: PSYCHIATRIC SERVICES ON SPECIAL POPULATIONS

Carl C. Bell, M.D., *President and Chief Executive Officer, Community Mental Health Council, Inc., and Professor of Psychiatry and Public Health, University of Illinois School of Medicine, 8704 South Constance Avenue, Chicago, IL 60617-2746*

SUMMARY:

Dr. Bell will review the contents of Hospital and Community Psychiatry/Psychiatric Services during the last 50 years as they relate to issues regarding children, violent mentally ill, and nonwhites. Although the journal has always been open to accepting articles on these special populations, the advent of the Civil Rights Movement in the late 1960s and the inclusion of editorial board members with diverse backgrounds and interests facilitated an even greater welcoming of articles on special groups. The author encourages the editorial board of Psychiatric Services to remain diverse in an effort to give voice to issues concerning special groups and to avoid ethnocentric mono-culturalism.

REFERENCES:

1. Geller JL: The last half-century of psychiatric services as reflected in Psychiatric Services. Psychiatric Services 2000; 51:41–67.
2. Grob GN: From Asylum to Community. Princeton, NJ, Princeton University Press, 1991.
3. Appelbaum PS: Almost a Revolution: Mental Health Law and the Limits of Change. New York, Oxford University Press, 1994.
4. Gutheil TG, Appelbaum PS: Clinical Handbook of Psychiatry and the Law, 3rd edition, Baltimore, Lippincott/Williams & Wilkins, 2000.
5. Lamb HR: Deinstitutionalization at the beginning of the new millennium. Harvard Review of Psychaitry 1998; 6:1–10.
6. Sharfstein SS, Stoline AM, Goldman HH: Psychiatric care and health insurance reform. American Journal of Psychiatry 1993; 150:7–18.
7. Frank R: The creation of Medicare and Medicaid: the emergence of insurance and markets for mental health services. Psychiatric Services 2000: 51 (4): 465–468.
8. Goldman H, Taube C, Jencks S: The organization of the psychiatric inpatient services system. Medical Care 1987; 25 (9supplement):S6–S21.
9. Hospital and Community Psychiatry 1986;37:(1).
10. Violent Behavior and Mental Illness. Washington, D.C., Psychiatric Services, 1997.

Symposium 9 **Friday, October 27**
8:30 a.m.-11:30 a.m.

GROUP THERAPY FOR MEN: CHALLENGES AND NEW DIRECTIONS

Laurence P. Karper, M.D., *Medical Director, Psychiatric Emergency Services, Substance Abuse and Adult Inpatient Unit, Lehigh Valley Hospital, 400 North 17th Street, Suite 207, Allentown, PA 18104;* Gerald Rodriguez, A.C.S.W., *Licensed Social Worker, 400 North 17th Street, Suite 207, Allentown, PA 18104*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe and understand various approaches to group therapy for men and to effectively engage men in group treatment.

SUMMARY:

Group therapy and support groups can be a cost-effective treatment for many patients. Group treatment may be a particularly effective approach for fostering improved communication skills and for eliciting peer feedback and support. Women are more likely to seek counseling and out number men by as much as 2 to 1 in outpatient settings. Men may be resistant to seek treatment in clinical settings due to gender specific and general causes. This symposium speaks to present several different approaches in order to engage men in group treatment. Much attention has rightly been focused on the negative effects of "gender-blind" approaches in the treatment of women. The presenters of this symposium describe their own experiences in a variety of therapy and support groups for men. The aim of this symposium is to spark interest in and provide direction to those clinicians seeking to successfully engage men in group treatment.

No. 9A
ORGANIZING A MEN'S GROUP IN A MANAGED CARE ENVIRONMENT

Gerald Rodríguez, A.C.S.W., *Licensed Social Worker, 400 North 17th Street, Suite 207, Allentown, PA 18104;* Michael W. Kaufmann, M.D.; Laurence P. Karper, M.D.

SUMMARY:

In this era of diminishing resources, significant gaps in the continuity of care exist. This paper details our efforts to create, organize, and sustain a men's group in a managed care environment. After discharge from inpatient services, patients frequently continue to have significant difficulty with mood regulation and aggressive impulses. Based on these clinical needs, we developed an eight-session men's group to focus on the treatment of men with mood disorders. A licensed clinical social worker and psychiatrist with expertise in men's issues developed a cognitive-behavioral group to meet these needs. Coordinating referrals, negotiating with managed care organizations and public outreach, in addition to the necessary clinical skills was required for success. The group consists of eight modules focusing on improving communication skills, mood regulation, conflict resolution, community resource development,

cognitive-behavioral strategies for impulse control, and discharge planning. The format of each session consists of self-assessment, skills education, self-help practice, and review. Outcomes data were gathered to justify to the managed care organization the benefit of the group. Results for three cycles of eight sessions will be discussed including number of referrals, referral sources, attendance, and billing. In summary, the successful implementation of group therapy in a managed care environment depends on the critical integration of short-term solutions-oriented treatment, outcomes data, and outreach.

No. 9B
THE UTILIZATION OF SELF-ASSESSMENT SCALES TO DOCUMENT EFFICACY IN A MEN'S GROUP

Laurence P. Karper, M.D., *Medical Director, Psychiatric Emergency Services, Substance Abuse and Adult Inpatient Unit, Lehigh Valley Hospital, 400 North 17th Street, Suite 207, Allentown, PA 18104;* Gerald Rodriguez, A.C.S.W.; Michael W. Kaufmann, M.D.

SUMMARY:

The documentation of efficacy can no longer be considered a luxury in mental health treatment. Group therapy is a cost-effective approach when implemented effectively. We present data on our efforts to document the effectiveness of a structured short-term group utilizing cognitive-behavioral approaches to improve mood and reduce impulsivity in men.

Methodology: Data were collected on three completed groups consisting of 20 subjects. Rating instruments included the Basis 32, the Burns Anxiety Inventory, and the Burns Depression Checklist. Subjects completed rating instruments prior to initiating the group and at each session. In addition, we measured therapist's empathy and relationship satisfaction.

Results: Large clinically significant improvements in sub-scale scores that measured depression, anxiety, anger, and impulsivity occurred. These changes were consistent with clinicians' impressions and patients' reports. Overall, Basis 32 scores improved from 1.70 at admission to 0.66 on discharge. Impulsive/addictive subscale score improved from 1.03 to 0.28 at discharge. Depression/anxiety score improved from 1.73 to 0.68 at discharge. Burns self-assessment scores likewise improved during treatment. The anger sub-scale score improved from 6.60 on admission to 0.98 on discharge. Relationship satisfaction also improved from 5.89 to 17.93. A measurement of therapist empathy improved from 10 to 13.

No. 9C
A LEADERLESS MEN'S PEER SUPPORT GROUP

Theodore Glackman, M.Ed., *Psychologist, Department of Psychiatry, Lehigh Valley Hospital, 236 North 17th Street, Allentown, PA 18104;* David Kern, M.Ed.

SUMMARY:

The authors, both licensed psychologists, facilitated the founding of a leaderless men's peer support group in October 1998. One of the authors had participated in a similar group for approximately 10 years. Both are experienced group therapy leaders in a variety of settings and with diverse populations. There were several general goals at the outset. It was hoped that the group would create a safe and supportive setting to allow the participants to discuss personal issues and conflicts. Desired outcomes included the formation of meaningful relationships with other men, the facilitation of personal growth, and the mutual sharing of ways to cope with stress from relationships, family, and work. The presentation reviews the development of the group over a two-year period. Included is a review of the formation of the group, the stages of group development, the evolution of the meeting format, and the range of group activities. Each of the seven group participants was interviewed to determine reasons for choosing to join, how the stated goals were addressed, and any additional issues that were elicited by the group. Considerations for the formation and maintenance of similar groups will be discussed.

No. 9D
MOUNTAIN PATH: A MEN'S WILDERNESS RETREAT

Robert Garfield, M.D., *191 Presidential Boulvard, Suite W-10, Bala Cynwyd, PA 19004;* Jacob Kriger, M.S.S.

SUMMARY:

The authors, a psychiatrist and a clinical social worker, have co-led men's groups and wilderness outings for the past ten years. Mountain Path is a weeklong hiking experience in the wilderness of the Canadian Rockies. The purpose is for participants to achieve a sense of personal renewal and more meaningful connections in their relationships with others and with nature. The main focus of the experience is to integrate daily experience on the trail with one's personal life. Participants are encouraged to use their senses, their emotions, and their interactions with others to gain new insights into their own nature. Experiential exercises, solo journeys, and silent meditation are included to enhance the participants' learning during the hikes. Participants are encouraged to record their impressions of their experiences in

journals. It is hoped that participants will take their newfound sense of purpose and vitality back to their urban and suburban environments, introducing the new insights into their day-to-day lives, their families, and their work settings. The retreat leaders contact participants in the weeks following the retreat and invite them to meet and share their reentry experiences. A review of the overall experience and perceived outcomes will be discussed.

REFERENCES:

1. Andronico M (Ed): Men in Group: Insights, Interventions, and Psychoeducational Work. Washington DC: APA, 1997.
2. Burns DD: Ten Days to Self-Esteem: The Leader's Manual. New York, Quill, 1993.
3. Eisen SV, Dill DL, Grob MC: Reliability and validity of a brief patient-report instrument for psychiatric outcome evaluation. Hospital and Community Psychiatry 1994; 242–247.
4. Andronico MP: Men In Groups: Insights, Interventions, and Psychoeducational Work. Washington, DC, APA Books, 1999.
5. Osherson S: Finding Our Fathers: The Unfinished Business of Manhood. The Free Press, 1986.
6. Tiger L: Men in Groups. Random House, 1969.
7. Miller S: Men and Friendship. Gateway Books, 1983.

Symposium 10 **Friday, October 27**
8:30 a.m.-11:30 a.m.

QUALITY INDICATORS IN PSYCHIATRY

APA Council on Quality Improvement

John M. Oldham, M.D., *Director, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 4, New York, NY 10032;* John S. McIntyre, M.D., *Chair, Department of Psychiatry and Behavioral Health, Unity Health System, and Past President, American Psychiatric Association, 81 Lake Avenue, 3rd Floor, Rochester, NY 14608;* Sara C. Charles, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand performance measurements; the definition of quality indicator, measure, and standard; and the dimensions of care (access, quality, perception of care, outcomes) being developed by the APA Committee on Quality Indicators.

SUMMARY:

There is a groundswell of interest in the development of performance measures, so that health care systems can be held accountable for the care they provide. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has recently introduced an ambitious performance measurement program. Other organizations, such as the National Committee on Quality Assurance (NCQA), and the American Medical Accreditation Program (AMAP), are developing methods to evaluate health care, and JCAHO, NCQA, and AMAP have announced a collaboration on an initiative to coordinate performance measurement activities across the entire health care system. The American Psychiatric Association established a Task Force on Quality Indicators to develop a professionally driven, clinically based framework for performance measurement. After determining four key dimensions of care to be evaluated (access, quality, perception of care, and outcome), the Task Force identified priority areas of importance (populations [e.g. children, the elderly] and diagnoses [e.g. schizophrenia, substance abuse]), as well as a series of clinical recommendations/goals and sample quality indicators, to be used in evaluating the provision of behavioral health care.

Participants in this symposium will be invited to provide input and suggestions for the future development of additional quality indicators.

No. 10A
CLINICALLY BASED QUALITY INDICATORS

John M. Oldham, M.D., *Director, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 4, New York, NY 10032*

SUMMARY:

The American Psychiatric Association Task Force on Quality Indicators submitted its final report to the Board of Trustees in March 1999, and it was approved. Subsequently, a standing committee, the Committee on Quality Indicators, was established, within the newly established Council on Quality Improvement. Working closely with the Steering Committee on Practice Guidelines, the APA Office of Quality Improvement and Psychiatric Services, and other councils and components, the Committee has begun its work to develop a strategy to field-test the sample quality indicators already developed, utilizing Practice Research Network data along with other available datasets. A "high confidence" set of indicators will then be selected from those that are field tested, for priority utilization by organized systems of care and by reviewing and accrediting organizations. The evolving work of the Committee on Quality Indicators to collect data on existing quality indicators and to develop additional indicators linked, when possible, to the practice guidelines, will be presented.

No. 10B
QUALITY INDICATORS AND PRACTICE GUIDELINES

John S. McIntyre, M.D., *Chair, Department of Psychiatry and Behavioral Health, Unity Health System, and Past President, American Psychiatric Association, 81 Lake Avenue, 3rd Floor, Rochester, NY 14608*

SUMMARY:

Practice guidelines have become increasingly important in the practice of medicine. Thousands of guidelines have been developed by professional associations, government agencies, payors, and provider groups. The American Psychiatric Association has approved and published ten practice guidelines (two of which have recently been revised). At present major focus of guidelines efforts throughout medicine is the effective dissemination of the guidelines. Research has demonstrated that publishing the guidelines is insufficient in changing physician behavior. Monitoring the use of guidelines will become increasingly important for quality improvement efforts as well as meeting the challenge of increased accountability. In order to measure the conformance to guidelines, indicators that are systematically derived from guidelines are essential. This presentation will explore issues and methods in deriving indicators from evidence-based guidelines.

No. 10C
CONFORMANCE WITH QUALITY INDICATORS IN ROUTINE PRACTICE

Joyce C. West, Ph.D., M.P.P., *Director, American Psychiatric Practice Research Network, 1400 K Street, N.W., Washington, DC 20005;* Deborah A. Zarin, M.D.; Philip S. Wang, M.D., D.P.H.; Christine Rose, M.S.; Steven C. Marcus, Ph.D.

SUMMARY:

Objectives: (1) Identify patient, psychiatrist, health plan, and setting factors associated with conformance with key evidence-based practice guideline treatment recommendations, and (2) distinguish clinically appropriate from clinically inappropriate reasons for non-conformance.

Methods: Nationally representative data from the APA Practice Research Network's 1997 Study of Psychiatric Patients and Treatments on 1,228 adult patients of psychiatrists. Logistic regression was used to assess the relationship between guideline conformance with key treatment recommendations and patient, psychiatrist, health plan, and setting characteristics.

Results: Analyses have been conducted for all three disorders assessing overall rates of conformance with specific recommendations and factors associated with conformance. For example, for patients with bipolar disorder, conformance with the psychopharmacologic and psychiatric management recommendations ranged from 71% to 93%. A total of 93% of the bipolar patients received psychiatric management; 81% of the patients with BP Type I not in remission were currently receiving a mood stabilizer; and 71% of the patients who were currently receiving an antidepressant were also receiving a mood stabilizer. Clinical data provided insight regarding potential reasons for non-conformance with the specific recommendations studied and will be presented.

Conclusions: Findings have implications for designing and targeting quality improvement initiatives and developing and using evidence-based practice guidelines and guideline-based quality of care indicators.

Funding provided by the MacArthur Foundation, NIMH, and CMHS.

No. 10D
QUALITY MEASUREMENT IN A CLINICAL FACILITY

Lloyd I. Sederer, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

Changes in the health care delivery system have made assessing the effectiveness of medical treatment a clinical imperative. Assessing outcome in clinical practice offers a wide range of applications, including quality improvement, meeting regulatory and accreditation standards, fostering patient and family trust, meeting payer demands for evidence of effectiveness, community relations, and marketing of clinical services.

This presentation will detail the quality assessment and quality improvement approach used at McLean Hospital. Four domains of assessment will be described and demonstrated: (1) clinical outcomes, (2) patient satisfaction, (3) readmissions, and (4) high-risk events. I will explain the instruments and measurements used and demonstrate their application in both inpatient and ambulatory settings.

REFERENCES:

1. Eddy DM: Performance measurement: problems and solutions. Health Affairs 1998; 17:7025.
2. McIntyre JS, Zarin DA, Pincus HA: Practice guidelines in psychiatry and a psychiatric practice research network in: S Weissman, M Sabshin, H Eist (eds) Psychiatry in the New Millennium, 143–162. American Psychiatric Press, 1999.
3. McGlynn EA, Asch SM: Developing a clinical performance measure. Am J Prev Med 1998; 14–21.

4. Sederer L. Dickey B: Outcomes Assessment in Clinical Practice. Baltimore, MD: Williams & Wilkins, 1996.
5. Report of the American Psychiatric Association Task Force on Quality Indicators, March 1, 1999.
6. McIntyre JS, Zarin DA, Pincus HA: Practice guidelines in psychiatry and a psychiatric practice research network, in Psychiatry in the New Millennium. Edited by Weissman S, Sabshin M, Eist H. American Psychiatric Press, 1999, pp 143–162.
7. McGlynn EA, Asch SM: Developing a clinical performance measure. Am J Prev Med. 1998; 14–21.
8. Sederer LI, Dickey B: Outcome Assessment in Clinical Practice, Baltimore. Williams & Wilkins, 1996.
9. Dickey B, Sederer LI: Achieving Quality in Psychiatric and Substance Abuse Practice: Concepts and Case Examples, Washington, D.C., APPI Press, 2000 (forthcoming).

Symposium 11 **Friday, October 27**
2:00 p.m.-5:00 p.m.

CURRENT LEVEL OF CARE ASSESSMENT TOOLS FOR PSYCHIATRIC AND SUBSTANCE DISORDERS

Kenneth Minkoff, M.D., *Medical Director, Arbour Choate Health Management, 12 Jefferson Drive, Acton, MA 01720*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the concept of independent de-linked dimensions of service intensity, and identify four such dimensions; discuss the concept of multidimensional service intensity assessment and identify six assessment dimensions for addiction patients and for psychiatric patients; and describe the current availability, utility, validity, and reliability of the ASAM PPC2R, the LOCUS, the CALOCUS, the CHOICE, and the CHOICE-Dual.

SUMMARY:

Despite the fact that there has been extensive controversy regarding managed care, and concern that managed care reviewers may inappropriately deny access to intensive services, there has been surprisingly little available objective data on the process of utilization management and level of care determination. Fortunately, in recent years, this has begun to change, as there has been increasing development and investigation of more sophisticated instruments for assessment of level of care or service intensity requirements.

This symposium attempts to bring together in a single forum a presentation of the most up-to-date level of care assessment tools available in the public domain. The symposium begins with a presentation of general principles of utilization management, including the description of independent dimensions of service intensity and the concept of multidimensional service intensity assessment, and illustrates the application of these concepts to the development of utilization management manuals (CHOICE—the Choate Outline for Intensity of Care Evaluations) in managed care oriented service continuum. The symposium continues with a description of the latest version of the American Society of Addiction Medicine Placement Criteria (2R), which incorporates increased sophistication regarding assessment of comorbid psychiatric disorders in the addiction placement process. This presentation is followed by a presentation on the NIDA funded ASAM Criteria Validity Study, which is attempting to demonstrate objective support for the ASAM PPC2.

The final section of the symposium focuses on level of care assessment tools that originated on the psychiatric side, (though also incorporating addressing comorbidity): first, the LOCUS, developed by the American Association of Community Psychiatrists (AACP), and then the Child and Adolescent LOCUS (CALOCUS) developed by AACP in collaboration with the Academy of Child and Adolescent Psychiatry.

In total, the symposium will present the listener with an accurate portrayal of the current field of level of care assessment, and the directions of future research. This material will be invaluable for anyone involved, or planning to be involved in the development of, or delivery of service in, managed care systems.

No. 11A
PRINCIPLES OF UTILIZATION MANAGEMENT AND LEVEL OF CARE ASSESSMENT

Kenneth Minkoff, M.D., *Medical Director, Arbour Choate Health Management, 12 Jefferson Drive, Acton, MA 01720*

SUMMARY:

The presentation begins with an outline of basic principles of utilization management. This will include the concept of independent dimensions of service intensity, including biomedical, residential, treatment, and case management intensity, which lead in turn to the reconceptualization of "levels of care" as "matrices of service intensity." In this model, the independent dimensions are "de-linked" so that program models can vary flexibly across dimensional categories.

The second key concept is that of multidimensional service intensity assessment. Level of care instruments are based on identifying these dimensions, and connect-

ing ratings on each dimension, separately and together, to the identification of patient service intensity requirements. Later talks in the symposium will illustrate how this is currently being done for individuals who present with substance disorders, psychiatric disorders (for adults) and child and adolescent psychiatric disorders.

The final component of this presentation will be the application of the above concepts to the creation of a behaviorally descriptive utilization management manual (CHOICE, CHOICE-DUAL) that has been utilized in a public sector managed care case rate program in a vertically integrated continuum of care with a wide range of available service intensities.

No. 11B
NEW REVISED CRITERIA OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

David Mee-Lee, M.D., *Assistant Clinical Professor of Psychiatry, University of California, Davis, 4228 Boxelder Place, Davis, CA 95616*

SUMMARY:

The original ASAM criteria published in 1991 consisted of admission, continued stay, and discharge criteria and defined four levels of care (separate for adults and adolescents) that reflected two years' work by two task forces of addiction treatment specialists, involving counselors, psychologists, social workers, and physicians. The second edition, published in 1996, greatly expanded the continuum of care to be more responsive to the needs of the public sector. In the newly revised second edition (PPC-2R), the adolescent criteria were revised; criteria for Level I Outpatient were broadened to include individuals in early stages of readiness to change; additions were made to clarify the use of Level III, Residential/Inpatient Levels of Service; and new criteria included for Co-Occurring Mental and Substance-Related Disorders were added. There is also a chapter that provides new directions in the adolescent criteria and in assessing Dimension 5, Relapse/Continued Use Potential.

This presentation will highlight new directions arising from almost 10 years of experience with criteria that are mandated in 20 states; used within the Department of Defense worldwide; and adopted by a national managed behavioral health care company that manages over 20 million lives and another national health maintenance organization.

No. 11C
PLACEMENT CRITERIA: CHALLENGES AND TECHNICAL PROGRESS

David R. Gastfriend, M.D., *Associate Professor of Psychiatry, Harvard Medical School, 15 Parkman Street, Wall-812, Boston, MA 02114;* Sharon Estee, Psy.D.; Amy Rubin, Ph.D.

SUMMARY:

Clinical experience suggests that treatment intensity should match need. One glove should not fit all, particularly the cheapest glove. What is the scientific evidence for this assumption? Patient placement criteria are evolving that are comprehensive, with adequate reliability, feasibility, and resolution. An independent panel of the U.S. Center for Substance Abuse Treatment found sufficient face validity to recommend that states proceed with implementation and evaluation of criteria such as the ASAM criteria. A high degree of concordance of decisions between MCOs and the ASAM criteria has been reported. Support for concurrent validity comes from the ASAM Criteria Validity Study at the Massachusetts General Hospital. Early evidence is also emerging for outcome validity of the ASAM criteria. The Boston Target Cities Project suggested that the central intake model, using a coarse implementation of the ASAM criteria, was associated with improved treatment retention. In a V.A. hospital, naturalistic ASAM matching was associated with less subsequent service utilization than mismatching. Standardization through the use of criteria seems likely to facilitate improved care and efficiency of addictions treatment.

No. 11D
AMERICAN ASSOCIATION OF COMMUNITY PSYCHIATRISTS LEVEL OF CARE UTILIZATION SYSTEM

Wesley E. Sowers, M.D., *Medical Director, Center for Chemical Dependency Treatment, and Chief Corporate Officer, Center for Addiction Services, Department of Psychiatry, St. Francis Medical Center, 400 45th Street, Pittsburgh, PA 15201*

SUMMARY:

This presentation will examine the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) developed by the American Association of Community Psychiatrists. This instrument was developed using principles that would address both quality and resource utilization issues and that would enable the selection of the most appropriate level of care to suit client needs and to maintain the appropriate utilization of resources. These principles are 1) the use of simple, relevant, and dynamic dimensional ratings; 2) integration of psychiatric and addiction criteria; 3) quantifiable criteria to allow interactivity, communicability, and simplification of placement determinations; 4) user friendliness allowing easy understanding and mastery; 5) universality: incorporating flexibility, adaptability, and

balance between provider and payor concerns; 6) flexible multimodal continuum, and 7) ability to be used reliably and with valid results. Early experiences with its use will be presented along with the results of preliminary reliability and validity testing.

No. 11E
CALOCUS: CHILD AND ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM

Theodore J. Fallon, Jr., M.D., M.P.H., *Medical Director, Children's Medical Hospital of Philadelphia, 111 North 49th Street, Philadelphia, PA 19139*

SUMMARY:

This presentation will describe the development of the Child and Adolescent Level of Care Utilization System (CALOCUS). Based on the already existent adult LOCUS, the CALOCUS reflects the efforts of a creative team of community oriented child psychiatrists to attempt to find objective and systems-oriented measures for assessing level of care requirements for children, and for defining the components of a comprehensive service array with multiple types of service intensity. The presentation will illustrate the CALOCUS, describe how to use it and the concepts behind it, and discuss the current status of validity and reliability testing.

REFERENCES:

1. Minkoff K, et al: Utilization Management in Managed MH Care in the Public Sector; A Survival Manual. Edited by Minkoff & Pollack. Harwood Acad. Publishers, Amsterdam, 1997.
2. Minkoff K, Regner J: Innovations in dual diagnosis treatment in managed care: The Choate Dual Diagnosis Case Rate Program, J Psychoactive Drugs Jan-Mar, 1999, pp 1–11.
3. American Society of Addiction Medicine: Patient Placement Criteria 2, ASAM, Wash. D.C., 1995.
4. American Society of Addiction Medicine: Patient Placement Criteria 2R, (Field Review Draft), 1999.
5. Gastfriend D: Patient placement criteria in, Galanter M, Kleber HD, eds. Textbook of Substance Abuse Treatment, second ed. Washington, American Psychiatric Press; pp. 121–127, 1999.
6. Amer. Assn of Community Psychiatrists, Level of Care Utilization System (LOCUS), version 2.0, 1998.
7. AACP/AACAP-Child & Adolescent Level of Care Utilization System, 1999.

Symposium 12 **Friday, October 27**
2:00 p.m.-5:00 p.m.

PSYCHIATRIC PATIENT EDUCATION: DIRECTIONS IN RESEARCH AND PRACTICE

Therapeutic Education Association

Cynthia C. Bisbee, Ph.D., *Clinical Director, Montgomery Area Mental Health Authority, 101 Coliseum Boulevard, Box 3223, Montgomery, AL 36109*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to summarize the findings of research on efficacy of psychiatric patient education, be familiar with two models of consumer education, identify gaps in provider knowledge about educational topics, and identify directions for the field of psychiatric patient education.

SUMMARY:

Programming in psychiatric patient education—also called consumer education, psychoeducation, or mental illness education—has been expanding at a rapid pace in recent years. Tremendous creativity is in evidence in the richness and variety of these programs. On the other hand, research regarding the efficacy of these programs has been limited in a number of ways—research design, programs evaluated, and methodology—and findings on efficacy have been equivocal. Many of the outcomes touted by the particular programs have not been supported by results of rigorous research. Yet, education continues for reasons that may not be related to the outcome research findings. This symposium reviews the status of the efficacy research on education about schizophrenia, giving comparisons of study design and findings. It then presents two very different models of consumer education. Data on the knowledge base of educators are from a variety of settings. Finally a summary and overview provides some possible directions that the field of psychiatric patient education might take. This symposium's target audience includes consumers, families, and providers of psychiatric patient/consumer education, and anyone who is interested in research and practice issues in the field. No background is specifically required, although the symposium will be most beneficial to those who have some familiarity with techniques of psychiatric patient education, psychoeducation, or consumer education about mental illness.

No. 12A
BENEFITS OF PATIENT EDUCATION ABOUT SCHIZOPHRENIA: EMPIRICAL FINDINGS

Haya Ascher-Svanum, Ph.D., *Department of Psychiatry, Roudebush VA Medical Center, 1481 West 10th Street, Indianapolis, IN 46202*

SUMMARY:

Educating patients about their illness self-management has become a prevalent therapeutic modality. Despite extensive use of such interventions, particularly for individuals diagnosed with schizophrenia, relatively little empirical knowledge is available about its efficacy. This presentation will review and evaluate claimed benefits of patient psychoeducation about schizophrenia. It will focus on data published in controlled outcome studies, assessing the benefits of patient education, as related to the following clinical variables: relapse rate adherence to medication regimen severity of positive and negative symptoms length of participation in aftercare programs level of functioning in the community knowledge about the illness and its management insight into illness, attitudes toward medication intake and satisfaction with the education program. Practice implications of current data will be offered, along with suggestions for future outcome studies. The goals of this presentation are to provide participants with the opportunity to critically appraise the effectiveness of patient education, become familiar with specific clinical outcome measures, and identify patient characteristics, which are linked to educational gains.

No. 12B
PEBBLES IN THE POND: CONSUMER, FAMILY AND PROVIDER EDUCATION

Larry S. Baker, M.Div., *Director of Training, Comprehensive Mental Health Partnership, 1201 South Proctor Street, Tacoma, WA 98405;* Karen A. Landwehr, M.C.

SUMMARY:

Participation in simultaneous psychoeducation has previously been associated with an 86% decrease in hospitalization days. *Pebbles in the Pond: Living with Chronic Neurobiological Disorders* is an interdisciplinary program that combines the simultaneous approach with shared praxis methodology and incorporates information from the fields of general medicine, psychiatry, and social science. This innovative approach to psychoeducation brings together consumers of mental health services, their families, and service providers for a 12-week educational experience. Each class member is both teacher and learner. Topics covered include brain anatomy and physiology, DSM-IV diagnostic criteria for major mental illness categories, current treatment practices, relapse prevention, and the role of anxiety in exacerbating symptoms. Outcomes to be presented are: 1) the potential for reducing rate of return to inpatient settings by as much as 80%, and 2) the role psychoeducation plays in bridging medication services and clinical case management in community mental health settings. Recent research on service use patterns will be presented. The *Pebbles in the Pond* program has been offered at Comprehensive Mental Health in Tacoma, Washington and at nearby Western State Hospital since 1996. There is no charge for the three-hour classes or the 350-page workbook provided to class participants.

No. 12C
NATIONAL ALLIANCE FOR THE MENTALLY ILL CONSUMER EDUCATION PROGRAMS

Maggie Scheie-Lurie, B.A., *Consumer Outreach Coordinator, National Alliance for the Mentally Ill, 2107 Wilson Boulevard, Suite 300, Arlington, VA 22201-3042;* Lainie Demelle, B.A.

SUMMARY:

This presentation will address NAMI's three consumer education and support programs: Living with Schizophrenia and Other Mental Illnesses, NAMI CARE, and a new peer-to-peer education course.

Living with Schizophrenia and Other Mental Illnesses is a recovery-education program presented by trained consumer presenters/facilitators to other consumers. This multimedia, interactive program educates consumers about realistic coping strategies and living fulfilling, satisfying lives with meaning and dignity. It features a video of four consumers sharing their experiences in six areas central to recovery: Dark Days, Acceptance, Medications, Coping, Success, and Hopes and Dreams. The consumer presenter briefly relates his or her personal experience with the topics raised in the video, then opens a discussion on these topics with the audience.

NAMI CARH helps consumers start peer support groups associated with local NAMI affiliates through written materials, technical assistance, and facilitator training programs. The peer-to-peer program will consist of a nine-week consumer education curriculum offering a unique experiential learning experience laught by trained consumer educators.

Results: Those attending this presentation will be able to identify and distinguish between the diverse consumer-run education programs offered by NAMI and know steps to take to promote establishment of these programs in one's local area.

No. 12D
ARE WE KNOWLEDGEABLE ENOUGH TO BE EFFECTIVE EDUCATORS?

Patricia L. Scheifler, M.S.W., *Director, Partnership for Recovery, P.O. Box 55053, Birmingham, AL 35255*

SUMMARY:

The field of psychiatry has recently experienced many major breakthroughs in the treatment of severe and persistent mental illnesses. As new treatments have emerged, it has become increasingly important for patient educators and nonphysician clinicians to keep up with pharmacological advances. Educators and clinicians need to acquire a solid working knowledge of medications, symptoms, and side effects to effectively fulfill three important functions: (1) educate patients and families, (2) identify and report problems that may indicate a need for medication changes, and (3) competently participate in treatment decisions. This presentation will identify knowledge about antipsychotic medication that educators and nonphysician clinicians need to master, give examples of common knowledge deficits, and present pre and post knowledge assessment data. Data indicate that a majority of nonphysician staff lacked the knowledge necessary to fulfill these important functions effectively but made substantial improvement at the conclusion of an intensive training session.

No. 12E
DIRECTIONS FOR THE FIELD OF PATIENT EDUCATION

Cynthia C. Bisbee, Ph.D., *Clinical Director, Montgomery Area Mental Health Authority, 101 Coliseum Boulevard, Box 3223, Montgomery, AL 36109*

SUMMARY:

The field of psychiatric patient education/consumer education is expanding rapidly, with new programs being developed every day. The outcome research on these interventions is equivocal and has limitations as to design and methodology. This symposium has presented an overview of the efficacy research, two distinct models of consumer education, and a method for assessing knowledge of educational material for teaching. Although the field is in flux, there are a number of directions it could take in both aspects of research and practice. This presentation will outline some of these possible directions and attempt to synthesize the current status of the research and the continued growth of educational programming.

REFERENCES:

1. Ascher-Svanum H, Whitesel J: A randomized controlled study of two styles of group patient education. Psychiatric Services 1999; 50:926–930.
2. Merinder LB, Viuff AG, Laugesen HD, et al: Patient and relative education in community psychiatry: a randomized controlled trial regarding its effectiveness. Social Psychiatry Psychiatric Epidemiology 1999; 34:287–294.
3. Hatfield A, Lefley HP: Surviving Mental Illness: Stress, Coping and Adaptation. Guilford, 1993.
4. Boyd MA, Nihart MA: Psychiatric Nursing: Contemporary Practice. Lippincott, 1998.
5. Zinman S: Taking issue: self-help: the wave of the future. Hospital and Community Psychiatry 1986; 37:213.
6. Weiden P, Scheifler P, Diamond R, Ross R: Breakthroughs in Antipsychotic Medications. WW Norton and Company, 1999.
7. Bisbee C: Educating Patients and Families About Mental Illness: A Practical Guide. Birmingham, AL, Partnership for Recovery, 1991, 1995.

Symposium 13 **Friday, October 27**
2:00 p.m.-5:00 p.m.

WHAT'S REALLY GOING ON IN PSYCHIATRY TODAY? UPDATE FROM THE AMERICAN PSYCHIATRIC INSTITUTE FOR RESEARCH AND EDUCATION PRACTICE RESEARCH NETWORK

John S. McIntyre, M.D., *Chair, Department of Psychiatry and Behavioral Health, Unity Health System, and Past President, American Psychiatric Association, 81 Lake Avenue, 3rd Floor, Rochester, NY 14608*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants should be able to become acquainted with the research aims and methods of the APIRE's Practice Research Network; to learn about the major trends in psychiatric practice and better understand clinical care patterns including the impact of managed care on clinical practice.

SUMMARY:

This symposium will review findings from the American Psychiatric Institute for Research and Education Practice Research Network (PRN), a practice-based research initiative that aims to gather information on what's happening in the "real world" of psychiatry. The PRN consists of APA members who have either been randomly recruited to participate or who have contacted the PRN voluntarily. PRN members (n=800) work

in the full range of practice settings (e.g., public hospitals, private practice, correctional facilities) and treat patients of all ages with diverse psychiatric profiles. This symposium will present data from PRN core studies. The *National Survey of Psychiatric Practice* (NSPP), a biennial survey of a large random sample of APA members, collects nationally representative data on psychiatrists' professional activities, work settings, and patient caseloads. The *Study of Psychiatric Patients and Treatments* (SPPT) surveys PRN members, collecting detailed clinical, diagnostic and treatment data on randomly assigned and systematically selected patients. In addition, it provides information about the treatment setting and system of care, including health plan characteristics, in which the patients are treated. This symposium is targeted toward clinicians interested in practice-based research and mental health policy issues, policy makers and mental health services researchers.

No. 13A
TEN-YEAR TRENDS IN PSYCHIATRIC PRACTICE: COMPARISONS BETWEEN THE 1998 NATIONAL SURVEY OF PSYCHIATRIC PRACTICE AND THE 1988–1989 PROFESSIONAL ACTIVITIES SURVEY

Ana P. Suárez, M.P.H., *Research Associate, Practice Research Network, American Institute for Research and Education, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005;* Steven C. Marcus, Ph.D.; Max Sederer, B.A.

SUMMARY:

Recent changes in mental health policy and treatment advances are believed to have had a great impact on the practice of psychiatry in the United States. The 1988-89 Professional Activities Survey (PAS) and 1998 National Survey of Psychiatric Practice (NSPP) are self-administered mailed surveys conducted by APA among its members (the 1988-89 PAS also included non-APA members) that provide information to help assess how psychiatric practice has changed over the past 10 years. Both surveys asked psychiatrists to report information about their professional activities, work settings, and practice financial arrangements, as well as aggregate information about their patient caseload. For this analysis, weighted responses to the 1998 NSPP (N=976) and the 1988-89 PAS (N=19,431) from active psychiatrists are compared using standard statistical testing techniques. Preliminary analyses using published 1988–89 PAS findings showed that while psychiatrists today continue to work, on average, the same number of hours per week, they are seeing more patients and spending less time with those patients. Furthermore, psychiatrists today report spending, on average, a higher proportion of their time in administrative activities and a lower proportion of their time in direct patient care than did psychiatrists 10 years ago. The clinical implications of these findings will be discussed.

No. 13B
HEALTH PLAN CHARACTERISTICS AND PSYCHIATRIC TREATMENT VARIATIONS

Joyce C. West, Ph.D., M.P.P., *Director, American Psychiatric Practice Research Network, 1400 K Street, N.W., Washington, DC 20005;* Deborah A. Zarin, M.D.; Harold Alan Pincus, M.D.

SUMMARY:

Objective: To assess whether different health plan organizational, procedural, and financial arrangements are associated with the type, intensity, and duration of psychiatric treatments.

Methods: Nationally representative (weighted) data on 1,228 psychiatric patients from the 1997 Study of Psychiatric Patients and Treatments were used. The study examined whether health plan type, payment source, psychiatrist reimbursement mechanism, utilization management techniques, and financial considerations were associated with: 1) receipt of medications alone without psychotherapy; 2) number of medications prescribed; 3) visit length; 4) number of patient visits; and 5) length of treatment. Logistic and general linear regression techniques, controlling for patient case mix, were used.

Results: Variations in psychiatric treatment patterns were observed to be associated with health plan characteristics even after adjusting for patient case mix. After adjusting for both patient case mix and payment source, the data showed that: 1) patients in full-service HMOs and PPOs were more likely to have shorter visit lengths and fewer visits than patients in non-managed, privately insured plans; 2) self-pay patients had longer visit lengths, greater number of visits, and longer lengths of treatment than patients with private insurance; and 3) patients treated by salaried psychiatrists were more likely to receive medications alone than those treated by undiscounted fee-for-service psychiatrists.

Conclusions: These findings highlight the importance of using multidimensional measures of health plans and sufficiently detailed clinical data to risk adjust analyses of treatment pattern variations and health plan features.

No. 13C
CHARACTERISTICS OF PSYCHIATRIC PATIENTS FOR WHOM FINANCIAL CONSIDERATIONS AFFECT THE PROVISION OF TREATMENTS

Joyce C. West, Ph.D., M.P.P., *Director, American Psychiatric Practice Research Network, 1400 K Street, N.W., Washington, DC 20005;* Farifteh F. Duffy, Ph.D., M.H.S.

SUMMARY:

Objective: To describe the characteristics of a large, nationally representative sample of psychiatric patients for whom financial or resource considerations affected the provision of "optimal" treatments as perceived by the patient's treating psychiatrist.

Methods: Nationally representative (weighted) data on 1,228 psychiatric patients from the 1997 Study of Psychiatric Patients and Treatments were used. Multivariate logistic regression analyses assessed which patient, setting, health plan, and psychiatrist factors were most strongly associated with financial considerations (such as managed care limitations, patient's resources, or limitations of a public system) adversely affecting the provision of "optimal" treatments as defined by the psychiatrist.

Results: For one-third of the patients, their psychiatrists reported that financial considerations had adversely affected the provision of "optimal" treatments. These patients were more likely to be severely ill, have a comorbid mental condition; have a psychosocial problem, have a substance use or dependence or personality disorder, and receive treatment through a managed care plan or plan with managed care financial or utilization management techniques. Taking into account the psychiatrist's demographic and practice characteristics (including age, case load size, and payer/managed care mix) did not change these findings.

Conclusions: For a significant proportion of psychiatric patients, their psychiatrist may be providing less optimal treatment due to financial constraints. These patients are more severely ill, clinically complex, and medically needy, a population for whom access to effective treatments may be particularly important.

No. 13D
VARIATION IN PSYCHIATRIC CONDITIONS, HEALTH CARE COVERAGE AND TREATMENT BY PATIENTS' RACE-ETHNICITY

Wendy L. Colquitt, Ph.D., Practice *Research Network, American Psychiatric Institute for Research and Education, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005;* Diane Herbeck, M.A.

SUMMARY:

Objective: Members of racial-ethnic minorities experience more limited access to health care in the U.S. in a variety of ways. This research explores such issues in the mental health arena by examining variation in psychiatric conditions observed in racial-ethnic minority and nonminority patients, comparing patients' background characteristics, health plans, diagnoses, severity and complexity of conditions, and treatments received.

Methods: Bivariate and multivariate analyses were conducted on detailed patient-level data collected from a nationally representative sample of 1,844 psychiatric patients. Patient and treatment information was gathered from a biennial survey of psychiatrists participating in the Practice Research Network (PRN) of the American Psychiatric Institute for Research and Education. Data from this survey, the 1999 Study of Psychiatric Patients and Treatments, were analyzed to explore the extent to which patients from different racial-ethnic backgrounds experience mental health care differently.

Results: Significant variations in type of health care coverage, diagnoses, and certain features of treatment settings, services, and medications were found.

Conclusions: Study results point to the need for policy makers to carefully assess access and quality of care among different racial-ethnic patient groups.

REFERENCES:

1. Dorwart RA, Chartock LR, Dial T, et al: A national study of psychiatrists' professional activities. American Journal of Psychiatry 1992; 149:1499–1505.
2. Zarin DA, Peterson BD, West JC, et al: Characterizing psychiatry: findings from the 1996 National Survey of Psychiatric Practice. American Journal of Psychiatry 1998; 155:397–404.
3. Wells KB, Astrachan BM, Tischler GL, Unutzer J: Issues and approaches in evaluating managed mental health care. Milbank Q. 1995; 73:57-75.
4. Zarin DA, West JC, Pincus HA, Tanielian TL: Characteristics of health plans that treat psychiatric patients. Health Aff (Millwood.) 1999; 18:226-236.
5. Jensen GA, Morrisey MA, Gaffney S, Liston DK: The new dominance of managed care: insurance trends in the 1990s. Health Affairs 1997; 16:125-136.
6. NIMH National Advisory Mental Health Council: Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access & Quality. An Interim Report to Congress by the National Advisory Mental Health Council. U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health, 1998.

7. Gallo JJ, Marino S, Ford D, Anthony JC: Filters on the pathway to mental health care, II. Sociodemographic factors. Psychol Med 1995; 25:1149-60.
8. Baker FM, Bell CC: Issues in the psychiatric treatment of African Americans. Psychiatr Serv 1999; 50:362-8.

Symposium 14 **Saturday, October 28 8:30 a.m.-11:30 a.m.**

PSYCHOSOCIAL REHABILITATION ADVANCES FOR THE SEVERELY AND PERSISTENTLY MENTALLY

Troy L. Thompson II, M.D., *Consultant, APA Institute Scientific Program Committee, and Professor of Psychiatry, Jefferson Medical College, 841 Chestnut Street, Suite 1001, Philadelphia, PA 19107-5005*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to learn about recent advances in psychosocial rehabilitation and the negative impact that public sector managed care has had on those, its role in psychiatric care in several settings, the components of an Ohio recovery program, and key aspects of an APA committee report on this topic.

SUMMARY:

Recognizing the need to better integrate important findings from the rapidly advancing field of psychosocial rehabilitation of the severely and persistently mentally ill (SPMI) into other clinical, educational, research, and administrative aspects of psychiatry, Rodrigo A. Muñoz, M.D., (APA President, 1998–99) appointed an advisory committee to serve during his presidency to make recommendations to him and others in APA in this regard. The committee members were from a wide diversity of clinical practice settings (private practice, state hospital, academic etc.) and geographic locations. A report was generated by that committee with a primary goal of passing on this information to ongoing committees and other components of APA with the ultimate goal being to better educate and support psychiatrists to help provide this important aspect of treatment of the SPMI. This symposium will include presentations on several key areas by several committee members and review the committee report. The field of psychosocial rehabilitation has burgeoned in the past 25 years, and a number of models, philosophies and programs of recovery have been developed for the rehabilitation of SPMI patients with disabilities. Health services research is progressively documenting the effectiveness of psychosocial rehabilitation in the care and recovery of these patients. Many psychiatrists and are not well informed about these developments. Therefore, it is timely to consider how the APA could institute and renew efforts to better understand psychosocial rehabilitation and to make information about successful programs more accessible to its membership to help psychiatrists advance the vital interests of the most vulnerable patients we serve.

No. 14A
THE IMPACT OF PUBLIC SECTOR MANAGED CARE ON PSYCHOSOCIAL REHABILITATION

Clifton R. Tennison, Jr., M.D., *Chief Clinical Officer, Helen Ross McNabb Center, Clinical Assistant Professor of Medicine, University of Tennessee Medical Center, and Clinical Professor of Psychiatry, East Tennessee State University School of Medicine, 1520 Cherokee Trail, Knoxville, TN 37920*

SUMMARY:

The proliferation of restrictive, underfunded, and poorly managed public sector managed care schemes over the past five years threatens our capacity to offer psychotherapy, prevention, and rehabilitation programs. An example of a poorly planned system, TennCare Partners, the mental health carveout for Tennessee's Medicaid waiver initiative, has by design or mismanagement destroyed most of the psychosocial efforts in the state. Falling below one's own standard of care and watching the deterioration of rehabilitative programming, interagency collaborations, and the essential safety net are not only demoralizing but also dangerous, resulting in increased recidivism, homelessness, incarceration, crisis, suicide, and homicide. These sentinel events are far outpaced by the numbers of patients who would have achieved varying levels of improved family, social, occupational, and self-care functioning had the programs not been cut. Aggressive and creative diversification is required in order to obtain non-Medicaid funding to creative necessary wraparound services for severe, persistently mentally ill adults and seriously emotionally disordered children and adolescents. Such programs may include forensic and adult corrections services, independent drop-in centers and vocational skills development programs, school and juvenile court based programs, primary prevention and primary care interface programs, enhanced collaborations with alcohol and drug treatment programs, and closer affiliations with training programs.

No. 14B
BOTH TREATMENT AND REHABILITATION FOR THE SEVERELY AND PERSISTENTLY MENTALLY ILL

Selby C. Jacobs, M.D., *Department of Psychiatry, Yale University, 34 Park Street, Room 168, New Haven, CT 06519;* Jeanne L. Steiner, D.O.

SUMMARY:

Psychosocial rehabilitation has grown enormously since the 1970s. Psychiatrists have made essential contributions to this growth, yet a gulf exists between the treatment models of psychiatrists and the recovery models of psychosocial rehabilitation specialists. With growing evidence for the effectiveness of rehabilitative interventions in the face of potential neglect of rehabilitative tasks for seriously ill persons under managed care, it is timely to reconsider the role of psychosocial rehabilitation in psychiatric care. Revisiting this question provides a renewed opportunity to narrow the gap between the two arenas of treatment for symptoms and rehabilitation for disabilities. This presentation considers the evidence for rehabilitative interventions, the complementary relationship of rehabilitation to treatment, the need and strategies for integration, and roles for psychiatrists and other professionals in comprehensive care of the seriously ill. Psychiatrist roles might include education for themselves and others about psychosocial rehabilitation, incorporation of rehabilitation into comprehensive plans of care, services research on the efficacy of rehabilitative interventions, advocacy for psychosocial rehabilitation to purchasers and care managers, and alliances with rehabilitation colleagues for these purposes. We illustrate with examples from an urban community mental health center and its affiliated, community-based rehabilitation agencies serving disadvantaged persons with serious illness and disabilities.

No. 14C
PSYCHOSOCIAL REHABILITATION: EMERGING BEST PRACTICES IN RECOVERY

Dale P. Svendsen, M.D., *Medical Director, Ohio Department of Mental Health, 30 East Broad Street, 8th Floor, Columbus, OH 43215–3414*

SUMMARY:

Recovery is a consumer-led personal process of overcoming the negative impact of a psychiatric disability despite its continued presence. It is based on the philosophy that people with severe mental illness live in community and participate in a lifestyle of their choice. Consumers, families, clinicians, and administrators in Ohio identified nine essential components needed in order for a community to provide effective services and support. These are: (1) clinical care, (2) family support, (3) peer support and relationships, (4) work/meaningful activity, (5) power and control, (6) stigma, (7) community involvement, (8) access to resources, and (9) education.

Stakeholder workgroups also identified developmental steps in the recovery process. These steps are dependent/unaware, independent/unaware, independent/aware, and interdependent/aware. These emerging best practices in recovery guide clinicians, families, consumers, and the system of care. We will share the guidelines using examples from hospitals and the community.

No. 14D
THE APA PSYCHOSOCIAL REHABILITATION COMMITTEE REPORT

Troy L. Thompson II, M.D., *Consultant, APA Institute Scientific Program Committee, and Professor of Psychiatry, Jefferson Medical College, 841 Chestnut Street, Suite 1001, Philadelphia, PA 19107-5005*

SUMMARY:

As chair of the APA Psychosocial Rehabilitation Committee, I will review key aspects of that group's report, including six principles that should guide the future development of psychosocial rehabilitation. The committee also made recommendations related to light issues at the interfaces of psychosocial rehabilitation and psychiatry care. The rationale and obstacles to implementation (and possible solutions) and key references for each issue will be discussed. The recommendations focus on:

1) improving the relationships of psychiatry to others who work in psychosocial rehabilitation, 2) psychiatry's support of psychosocial rehabilitation technologies proven to be efficacious, 3) how clinical psychiatrists can further utilize psychosocial rehabilitation most effectively, 4) improving the awareness/knowledge of psychiatric administrators about psychosocial rehabilitation, 5) how academic psychiatry programs might best address education about rehabilitation, 6) enhancing psychosocial rehabilitation's acceptance and roles in managed care environments, 7) incorporating psychosocial rehabilitation on public and private psychiatry inpatient units, 8) treatment guidelines on appropriate utilization of psychosocial rehabilitation in patient care in multiple clinical settings.

REFERENCES:

1. Geller J: When less is more; when less is less. Psychiatric Services, November 1995.
2. Bachrach LL: Psychosocial rehabilitation and psychiatry in the care of long-term patients. American Journal of Psychiatry 1992; 149:1455–1463.
3. Canaan RA: Blankertz L, et al: Psychosocial rehabilitation: toward a definition. Psychosocial Rehabilitation Journal 1988; V. 4.
4. Bachrach L: Psychosocial rehabilitation and psychiatry: what are the boundaries? Can J Psychiatry 1996; 41:28–35.

Symposium 15 **Saturday, October 28**
8:30 a.m.-11:30 a.m.

PSYCHIATRY AND THE PHARMACEUTICAL INDUSTRY: WHERE IS THE BOUNDARY?

Amy C. Brodkey, M.D., *Clinical Associate Professor of Psychiatry, University of Pennsylvania, 4641 Roosevelt Boulevard, Philadelphia, PA 19124*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to appreciate the effectiveness of the pharmaceutical industry in shaping psychiatric education and practice and to discuss some responses to this influence.

SUMMARY:

The 1990s have witnessed profound changes in every aspect of the relationships between the psychiatric profession and the pharmaceutical industry. This symposium will begin with an examination of the current status of the industry and a review of the literature demonstrating the influence of drug companies on physician prescribing practices through advertising, detailing, gifting, and continuing medical education. We will discuss the ethical problems inherent in this relationship and the public's perceptions of these activities. We will then investigate the interconnection between the pharmaceutical industry and academia, with special emphasis on undergraduate and graduate medical education, and discuss guidelines for trainee education and interactions with pharmaceutical representatives. Issues of relevance to public sector psychiatry, such as choice of agents in light of their cost, use of generics, sampling and patient assistance programs, and relationships to pharmacies, will then be reviewed. Finally, a psychiatrist who is a frequent industry-sponsored lecturer will give an inside view of the dilemmas faced by such speakers and will discuss her methods of attempting to achieve balance between the demands of sponsors and those of educational objectivity. These multiple interactions illustrate the contributions of the pharmaceutical industry in the profound reshaping of the domain of psychiatry as we approach the 21st century.

No. 15A
PHARMACEUTICAL PROMOTION: THERE IS NO FREE LUNCH

Amy C. Brodkey, M.D., *Clinical Associate Professor of Psychiatry, University of Pennsylvania, 4641 Roosevelt Boulevard, Philadelphia, PA 19124*

SUMMARY:

The pharmaceutical industry is now the most profitable business in the United States; 1999 sales are expected to reach over $120 billion for U.S. "ethical" (brand name) drug companies alone. A conservative estimate of $10–15 billion, more than $10,000 per doctor per year, is spent on detailing, gifts, speakers, journals, and other forms of advertising, and this figure continues to rise at an exponential rate. There is a substantial literature demonstrating that despite many physicians' protestations to the contrary, their opinions and prescribing practices are affected by such promotion. In addition, a number of studies demonstrate the bias and inaccuracy of industry-sponsored advertising, detailing, promotional materials, continuing medical education seminars, published symposia, and sponsored research. The ethical problems inherent in accepting gifts from drug companies, and the public's negative perceptions of this relationship, will be reviewed. Over-reliance on readily available industry funding has limited the development of alternative sources of education, and the increasing encroachment of drug company sponsorship of psychiatric education has had the additional impact of redefining the scope of our profession. We need to establish a firm barrier between commercial and professional aspects of psychiatry to safeguard the profession and our patients.

No. 15B
MEDICAL STUDENTS, RESIDENTS AND DRUG COMPANY PROMOTIONS

Frederick S. Sierles, M.D., *Professor, Chair and Residency Director, Department of Psychiatry, Chicago Medical School, 3333 Green Bay Road, North Chicago, IL 60064*

SUMMARY:

Trainees are a prime audience for drug company (DC) marketing. Extensive advertising to trainees, often unrestricted, takes many forms (e.g., pens, lunches, and trips). A large literature exists on the extent and influence of DC promotions to MDs and students. Multiple organizations have guidelines—focusing on attending MDs and CME programs—for MD interaction with DCs. The literature documents trainee cynicism about DC promotions and trainee desire for education about dealing with DC representatives.

It also shows—as is the case for attending MDs—widespread perception by trainees that they are "objective" and, hence, immune to the influence of promotions on their prescribing practices, despite strong evidence to the contrary. It demonstrates that modest educational intervention (e.g., one class on the topic) and program policies can influence trainee attitudes. Consequently,

we will propose guidelines for teaching trainees about, and setting program standards for, DC promotions.

No. 15C
THE PHARMACEUTICAL INDUSTRY AND PUBLIC PSYCHIATRY

Robert M. Factor, M.D., Ph.D., *Medical Director, Emergency Services, Mental Health Center of Dane County, 625 West Washington, Madison, WI 53703*

SUMMARY:

Over the past 10 years, there has been a dramatic change in the medications used to treat persons with serious and persistent mental illness. New generation antipsychotic and antidepressant drugs have replaced many older medications. Antiepileptic drugs are being used with greater frequency as mood stabilizers. Newer benzodiazepines have replaced older ones. In many of these cases, the newer drugs offer the promise of greater efficacy and fewer side effects. These newer drugs are also significantly more expensive than the drugs that they have replaced. Almost all of them are on patent. With these increased medication options, there is a greater need for information about how to choose them, how to prescribe them, and how they may interact. This information is available from a variety of sources, some from sources obviously related to industry, and others apparently not. These facts raise particular questions for practitioners in the public sector. How do we choose drugs when the costs are being paid by public funds? When do we prescribe a generic drug? What use do we make of educational and other materials offered by the pharmaceutical industry? Upon what sources of information can we rely? How do we relate to industry representatives and make use of samples and patient assistance programs? How do we relate to pharmacies? I will discuss these questions using national data and local case examples.

No. 15D
INDUSTRY-SUPPORTED MEDICAL EDUCATION: WHEN EDUCATORS SERVE TWO MASTERS

Diana M. Koziupa, M.D., *Staff Psychiatrist, Penn Foundation, 807 Lawn Avenue, Sellersville, PA 18960*

SUMMARY:

Industry-sponsored educational activities have an enormous influence on the prescribing practices of physicians. This presentation discusses the issues that industry-sponsored speakers face when providing educational experiences for clinicians, both for CME credit, and not for credit. A large number of noncredit educational activities are funded by the pharmaceutical industry, ranging from lectures to roundtable discussions, on subjects directly or indirectly related to their products.

This presentation will address some dilemmas that speakers face when providing these educational experiences, including the overt and covert influence of the sponsors to promote their specific product. Highlighted will be ways that speakers can ensure that they provide balanced, objective educational experiences, including appropriate discussion of positive and negative research, off-label or investigational usage, as well as discussion of other pharmaceutical products.

REFERENCES:

1. Chren MM, Landefeld CS: Physicians' behavior and their interactions with drug companies. JAMA 1994; 271:684–9.
2. Avorn J, Chen M, Hartley R: Scientific versus commercial sources of influence on the prescribing behavior of physicians. Am J Med 1982; 73:4–8.
3. Vinson DC, McCandless B, Hosokawa MC: Medical students' attitudes towards pharmaceutical marketing: possibilities for change. Fam Med 1993; 25:31–33.
4. Spingarn RW, Berlin JA, Strom BL: When pharmaceutical manufacturers' employees present grand rounds, what do residents remember? Acad Med 1996; 71:86–88.
5. Griffith D: Reasons for not seeing drug representatives. BMJ 1999; 319:69–70.
6. Lexchin J: Interactions between physicians and the pharmaceutical industry: what does the literature say? CMAJ 1993; 149:1391–1392.
7. Bowman MA, Pearle DL: Changes in drug prescribing patterns related to commercial company funding of continuing medical education. J Contin Educ Health Prof 1988; 8:13–20.

Presidential Symposium 16 — **Saturday, October 28 2:00 p.m.-5:00 p.m.**

HOW TO MAKE DYNAMIC PSYCHOTHERAPY WORK

American Academy of Psychoanalysis

Sheila Hafter Gray, M.D., *President, American Academy of Psychoanalysis, P.O. Box 40612, Palisades Station, Washington, DC 20016-0612*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the application of dynamic

psychotherapy in diverse settings and with differing patient populations.

SUMMARY:

This symposium will include papers describing the application of psychodynamic psychotherapy in diverse settings, including private practice under managed care review and in a community-based setting with a homeless population, and with patients whose need for medication (e.g., for control of bipolar disorder) or whose self-destructiveness may have been thought to preclude a dynamic psychotherapeutic approach. These discussions may be of use to a range of psychiatrists and mental health practitioners working in diverse settings who may want to incorporate a dynamic approach to their own patients.

No. 16A
PSYCHOTHERAPY WITH A BIPOLAR PATIENT

Jack Drescher, M.D., *Supervising Psychoanalyst, William Alanson White Institute, and Clinical Assistant Professor of Psychiatry, State University of New York, Brooklyn, New York, 420 West 23rd Street, Apt. #7-D, New York, NY 10011-2174*

SUMMARY:

There are patients whose psychiatric conditions do not easily permit them to engage in traditional psychotherapies based on the premise that verbalization is the major source of psychological change and growth. These patients often require much more room to move and other ways to express themselves than traditional therapy models based on verbal communication will allow. Drawing upon Winnicott's innovative work on the developmental importance of play, this paper describes the treatment of a woman patient with bipolar disorder who would not be considered suitable for traditional psychotherapy. The paper illustrates the patient's use of the therapeutic session as a play space. The impact of this patient on a therapist's countertransference is also discussed. This paper also raises several questions about what is curative about psychotherapy.

No. 16B
DYNAMIC PSYCHOTHERAPY AND THE HOMELESS

Joseph P. Merlino, M.D., *Clinical Professor of Psychiatry, New York University School of Medicine, and Department of Community Medicine, Saint Vincent's Hospital and Medical Center, 205 East 78th Street, #17-J, New York, NY 10021*

SUMMARY:

As a psychiatrist trained as a psychoanalyst and in the private practice of dynamic psychotherapy, the author describes some of the experiences he has had in applying these techniques with this clinically challenging population.

An historical overview of public psychiatry is included to frame the current problems and challenges facing the mental health community working with this population.

No. 16C
THE ALLIANCE IN PSYCHOTHERAPY WITH SELF-DESTRUCTIVE BORDERLINE PATIENTS

Eric M. Plakun, M.D., *Director of Program Development and Admissions, Austin Riggs Center, P.O. Box 962, 25 Main Street, Stockbridge, MA 01262*

SUMMARY:

Self-destructive borderline patients pose a formidable treatment challenge because of their rage, primitive defenses, and substantial risk of suicide. Comorbidity with other disorders, such as mood disorders, increases the likelihood of treatment failure and suicide. Psychodynamic psychotherapy is the classical therapeutic approach to self-destructive borderline patients. Theory and clinical experience suggest the primary mechanism of therapeutic change in work with these patients is interpretation of the meaning of behavior within the evolving transference-countertransference matrix. However, establishing and maintaining a viable therapeutic alliance is a problem-prone and essential precondition for the interpretive work to proceed. This paper offers eight principles helpful in establishing and maintaining a therapeutic alliance in the psychodynamic psychotherapy of self-destructive borderline patients. The principles are: (1) differentiation of lethal from nonlethal self-destructive behavior; (2) inclusion of lethal self-destructive behavior in the initial therapeutic contract; (3) metabolism of the countertransference; (4) engagement of affect; (5) nonpunitive interpretation of the patient's aggression; (6) assignment of responsibility for the preservation of the treatment to the patient; (7) a search for the perceived injury from the therapist that may have precipitated the self-destructive behavior; and (8) provision of an opportunity for reparation. Case material will be offered to illustrate application of the principles.

No. 16D
MANAGED CARE AND PSYCHODYNAMIC PSYCHOTHERAPY

Mariam C. Cohen, M.D., *Faculty, Institute of Behavioral Medicine, Good Samaritan Regional Medical Center, 4810 East Andora Drive, Scottsdale, AZ 85254-3514*

SUMMARY:

The author explores the difficulties encountered in working in the practice of psychodynamic psychiatry in a private setting when many patients must fund their care through insurance and managed care review. Unconscious factors in the interaction between the psychodynamically oriented psychiatrist and the managed care reviewer are discussed. Examples are provided of the ways this interaction can be integrated into the psychotherapeutic relationship and ways in which obstacles to providing intensive psychotherapy can be overcome.

REFERENCES:

1. Winnicott DW: Playing and Reality. New York, Routledge, 1971.
2. Drescher J: Psychotherapy, medication and belief. Issues in Psychoanal Psychol 17:7–28.
3. Health Care of Homeless People. Edited by Brickner PW. New York, Springer Publishing Company, 1985.
4. Under the Safety Net. Edited by Brickner PW. New York, W.W. Norton & Company, 1990.
5. The Goals of Medicine. Edited by Hanson MJ, Callahan D. Washington, Georgetown University Press, 1999.
6. Plakun EM: Prediction of outcome in borderline personality disorder. Journal of Personality Disorders 1991; 5:93–101.
7. Plakun EM: Principles in the psychotherapy of self-destructive borderline patients. Journal of Psychotherapy Practice and Research 1994; 3:138–148.
8. Cohen M: Managed care and the unconscious. The Academy Forum 1996; 40:11–13.

Symposium 17 **Saturday, October 28**
2:00 p.m.-5:00 p.m.

MUSIC THERAPY: INTEGRATIVE MEDICINE FOR THE MIND, BODY AND SPIRIT

American Music Therapy Association

John S. McIntyre, M.D., *Chair, Department of Psychiatry and Behavioral Health, Unity Health System, and Past President, American Psychiatric Association, 81 Lake Avenue, 3rd Floor, Rochester, NY 14608;* Bryan C. Hunter, Ph.D., *Associate Professor of Music, Nazareth College, 4245 East Avenue, Rochester, NY 14618;* Donald J. Kushon, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to define music therapy, describe outcome data regarding the efficacy of music therapy in the biopsychosocial treatment of patients with a variety of diagnoses, and explain the term Mozart Effect.

SUMMARY:

The growing public use and demand for complementary and alternative therapies resulted in the establishment of the Office of Alternative Medicine at NIH, and a call for scientific verification of efficacy. The ability of music therapy to help decrease depression, pain perception, and medication demands; and increase positive attitude, adaptive behavior skills, and muscle relaxation and coordination, has been increasingly documented in the *Journal of Music Therapy* and numerous other periodicals. The empirical foundation for the practice of music therapy with patients ranging in age from birth to the elderly has led to exciting applications in diverse settings; from neonatal units to programs in geriatric medicine, from psychiatric units to oncology units, from neurology units to obstetrics, and in other programs throughout much of medicine.

This symposium will focus on music therapy applications in the biopsychosocial treatment of patients with a variety of diagnoses. The presentations will describe clinical techniques (including guided imagery and music), case studies, and outcome research data. In addition, a critical examination of the Mozart Effect will be presented. Presenters will include a past-president of the American Psychiatric Association, three past-presidents of the American Music Therapy Association, and other experts in the field of music therapy.

No. 17A
MUSIC THERAPY WITH MEDICAL PATIENTS

Cheryl L. Dileo, Ph.D., *Professor of Music Therapy, Temple University, 538 Covered Bridge Road, Cherry Hill, NJ 08034*

SUMMARY:

This lecture presents a brief overview of the uses of music therapy with medical patients and its biopsychosocial effects as summarized from the research and clinical literature. Clinical examples of the music therapy process with cardiac patients will be provided from a biopsychosocial perspective. Levels of music therapy interventions with these patients will be discussed.

No. 17B
MUSIC THERAPY IN CONSULTATION/ LIAISON PSYCHIATRY

Paul Nolan, M.C.A.T., *Director of Music Therapy Education, Medical College of Pennsylvania, 1505 Race Street, 10th Floor, Philadelphia, PA 19102;* Donald J. Kushon, Jr., M.D.

SUMMARY:

This presentation will describe an integrated music therapy consultation/liaison psychiatry service within a large urban hospital. A brief report of the history of this service will be followed by a description of the rationale, referral process, and current trends, including the attraction of patients toward the integrative medicine and nonpharmacological properties of music therapy. Typically, in this setting, music therapy is referred for patients with anxiety, mild to moderate depression, or chronic pain, and it enhances the overall well-being of the patient. Less typical cases of dementia and psychosis also are referred. Video case vignettes will describe uses of improvisational music therapy and other expressive and receptive music therapy methods as well as the relationship between the patient, psychiatrist, and music therapist. Outcome qualitative and quantitative research projects that describe the patient's response to, and efficacy of, music therapy will conclude the presentation.

No. 17C
THERAPY THROUGH MUSIC AND IMAGERY

Kenneth Bruscia, Ph.D., *Professor of Music Therapy, Temple University, 2001 North 13th Street, Philadelphia, PA 19123*

SUMMARY:

This presentation will outline a method called Guided Imagery and Music (GIM)—a form of therapy in which the client images to specially designed music programs in a deeply relaxed state, while dialoguing with the therapist. Each component of the session will be described, and examples will be given of the various forms of imagery experiences. The role of music will be explained, and case studies will be used to examine the dynamics of the client-therapist relationship and stages in the therapy process.

No. 17D
MUSIC THERAPY AND PAIN MANAGEMENT

Joanne V. Loewy, D.A., *Department of Pediatrics, Beth Israel Medical Center, 317 East 17th Street, 4 Filerman, New York, NY 10003*

SUMMARY:

The International Association for the Study of Pain defines pain as the sensory and emotional experience associated with actual or potential tissue damage. What is significant about pain is that unlike most other medical symptoms, pain includes not only the perception of the stimulus that can cause discomfort, but the response to that perception as well. Thus, pain is a factor that directly affects how a patient perceives his/her own ability to heal. Music therapy serves as an important diagnostic tool in the assessment of pain that enables the evaluation of intensity source, function, and degree of absorption or denial of pain within the body. This paper will examine several models of pain and the medical and biopsychosocial aspects of its effects in treatment. A review of the literature will focus on the growing use of music therapy in medical institutions. Current study and practice in conscious sedation and procedural, acute, and chronic pain management will be presented. The music therapy techniques of vibration, entrainment, integration, and psychoacoustics will be viewed as the sensory, emotional, and cognitive components are considered.

No. 17E
THE MOZART EFFECT: EDUCATION, MEDICINE OR MYTHOLOGY?

Bryan C. Hunter, Ph.D., *Associate Professor of Music, Nazareth College, 4245 East Avenue, Rochester, NY 14618*

SUMMARY:

In the past half decade an interesting public phenomenon regarding the education and health benefits of music has occurred, particularly focused on the music of Mozart. The phenomenon, which began as scientific inquiry, has rapidly evolved and given rise to what has nearly become a household phrase: The Mozart Effect.™ The trademark of the phrase itself is a clue to this phenomenon that is a unique confluence of scientific inquiry, music products industry funding, and marketing.

While the original scientific inquiry focused on the benefits of music on cognitive development in children, the now popularized phrase is being used in reference to virtually any educational, therapeutic, or spiritual benefit that music may offer to human beings. This paper will review the development of this phenomenon and the status of the original area of scientific inquiry regarding the impact of music on children's cognitive development. In addition, a clarification and overview of the now popular phrase will be presented.

REFERENCES:

1. Music Therapy and Medicine: Theoretical and Clinical Applications. Edited by Dileoc. Silver Spring, MD., American Music Therapy Assoc, 1999.
2. Nolan P: Music therapy with bone marrow transplant patients: reaching beyond the symptoms, in Music in Medicine. Edited by Droh R, Spintge R. St. Louis: MMB, 1991, pp. 209–212.

3. Bonny H: Guided Imagery and Music Monograph: The Role of Music. Salina, KS, The Bonny Foundation, 1978.
4. Music Therapy and Pediatric Pain. Edited by Loewy JV. Jeffrey Books, 1997.
5. Campbell D: The Mozart Effect. New York, NY, Avon Books, 1997.
6. Rauscher F, Shaw G, Ky K: Music and spatial task performance. Nature 1993; 364:611.

Symposium 18 **Saturday, October 28**
2:00 p.m.-5:00 p.m.

COUNTERTRANSFERENCE IN COLOR: CULTURE BIAS IN DIAGNOSIS AND TREATMENT

American Association of Community Psychiatrists

Andrés J. Pumariega, M.D., *Professor and Chair, Department of Psychiatry and Behavioral Sciences, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567;* Warachal E. Faison, M.D., *Department of Psychiatry, Dorothea Dix Hospital, 1999–2000 American Psychoanalytic Association Fellow, and 1998–2000 APA/Bristol-Myers Squibb Fellow, 1000 Smith Level Road, #I-7, Carrboro, NC 27510*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) recognize the presence of culturally/racially-based biases or contertransference in clinical treatment, (2) identify approaches to self monitoring and addressing such biases.

SUMMARY:

The concept of countertransference has been primarily reserved for understanding the influence that patient-related variables had on the behavior of psychotherapists within psychodynamically-based psychotherapy. Countertransference was categorized either as therapist reactions elicited by patient-initiated behaviors, or therapist initiated reactions to characteristics of the patient. The latter form of countertransference is the least discussed and understood type, usually calling for the greatest degree of self-evaluation by clinicians. The great majority of mental health clinicians are European-background whites and increasing numbers of patients come from non-European and non-white backgrounds. This divide leads to frequent and unavoidable opportunities for countertransference reactions in the daily provision of care in this nation. Even excluding outright racism on the part of therapists, it is unavoidable that biases learned and ingrained in early life and development in the lives of mental health clinicians play a role in their evaluation and treatment of patients who are culturally different. This symposium examines the occurrence of racially and culturally-based countertransference and how mental health clinicians can best address their reactions to patients in order to deliver culturally competent and effective mental health services. It includes presentations that provide epidemiological data on the frequency of this phenomenon, present a framework for clinician self-evaluation, and presents guidelines for the recognition and management of countertransference arising from race and from sexual orientation. At its conclusion, the co-chair will moderate an open audience discussion that will provide participants ample opportunity to react and explore the perspectives of the presenters.

No. 18A
RESEARCH EVIDENCE FOR RACIAL AND CULTURAL BIAS

Andrés J. Pumariega, M.D., *Professor and Chair, Department of Psychiatry and Behavioral Sciences, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567*

SUMMARY:

Racially based biases in diagnosis and treatment have been difficult to acknowledge and address for American psychiatrists and mental health professionals. This is in the face of an increasing body of literature in psychiatry in particular and medicine in general of racially and culturally based disparities in the type of health and mental health services received by culturally diverse populations. This presentation will review a series of psychiatric studies whose results support the presence of these disparities. The studies include: 1) a study of the diagnoses of white versus African-American adolescents in an academically affiliated state psychiatric facility; 2) a study of the utilization of treatment by depressed white and African-American adolescents from a community epidemiological study of psychopathology; 3) a community-based tri-ethnic study of mental health service utilization in adolescents; and 4) a study of data from a state mental health database examining diagnostic evaluation and service utilization for children and adolescents. The results of these studies point to large-scale clinician-based bias that affects access to services and ultimately leads to adverse outcomes for culturally diverse populations.

No. 18B
SELF-EVALUATION IN DEVELOPING CULTURAL COMPETENCE

Francis G. Lu, M.D., *Clinical Professor of Psychiatry, University of California, San Francisco, and Director,*

Cultural Competence and Diversity Program, San Francisco General Hospital, 1001 Potrero Avenue, San Francisco, CA 94110-3518

SUMMARY:

Change in the attitudes of mental health professionals, along with the acquisition of culturally-based knowledge and intercultural skills, are an essential part of the development of cultural competence. The process of cultural self-examination recommended as the process for this attitudinal change parallels the process of self-examination that is recommended for psychotherapists as part of preventing adverse consequences from countertransference in the patient-therapist encounter. This presentation provides an overview of this process and the issues that mental health clinicians need to confront as a part of this self-examination. These include biases about race, ethnicity, religion, and socioeconomic status, which may have been ingrained in the clinician's upbringing and family/community background. It also includes biases inherent in the professional culture and mythology about these patient characteristics, such as the "JARVIS" patient and the lack of capacity for insight associated with patients of color. Perhaps the most unspoken source of such bias is that of religion. Psychiatry and psychotherapy has had an uncomfortable stance vis-a-vis spirituality and religious belief since the days of Freud, yet we live in a society that is extremely oriented toward diverse expressions of spirituality. The presenter will use the example of religious bias to illustrate the process of self-examination, which mental health clinicians need to undergo, and goals for its successful outcome.

No. 18C
ETHNOCULTURALLY-BASED COUNTERTRANSFERENCE

Todd D. Mitchell, M.D., *Psychiatry Resident, University of California, San Francisco, 1001 Potrero Avenue, Room 7-M, San Francisco, CA 94110*

SUMMARY:

Psychotherapy with patients from racial and ethnic backgrounds different than that of the therapist is fraught with additional complexities not encountered in dyads from similar backgrounds. The patients' or therapists' prior experiences with crosscultural adaptation and discrimination can come into play in the therapeutic relationship. This is particularly true when the therapist is from the mainstream culture and the patient is not, but is also true when the patient and therapist are both from minority backgrounds and have dealt with these challenges and stressors in different ways. The therapists' ingrained biases about cultures different from their own can also distort their assessment of the unconscious processes and interpersonal dynamics impacting on their patient. Mismatches in communication style and expectations of affective expression also make for therapist-patient miscommunication and misperception. Ignorance of ethnoculturally based countertransference phenomena can lead to significant obstacles to effective psychotherapy and eventually to premature treatment drop-out. This presentation will present different schema for the evaluation of countertransference phenomena developed by theorists in the field of crosscultural psychotherapy. It will also provide the participants with practical recommendations for addressing such countertransference challenges as well as for using their countertransferential reactions as useful information in cross-cultural therapeutic encounters.

No. 18D
COUNTERTRANSFERENCE WITH GAY AND LESBIAN PATIENTS

Debbie R. Carter, M.D., *Department of Psychiatry, University of Colorado Health Sciences Center, 4200 East Ninth Avenue, Denver, CO 80262*

SUMMARY:

The American Psychiatric Association declared homosexuality as a normal variant of human behavior and experience in the mid-1970s, thus taking the lead at that time in the recognition of gay/lesbian rights. However, biases about homosexuality remain important sources of countertransference reactions for psychiatrists and mental health professionals. Although homosexuality is not a form of psychopathology, psychiatrists and mental health professionals still too often diagnose their gay and lesbian patients with personality disturbances that they associate with sexual orientation. Psychiatrists and mental health professionals also ignore unresolved issues about sexuality that can arise in dealing with gay and lesbian patients. On the other hand, they also underdiagnose and undertreat the traumatic consequences of homophobia, discrimination, and family conflict that gay and lesbian patients experience as a part of the coming-out process. This presentation focuses on the types and impact of countertransference that psychiatrists and mental health professionals experience in serving gay and lesbian patients and how they can address them in an effective manner.

REFERENCES:

1. Pumariega, AJ, Cross T. Cultural competence in child psychiatry, in Noshpitz J, Alessi N. Handbook of Child & Adolescent Psychiatry, Vol. IV. New York, J. Wiley & Sons, 1997.
2. Cross T, Bazron B, Dennis, K, Isaacs M: Towards a Culturally Competent System of Care for Children

with SED. Washington, DC, Georgetown Univ., CASSP Tech Assist Org 1987.
3. Comas-Diaz L, Jacobsen FM: Ethnocultural transference and countertransference in the therapeutic dyad. Am J Orthopsychiatry 1991; 61:392–402.
4. Sue DW: Counseling the Culturally Different: Theory and Practice. NY, Wiley Interscience, 1990.
5. Hellman RE: Issues in the treatment of lesbian women and gay men with chronic mental illness. Psych Sciences 1996; 47(10):1093–1098.
6. Frost JC: Countertransference considerations for the gay male when leading psychotherapy groups for gay men. Int J Group Psychotherapy 1998; 48(1):3–24.

Symposium 19 **Sunday, October 29**
8:30 a.m.-11:30 a.m.

NATIONAL ALLIANCE FOR THE MENTALLY ILL: PROGRAMS IN PROVIDER TRAINING AND FAMILY EDUCATION

National Alliance for the Mentally Ill

Joyce C. Burland, Ph.D., *Director, National Alliance for the Mentally Ill Family/Provider Education Program, 38 Park Place, Brattleboro, VT 05301;* Laurie M. Flynn, *Executive Director, National Alliance for the Mentally Ill, 2107 Wilson Boulevard, Suite 300, Arlington, VA 22201–3042;* Rex W. Cowdry, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the value of family-to-family as well as wider education for better serving people with serious mental illness. Participants will get an overview of NAMI curricula to see how these cost-effective programs can help the busy professional, especially in the managed care environment.

SUMMARY:

Family-professional collaboration has long been a vision in the theoretical structure of effective community service for individuals with serious and persistent mental illness. NAMI now offers two flagship programs at the national level which are making this vision a reality.

The NAMI Provider Education Program offers basic training in mental illness and family-client-provider team collaboration. Designed for the staff in public mental health agencies, this 10 week course is taught by trained family members and consumers, with a family-member professional serving as facilitator on the teaching team. A panel will report on the field experience of this innovative training program in four states and review NAMI's plans to introduce the course in seven new states.

The NAMI Family-to-Family Education Program, a peer program for families of individuals coping with brain disorders, is now in full operation in 40 states. It is rapidly filling the void in direct family services that exists across the nation, and has become a vitally useful adjunct for the community psychiatrist as a community resource. A panel will briefly review the program and illustrate ways in which this peer program in family education can assist the busy professional.

No. 19A
FAMILY-TO-FAMILY AND PROVIDER EDUCATION

Joyce C. Burland, Ph.D., *Director, National Alliance for the Mentally Ill Family/Provider Education Program, 38 Park Place, Brattleboro, VT 05301*

SUMMARY:

Family-professional collaboration has long been a vision in the theoretical structure of effective community service for individuals with serious and persistent mental illness. NAMI now offers two flagship programs at the national level, which are making this vision a reality.

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No. 19B
THE NAMI PROVIDER COURSE EXPERIENCE IN RHODE ISLAND

William Emmet, *Deputy Director for Membership and Field Support, National Alliance for the Mentally Ill, 2107 Wilson Boulevard, Suite 300, Arlingon, VA 22201*

SUMMARY:

NAMI's Family-to-Family Provider Education Program was piloted at two community mental health centers in Rhode Island before it was made available nationwide. From that experience and other pilots, lessons were learned that helped the course's author to more effectively convey an understanding of consumer and family experiences to course participants.

Considerable information was gathered from evaluations and post-pilot focus-group meetings. While some who worked in the pilot agencies initially resisted participation in the course, the majority found that their perceptions of the consumers and families they serve were radically changed. Because the teaching teams consist of consumers and family members, those who work in the agencies developed a deepened, more integrated understanding of the experience of mental illness. They reported that they expected their daily interaction with clients and their families to reflect heightened sensitivity to the individual needs of those they encounter.

Agency administrators initially feared that it would be hard to justify the time spent on the course. When it was completed, however, they felt the course's benefits were clear. This presentation will include a further discussion of the advantages an agency can derive from the provider course, as illustrated by the Rhode Island pilot experience.

No. 19C
NAMI'S FAMILY AND PROVIDER EDUCATION: A CONSUMER REVIEW

James P. McNulty, *Board Treasurer, National Alliance for the Mentally III, and President, Manic-Depressive and Depressive Association of Rhode Island, 53 Lafayette Drive, Bristol, RI 02809*

SUMMARY:

The NAMI Family to Family Provider course provides a unique platform for multilaterial education of consumers, family members and providers. The structure of the course empowers consumers and family members by enabling them to be the givers of knowledge and information. The blending of technical and scientific course material with personal perspectives and experiences from trained consumer and family instructors brings an entirely new dynamic to the consumer-family-provider relationship by redressing a power balance often overlooked.

This equalization and empowerment of the family and consumer instructors also reemphasizes the medical part of mental illness, a facet sometimes not given enough weight in community mental health settings.

The mutual respect that is engendered in the course is something that has proven to have lasting benefit in the way that providers see themselves and the clients and families, especially in allowing providers to see the consumer-family perspective, which had never been emphasized in training or service delivery.

No. 19D
THE EFFECTIVENESS OF THE FAMILY TO FAMILY EDUCATION PROGRAM

Lisa B. Dixon, M.D., M.P.H., *Associate Professor of Psychiatry, Center for Mental Health Services Research, University of Maryland, 701 West Pratt Street, Room 476, Baltimore, MD 21201;* Joyce C. Burland, Ph.D.; Bette Stewart, M.A.

SUMMARY:

Purpose: This study assesses the effectiveness of the 12-week NAMI Family to Family Education Program (FFEP), a peer-based structured program for family members of persons with severe mental illness (SMI) that is widespread throughout the nation. The program provides support, education, problem-solving skills training, and crisis intervention help for families in accordance with best-practices standards.

Methods: A total of 38 consenting family-member FFEP participants were assessed prospectively at baseline, post-intervention, and six months post-FFEP. Trained family-member interviewers conducted assessments. Repeated measures analyses of variance were used to assess within-subject change over time.

Results: Participants had *significantly* increased gains in self-perceived knowledge about mental illness, empowerment, ability to cope with the mental health system, and ability to cope with their ill family member. Subjective burden of mental illness including worry and displeasure with the ill family member also *significantly* declined. Most importantly, post-program gains were sustained after six months.

Conclusions: This study provides substantial evidence that the FFEP, a consumer-run, volunteer-driven program that has received considerable financial support from the states, is effective at improving the experience of families of persons with SMI. A more rigorous controlled study to test the effectiveness of FFEP is merited.

No. 19E
FAMILY AND PROVIDER COURSES: SPREADING THE WORD

Laurie M. Flynn, *Executive Director, National Alliance for the Mentally III, 2107 Wilson Boulevard, Suite 300, Arlington, VA 22201*

SUMMARY:

In its 21 years, NAMI has learned that significant improvements can be made in community and hospital services when there is an organized effort to link families and consumers with peers who share the experience of mental illness. There is now a significant evidence base to demonstrate that the Family-to-Family program is a highly effective peer-to-peer educational model. Similarly, growing experience with the provider course confirms that services are improved by the addition of a formal mechanism imparting consumer and family perspectives to providers.

With the maturing of NAMI's Family-to-Family and Provider Education programs, there now exists a highly educated consumer and family constituency in many communities. Provider agencies that develop partnerships with NAMI affiliates and support Family-to-Family and/or Provider education report myriad benefits, including improved outcomes for their clients.

Testimony of doctors and other providers who have formed close collaborative partnerships with NAMI to expand educational opportunities will be shared in this presentation. Included will be examples of how to use these educational programs to build effective provider/consumer/family partnerships.

REFERENCES:

1. Burland J: NAMI Family-to-Family Education Program Teaching Manual (2nd edition), Arlington, VA, NAMI, 1998.
2. Burland J: NAMI Provider Education Program, Arlington, VA, NAMI, 1999.
3. Dixon L, Goldman HH, Hirad A: State policy and funding of services to families of adults with serious and persistent mental illness, Psychiatric Services 1999; 50:551–552.
4. Dixon L: Providing services to families of persons with schizophrenia: present and future. Journal of Mental Health Policy and Economics 1999; 2:3–8.

Symposium 20 **Sunday, October 29**
8:30 a.m.-11:30 a.m.

CALOCUS: LEVEL OF CARE DETERMINATION FOR CHILDREN AND YOUTH

American Association of Community Psychiatrists and American Academy of Child and Adolescent Psychiatry

Andrés J. Pumariega, M.D., *Professor and Chair, Department of Psychiatry and Behavioral Sciences, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567;* Wesley E. Sowers, M.D., *Medical Director, Center for Chemical Dependency Treatment, and Chief Corporate Officer, Center for Addiction Services, Department of Psychiatry, St. Francis Medical Center, 400 45th Street, Pittsburgh, PA 15201*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: (1) Understand the principles and factors governing level of core placement in children and adolescents, (2) Understand the basic operation of the CALOCUS as a tool for level of care placement.

SUMMARY:

An important process in the treatment of children and adolescents, which has long required a more objective and systematic approach, is the determination of level of care. This is a process that has always been fraught with disagreement across clinical team members given the multiple factors that need to be considered in arriving at its determination, such as dangerousness, stability of the child's holding environment, and level of function. The system of care movement has placed a greater emphasis on the level-of-care placement process through its advocacy for the use of least restrictive, community-based levels of care in the treatment of children. Economic factors have also played a significant role in level of care determination in the era of managed care, as more restrictive levels of care are linked with higher costs. However, to date there are have been objective, open guidelines for level of care placement of children outside of the mostly secretive protocols developed by industry. The Work Group on Community-Based Systems of Care of the American Academy of Child & Adolescent Psychiatry and the American Association of Community Psychiatrists joined forces to create a tool named the Child and Adolescent Level of Care Utilization System (CALOCUS) for decision support for level of care determination. Our goal is to develop an objective, open, and psychometrically sound instrument/tool for this most important process. This symposium reports the status of the development of this tool, including its conceptual basis, its construction, its psychometric testing, and its potential for application in assisting the individual child and adolescent psychiatrist or mental health professional, and its application in community-based systems of care for children's mental health.

No. 20A
LOCUS: ADULT PARENT OF CALOCUS

Wesley E. Sowers, M.D., *Medical Director, Center for Chemical Dependency Treatment, and Chief Corporate Officer, Center for Addiction Services, Department of Psychiatry, St. Francis Medical Center, 400 45th Street, Pittsburgh, PA 15201*

SUMMARY:

Community general psychiatrists were first faced with the restriction of access to more restrictive and intensive levels of care for the treatment of patients with serious mental illness and substance abuse. Increasingly, they saw the need for an objective tool to guide decisions on level-of care provision and on discharge planning. Different strategies such as defining the criteria for admission to different levels of care or demographically based profiles such as the Level of Need-Care Assessment have not proven to be effective for clinical decision making. The American Association of Community Psychiatrists used a number of principles and elements in the developed of LOCUS: 1) flexibility across different systems of care, 2) organization for ease of use, 3) limited and clearly defined assessment dimensions, 4) dimensions applicable to both substance abuse and psychiatric disorders, 5) dimensional variables directly relevant to service need and placement decisions rather than being diagnostically driven, 6) quantifiable dimensional ratings to allow the interaction across different dimensional variables. This presentation will review the construction and operation of the LOCUS. It will also review the psychometric properties of the instrument, which has now undergone two rounds of revisions and reliability/validity evaluation.

No. 20B
CALOCUS: DIMENSIONS, LEVELS OF CARE AND PRINCIPLES

Andrés J. Pumariega, M.D., *Professor and Chair, Department of Psychiatry and Behavioral Sciences, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567*

SUMMARY:

The assignment of a level of care for a child in psychiatric treatment presupposes the availability of multiple levels of care tailored for children with very different developmental and clinical needs. Such availability is ensured within a comprehensive community-based system of care where children are cared for in the least restrictive level. However, different levels of care are often delivered by different child-serving agencies, which is commonly overlooked by clinicians who are most commonly familiar with mental health-oriented services. The literature on level-of-care placement has also pointed to five main factors in the determination of level of care: individual level of function, the level of dangerousness faced by the child, the stability of the child's environment, the presence of multiple coexisting problems, and the engagement of the child and family in the treatment process. This presentation reviews the principles underlying the CALOCUS instrument, particularly the principles associated with community-based systems, the construction of the assessment dimensions, the definition of levels of care, and the scoring methods for the instrument. Modifications from the adult version, which account for the impact of development, the centrality of the family, and the vulnerability, and resiliency found in emotionally disturbed/mentally ill children and adolescents, are reviewed. The construction of levels-of-care-categories, which are interagency-oriented, independent of physical setting and restrictiveness of care, and include developmentally necessary services and family support services, are also reviewed.

No. 20C
CALOCUS: PSYCHOMETRIC TESTING AND PROPERTIES

Theodore J. Fallon, Jr., M.D., M.P.H., *Medical Director, Children's Medical Hospital of Philadelphia, 111 North 49th Street, Philadelphia, PA 19139;* Andrés J. Pumariega, M.D.

SUMMARY:

The construction of CALOCUS was undertaken from a conceptual basis with face validity. However, psychometric testing to evaluate its validity and reliability is essential to demonstrate its objectivity and utility. In this presentation, we will present the results of initial field testing by the combined CALOCUS Task Force. Alpha testing involved case vignettes developed by pairs of members of the combined task force for validity testing against the level of care intended by the authors. Reliability testing was determined across the level of care ratings of different task force members for each vignette, and for the ratings of different dimensions across vignettes. Results from alpha testing indicated that the instrument was potentially highly reliable and valid. The reliability coefficients for subscales were between 0.65 and 0.87, the overall reliability of CALOCUS scores was 0.84, the overall validity coefficients for CALOCUS scores as compared with intended levels of care for vignettes was 0.84, and the overall coefficient for CALOCUS scores compared with CGAS scores for the vignettes was 0.79. Beta testing is now currently ongoing with four sites across the nation, with four others being recruited, with field testing of interrater reliability and validity against clinician level of care determination being performed with actual patients. We will report on data from alpha testing and on the design and preliminary data from beta testing in this presentation. We will also present on initial directions for further instrument modification from user feedback.

No. 20D
CALOCUS: CLINICAL AND SYSTEMS UTILITY

Charles W. Huffine, Jr., M.D., *Assistant Medical Director for Child and Adolescent Programs, King County Mental Health Division, and Past President, American Association of Community Psychiatrists, 3123 Fairview Avenue, East, Seattle, WA 98102-3051*

SUMMARY:

The CALOCUS promises to provide significant assistance for the clinician or treatment team faced with the often difficult decision of determining the level of care placement of a child. It offers a level of objectivity for this process that has not been provided by other decision support tools, but without sacrificing the flexibility often needed in the treatment planning for a child and family with multiple clinical, developmental, and social needs. Systems of care for children's mental health also lack systematic data on the service needs of their covered populations and the relative utilization and need for different levels of care. CALOCUS has the potential of enhancing the information management systems that are essential to operate effective community-based systems of care. This presentation will first review the clinical use of CALOCUS using either audience generated case presentations or one of the case test vignettes developed for the initial testing of the instrument. The presenter will guide the participants through the steps of dimensional assessment and scoring, decision tree algorithm, and the assignment of a level-of-care rating. This presentation will also discuss the possible application of the CALOCUS within large systems of care for information management and system decision support/quality improvement. The CALOCUS can facilitate a process that is often difficult to accomplish objectively and communicate effectively.

REFERENCES:

1. Sower W: Level of care determination in psychiatry. Harvard Review of Psychiatry 1998; 5:286–290.
2. Klachu R, O'Malley K, Vaugh T, Kroeger K: CALOCUS User's Manual. Washington, DC & Dallas, Tx: AACAP & AACP, 1999.
3. Pumariega AJ, et al. Community-based systems of care approach to children's managed mental health services. J Child & Family Studies 1997; 6:149–164.

Workshop 1 **Wednesday, October 25**
8:00 a.m.-9:30 a.m.

VIRTUAL PSYCHIATRIC COMMUNITIES

John J. Haggerty, Jr., M.D., *Associate Professor of Psychiatry, University of North Carolina School of Medicine, CB-7160, Chapel Hill, NC 27599*; Kenneth S. Thompson, M.D.; Bertram Warren, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should (1) recognize the potential of the internet for organizing professional communities, (2) understand the process of creating and maintaining a successful psychiatric listserv.

SUMMARY:

This workshop examines issues involved in creating and maintaining listserv networks for psychiatrists and other mental health professionals. Presenters will describe two national and one regional listserv. The American Association of Community Psychiatrists (AACP) has maintained a large national listserv for community psychiatrists for over four years. Dr. Thompson will describe its evolution and current uses. Data will be presented from a survey of AACP members on the significance of the listserv.

Member to Member (M2M) is the original e-mail list of the American Psychiatric Association and is open to all members. Dr. Warren will report on the history and current status of M2M.

North Carolina community psychiatrists have established a statewide listserv to decrease isolation and provide education. Dr. Haggerty will present examples of its day to day use, including education, policy discussion, recruitment, clinical consultation, and political action. Information will also be provided on a pilot project using the internet as a tool for the exchange of secure clinical information between community and hospital based psychiatrists.

Together, presenters and audience will explore the implications of e-mail for the formation of professional "virtual communities" and will consider theoretical implications of the internet for human psychology and human communities.

REFERENCES:

1. Huang MP, Alessi NE: Challenges of the world wide web. Psychiatric Services 1999; 50(4):483–4, 491.
2. Huang MP, Alessi NE: Developing trend of the world wide web. Psychiatric Services 1999; 50(1):31–2, 41.

Workshop 2 **Wednesday, October 25**
8:00 a.m.-9:30 a.m.

TRANSITION FROM PRISON TO COMMUNITY

Erik J. Roskes, M.D., *Assistant Professor of Psychiatry, University of Maryland, 22 South Greene Street, P.O. Box 291, Baltimore, MD 21201*; Richard D. Craig, Ph.D.; Allison Warfield, L.C.S.W.; Ann M. Strangman, L.C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) identify barriers to the successful transition from prison to community for mentally ill offenders, and (2) demonstrate an understanding of a novel transition program within a state prison system designed to overcome these barriers

SUMMARY:

The transition between incarceration and the community is a difficult and stressful process, especially for mentally ill inmates. Recently, a new aftercare program in the Maryland Division of Corrections was implemented. In response to a variety of forces, the need for improved pre-release treatment, training, and case management was recognized, and the Mental Health Transitional Unit (MHTU) was developed to meet this need. The MHTU is designed to accept all inmates with known mental illness (including dual diagnosis) approximately six months before the scheduled release date. During the inmate's stay in the MHTU, a variety of treatment modules are offered, targeted at issues that are likely to cause the newly released mentally ill inmate difficulty in the community. In addition to training and education groups, a comprehensive reassessment of the inmate's psychiatric diagnosis and treatment needs is undertaken by the treatment staff of the MHTU. Finally, the MHTU social worker invites the appropriate community-based case manager or other provider to the MHTU. A coordinated effort at comprehensive linkage is undertaken by this team of institutional and community providers. Upon release, the staff of the MHTU attempt to follow up at 14, 30, and 90 days to document successful linkage to the needed services. This workshop will present our model and invite a lively discussion with the participants.

TARGET AUDIENCE:

Community and correctional mental health providers and administrators

REFERENCES:

1. Hartwell SW, Orr K: The Massachusetts Forensic Transition Program for Mentally Ill Offenders Re-

Entering the Community. Psychiatric Services 1999; 50(9):1220–1222.
2. McFarland BH, Blair C: Delivering comprehensive services to homeless mentally ill offenders. Psychiatric Services 1995; 16(2):179–181.

Workshop 3 **Wednesday, October 25**
8:00 a.m.-9:30 a.m.

REPLICATING ROADS: A MODEL FOR RURAL BEHAVIORAL HEALTH SERVICES

John A. Morris, M.S.W., *Director of Interdisciplinary Studies, South Carolina Department of Mental Health, and Professor, Department of Neuropsychiatry and Behavioral Science, University of South Carolina, 3555 Harden Street, 104-A, Columbia, SC 29203*; Kerry Lachance, M.A., L.M.S.W.; Nancy Halewood, R.N.; Ann H. Areson, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be familiar with a scientifically validated model for rural outreach; be oriented to potential barriers in developing and funding a rural service; and be aware of strategies for successful consensus development and implementation of an innovative model.

SUMMARY:

The workshop highlights the development and replication of a rural adaptation of an assertive community team approach in a rural Southern state. The presenters will describe the original model and the subsequent investment in building consensus for the migration of the model, and finally the status of implementation of the model in other sites. The original model (ROADS- Rural Outreach and Direct Services) was funded by NIMH. Subsequently, two CMHS knowledge dissemination grants have funded consensus development and implementation stages. The current program includes a partnership among the S.C. Department of Mental Health, the S.C. Department of Health and Environmental Control, and the Department of Neuropsychiatry and Behavioral Science of the USC School of Medicine, among others. The new service, now called RBHS (Rural Behavioral Health Service) is now operational in six sites in South Carolina. During the presentation, participants will see a videotape of clients and staff interacting in the rural environment, and will be able to review other materials developed to support consensus and implementation.

TARGET AUDIENCE:

Persons interested in assertive outreach programs for individuals with serious and persistent mental illnesses in rural areas.

REFERENCES:

1. Lachance KR, Deci PA, Santos AB, Halewood N: Rural assertive community treatment: taking mental health services on the road, in Innovative Services for Difficult to Treat Populations. Edited by Santos AB. Washington, DC, American Psychiatric Press, 1996, pp. 279–294.
2. Santos, AB, Deci PA, Lachance KR: Providing assertive community treatment for severely mentally ill patients in a rural area. Hospital and Community Psychiatry 1993; 44:34–39.

Workshop 4 **Wednesday, October 25**
8:00 a.m.-9:30 a.m.

EROTIC TRANSFERENCE AND COUNTERTRANSFERENCE: ISSUES IN RESIDENCY SUPERVISION

1999–2001 APA/Bristol-Myers Squibb Fellows

Karyn J. Horowitz, M.D., *1999–2001 APA/Bristol-Myers Squibb Fellow, and Department of Psychiatry, Columbia University College of Physicians and Surgeons, 1051 Riverside Drive, Box 90, New York, NY 10032*; Michele S. Baker, M.D., *1999–2001 APA/Bristol-Myers Squibb Fellows, and Department of Psychiatry, Harvard Longwood University, 91 Harvard Avenue, #1, Brookline, MA 02446*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should recognize some of the core psychodynamic issues present in erotic transference/countertransference, and recognize the importance of addressing erotic transference/countertransference for residents and supervisors.

SUMMARY:

Erotic transference, a transference composed of both sexual and loving feelings, can be a difficult management problem for therapists and particularly for trainees. A careful and nonjudgmental treatment approach, which explores the meaning of the erotic transference, including its role as both communication and resistance, may assist therapists with this stimulating and provocative form of transference.

Fundamental to understanding the meaning of erotic transference is exploration of the erotic countertransference, as erotic enactments can occur on a continuum from partial transference gratifications of both a verbal and nonverbal nature to overt sexual relations between

the patient and the analyst. These enactments are unavoidable and are potentially useful parts of the analysis that can be initiated by either the analyst or or the analysand, can be heterosexual or homosexual, and can have a variety of dynamic meanings and etiologies.

The importance of supervision in situations where powerful and compelling sexual feelings are present in the treatment cannot be overemphasized. Acting on sexual feelings toward patients can lead to unethical behaviors. Avoiding the feelings, however, can lead to a missed understanding of the patient's internal world. Thoughtful supervision may help trainees acknowledge feelings, tolerate anxiety, and facilitate a deepening of the therapeutic work.

REFERENCES:

1. Gabbard GO: Sexual excitement and countertransference love in the analyst. Journal of the American Psychoanalytic Association 1994; 42(4):1083–1105.
2. Gabbard GO: Psychodynamic Psychiatry in Clinical Practice: The DSM-IV Edition. Washington, DC, American Psychiatric Press, Inc., 1994; pp 571–584.

Workshop 5 **Wednesday, October 25**
10:00 a.m.-11:30 a.m.

STARTING FROM WHERE WE ARE: USING SHARED PRAXIS FOR PSYCHOEDUCATION

Karen A. Landwehr, M.C., *Clinician and Educator, Comprehensive Mental Health Partnership, 1201 South Proctor Street, Tacoma, WA 98405*; Larry S. Baker, M.Div., *Director of Training, Comprehensive Mental Health Partnership, 1201 South Proctor Street, Tacoma, WA 98405*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should (1) understand the shared praxis method of adult education, (2) apply the shared praxis process in mental health education, and (3) identify ways in which to incorporate the shared praxis process into therapeutic practice.

SUMMARY:

Although the Expert Consensus Guidelines emphasize the need to provide psychoeducation to mentally ill consumers and their family members, only 10% of consumers and family members report receiving such psychoeducation. Often, mental health providers seem unwilling to delegate resources to programs viewed as nontherapeutic or nonreimbursable. However, effective psychoeducation is a cost-effective strategy for decreasing reliance on non-emergency mental health resources and encouraging more effective use of emergency services. The shared praxis methodology used by the Pebbles in the Pond: Living with Chronic Neurobiological Disorders curriculum simultaneously addresses the psychoeducation needs of consumers, family members, and care providers in a unique and effective way. Building on the existing knowledge and experience of participants, shared praxis encourages knowledge acquisition, increased insight, and behavior change, factors important for effective symptom self-management. Research using pre- and post-attendance assessments of knowledge acquisition and service use patterns for participants in the Pebbles in the Pond program will be presented. Following this workshop, participants will understand the shared praxis process as applied to mental health education, will have experienced the methodology first-hand, and will have identified ways to incorporate the shared praxis process into their current treatment practice.

REFERENCES:

1. Lehman AF, Steinwachs DM: Translating research into practice: the schizophrenia patient outcomes research team (PORT) treatment recommendations. Schizophrenia Bulletin 1998; 24:1; 1–10.
2. Groome TH: Christian Religious Education: Sharing Our Story and Vision. San Francisco, Harper & Row, 1980.

Workshop 6 **Wednesday, October 25**
10:00 a.m.-11:30 a.m.

GETTING YOUR PATIENT ON SOCIAL SECURITY INSURANCE: AN INSIDER'S GUIDE

APA Committee on Poverty, Homelessness and Psychiatric Disorders

Ramanbhai C. Patel, M.D., *Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456*; Manoj R. Shah, M.D.,; Harvey Bluestone, M.D.; Albert A. Hyman, M.D.; Rajendra A. Morey, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) evaluate the most critical dimensions of a patient's functioning using SSI disability criteria, and (2) record the results of their knowledge of patients in a way that most effectively ensures SSI eligibility.

SUMMARY:

For many of the most seriousy psychiatrically disordered, access to entitlements (income support and Medicaid) serves as their "life preserver." The Committee on Poverty, Homelessness and Psychiatric Disorders has

spent a great deal of time over its last several meetings examining the critical role of income and health care supports in maintaining the stability of impoverished psychiatric patients in the community.

Often, those who might be eligible for SSI have their applications denied because of incomplete or poorly filled out evaluations by their treating physicians. In order to help address this issue, our interactive workshop will provide information on filling out SSI and disability evaluations.

The session will consist of a presentation of case histories of patients who are about to apply for SSI and a "pre-test" during which participants will be asked to fill in an evaluation form. The workshop will focus on helping participants to understand the structure and language that SSI looks for in evaluating applications. Finally, a second attempt at writing up an evaluation form for the videotaped patient will take place, with responses critiqued by the three SSI reviewers on the panel.

Ample opportunity will be made available for discussion with the panel. Printed materials will be distributed to take back to participants' home offices.

REFERENCES:

1. Pincus HA, Kennedy C, et al: Determining disability due to mental impairement: APA's evaluation of Social Security Administration guidelines. Am J Psychiatry 1991; 148(8):1037–43.
2. Kennedy C, Simmens SJ, et al: The social security disability evaluation study. New Dir Met Health Ser 1990; (45):29–36.

Workshop 7 **Wednesday, October 25**
10:00 a.m.-11:30 a.m.

THE ETHICS OF DISABILITY ASSESSMENT IN MEDICAL/ PSYCHIATRIC PRACTICE

Marie-Claude Rigaud, M.D., M.P.H., *President, Rigaud and Associates, 13 Mossfield Court, P.O. Box 2816, Aurora, IL 60507-2816*; Ernest Gosline, M.D.; Alexander E. Obolsky, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) recognize and understand the impact of the disability assessment process on the doctor-patient relationship, (2) demonstrate increased skills and knowledge in effectively, as well as ethically, performing his/her role in the disability process.

SUMMARY:

This workshop aims at raising awareness of psychiatrists to the potential for ethical and legal conflicts in the practice of disability assessment. It is especially important that these issues be addressed as the insurance industry and employers are becoming increasingly concerned by the large number and significant costs of psychiatric disability claims. In lieu of background, a brief description of the various roles of psychiatrists in disability assessment, as well as some of the resulting behaviors, will be given. This will be followed by a discussion, using actual case examples, of ethical-legal issues that often surface in that process. Special emphasis will be placed on analyzing potentials for clashes between ethics and doctor-patient relationships whenever treating psychiatrists or other physicians are required to make statements as to their patients' ability to work or certify as to their disability status. At the conclusion, the presenter will invite and lead the participants in a problem-solving discussion addressing these sensitive issues.

TARGET AUDIENCE:

Psychiatrists active in clinical practice, especially those involved in disability evaluation.

REFERENCES:

1. Strasburger LH, Gutheil TG, Brodsky A: On wearing two hats: role conflict in serving as both psychotherapist and expert witness. Am J Psychiatry 1997; 154: 445–456.
2. American Psychiatric Association: The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry.

Workshop 8 **Wednesday, October 25**
10:00 a.m.-11:30 a.m.

COMMUNITY OUTREACH PROJECTS: DIFFERENT APPROACHES FOR DIFFERENT POPULATIONS

1999–2001 APA/Bristol-Myers Squibb Fellows

Jacqueline C. McGregor, M.D., *1999-2001 APA/Bristol-Myers Squibb Fellow, and Resident, Department of Psychiatry, Baylor College of Medicine, 4108 Swarthmore, Houston, TX 77005*; Claudio O. Cabrejos, M.D., M.P.H.; Jacqueline Lebel, M.D., J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify potential target populations of community-based outreach programs and understand the planning, creation, and implementation of such programs.

SUMMARY:

Community-based outreach programs work on the front lines of public psychiatry. They are often challenging to plan and implement. We look at three such innovative approaches targeting specific populations, their genesis, structure, and applicability to other groups.

KIDS INC of Providence, RI, is a novel outreach program that involves the police department, public school system, and Bradley Hospital. It involves "police academy" training for high-risk adolescents, pairing with a police academy trainee/mentor, and financial backing for basic unmet needs—medical care, at-home psychiatric care, and family therapy.

Long-term residential care and rehabilitative services are provided to women in Houston, Tex., at The Women's Home. Individually structured programs offer education and job skills training while promoting physical and mental health along with nondenominational spiritual development. The Home prepares women in crisis to return to society as productive, self-sufficient individuals.

Fifteen years of civil war traumatized and displaced a large percentage of the rural population in the Peruvian Andes. One international trauma study is focusing on developing a community-based model for intervention in psychosocial issues toward improving general mental health status, quality of life, and recovery for these types of international populations.

REFERENCES:

1. Jones A, Scannell T: Outreach interventions for the homeless mentally ill. Br J of Nursing 1997; 6(21): 1236–8, 1240–3.
2. Sheldrick C: The assessment and management of risk in adolescents. J Child Psychol Psychiatry 1999; 40(4): 507–18.

Workshop 9 **Wednesday, October 25**
1:30 p.m.-3:00 p.m.

MARRIAGES, DOMESTIC VIOLENCE AND PSYCHOLOGICAL IMPLICATIONS IN ASIAN-INDIAN FAMILIES

Satyanarayana Chandragiri, M.D., *Senior Resident in Psychiatry, Temple University School of Medicine, and Former APA/Bristol-Myers Squibb Fellow, 3401 North Broad Street, Philadelphia, PA 19140*; Satyajit Satpathy, M.D.; Kanakalatha Abbagani, M.S.W., M.Phil.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the cultural aspect of Asian Indian marriages, it's relationship to domestic violence, and the psychological implication it has on the families. They will also learn the factors contributing to lack of help seeking behaviors in Asian Indian families both in India and U.S.A.

SUMMARY:

Violence against women is an important global health problem. Asian Indian women are particularly at high risk for abuse. The abuse ranges from being beaten to being burnt alive. Several culture-specific factors prevent women or their families from seeking professional help. These include sociocentricity of the society; taboo against divorce, separation, remarriage; shame and humiliation; dowry system and socio-economic implications, etc. The psychological burden on the family members is enormous. They often manifest as depression, anxiety, somatization, conversion, dissociation, suicide, and even homicide "Dowry Deaths."

Marriages are often "arranged" both in India and in Asian Indian families in the U.S. Similar dynamics play a role in families in both continents. It is only recently that social and legal changes have been made to address this problem. The mental health care for this population is meagre and if available, underutilized.

The presenters will discuss their work with Asian Indian families both in India and the U.S.

TARGET AUDIENCE:

Psychiatrist, mental health professionals, family therapists interested in cross-cultural psychiatry and women's issues.

REFERENCES:

1. Fernandez M: Domestic violence by extended family members in India; interplay of gender and generation. J Interpersonal Violence 1997; 12: 433–455.
2. Martin SL, Killagen B, Tsui AO, Maitra K, Singh KK: Wife abuse. JAMA 1999; 262:1967.

Workshop 10 **Wednesday, October 25**
1:30 p.m.-3:00 p.m.

APA/NETOUTCOMES' QUALITY CARE 2000: AN INTERNET TREATMENT OUTCOMES SYSTEM

APA Council on Quality Improvement

G. Richard Smith, Jr., M.D., *Professor of Psychiatry, University of Arkansas Center for Mental Health Research, and Director, Center for Outcomes and Effectiveness, 5800 West 10th Street, Suite 605, Little Rock, AR 72204-1761*; Sara C. Charles, M.D., *Department of Psychiatry, University of Illinois, and Chair, APA Council on Quality Improvement, 1300 North Lake Shore Drive, #15-A, Chicago, IL 60610-2179*; C. Win-

ston Brown, M.D.; Farifteh F. Duffy, Ph.D., M.H.S.; Joyce C. West, Ph.D., M.P.P.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant (1) will learn about APA/NetOutcomes' QC 2000, and its objectives, (2) understand the use of an internet based treatment outcomes management system (OMS); (3) understand the use of OMS data in clinical quality improvement in routine, clinical settings; and (4) understand the relationship among APA treatment guidelines, treatment outcomes assessment, and clinical quality improvement.

SUMMARY:

In our efforts to promote evidence-based medicine and guideline-concordant treatments, the APA's Office of Quality Improvement and Psychiatric Services is collaborating with the University of Arkansas for Medical Sciences' Center for Outcomes Research and Effectiveness (CORE) to develop APA/NetOutcomes' Quality Care 2000. The QC 2000 project provides APA members an opportunity to use an effective, easy-to-use treatment outcomes assessment tool for major depressive disorder at no cost. The assessment tool, a set of clinician and patient questionnaires administered over the course of treatment, is available at the Internet address, www.net-outcomes.net. Data collected by the tools are entered at the website and the resulting outcomes reports are downloaded there as well.

QC 2000 reports provide information about patient characteristics, processes of care, and outcomes. Real time patient reports complement clinical decision making and aggregate reports for a practice, individual or group, portray the course of care and its effectiveness for an entire practice population. The project-specific website will include a resource for behavioral health outcomes information and clinical quality improvement processes.

QC 2000 will be initiated as a pilot in Spring 2001 and is intended to generate information about current care effectiveness, provide APA members an affordable practice outcomes management system, and foster clinical quality improvement. The workshop will introduce the QC 2000 program, demonstrate the APA/NetOutcomes' internet site and system, review the patient and practice reports relevance to practice CQI, and report clinical data on the relationship between different patterns of treatment for major depression (including specific treatments and combinations of treatments) and outcomes of care.

REFERENCES:

1. Rost K, Smith GR, Burnam MA, Burns BJ: Measuring the outcomes of care for mental health problems. Medical Care 1992; 30(5):266–273.
2. Zarin DA, West JC, Hart CH: The APA's Evidence-Based Quality Improvement Agenda. Achieving Quality in Psychiatric and Substance Abuse Practice: Concepts and Case Reports. Edited by Dickey and Sederer. Washington DC: APPI, in press.

Workshop 11 **Wednesday, October 25**
1:30 p.m.-3:00 p.m.

PSYCHOTHERAPY OF DEPRESSION IN THE ELDERLY

Paul A. Kettl, M.D., *Professor of Community Psychiatry, and Chair, Department of Psychiatry, Milton S. Hershey Medical Center, Penn State University, Hershey, P.O. Box 850, Hershey, PA 17033-0850*; Patrick Ulmen, M.S.W.; Patricia Leocha, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should understand the usefulness of psychotherapy with elder clients and be better able to manage resistance to engaging in psychotherapy with the elderly.

SUMMARY:

Freud believed engaging in psychotherapy with the elderly was not a productive use of a therapist's time. Unfortunately, that view sometimes still permeates psychiatric practice today. The stigma associated with psychiatric treatment and psychotherapy is also keenly felt by the elderly who often do not want to accept psychotherapy as a form of help.

In the workshop, we will examine psychotherapy of depression in the elderly—not only the forms of psychotherapy available for depression, but also how to motivate elderly patients to make use of this form of treatment will be explored. In particular, we will address the usefulness of life review therapy, cognitive psychotherapy, and psychodynamic psychotherapy in the elderly. The usefulness of group therapy in the elderly will also be addressed.

Finally, the role of psychotherapy in the dementing illnesses will be examined. We will discuss the role of family therapy in managing the stress of a dementing illness in the family, as well as the role of life review therapy early in the course of dementia.

REFERENCES:

1. Teitelbaum M, Kettl P: Brief psychotherapy with a patient suffering from Guillain-Barre Syndrome. Psychosomatics 1988; 29:231–232.
2. Kettl PA: Major depression: the forgotten illness. Hospital Medicine 1999; 34:2–10.

Workshop 12 **Wednesday, October 25**
1:30 p.m.-3:00 p.m.

ETHICAL DILEMMAS IN TREATING THE HOMELESS MENTALLY ILL

David M. Band, M.D., *Clinical Director, Mobile Community Outreach Treatment Team, District of Columbia Commission on Mental Health Services, 3849 Alabama Avenue, S.E., Washington, DC 20020*; Stephen M. Goldfinger, M.D., *Liaison, APA Institute Scientific Program Committee, and Professor and Vice Chair, Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, Brooklyn, NY 11203*; Marcella Maguire, Ph.D.; Mohammed Nazimuddin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be familiar with some of the most common ethical dilemmas and challenges impeding the engagement and treatment of homeless mentally ill individuals and demonstrate approaches to overcoming these barriers.

SUMMARY:

During formal training, many of the ethical principles that are taught are based on the provision of treatment to the severe and persistent mentally ill individuals located in hospitals or traditional community-based care. For mental health professionals working with homeless mentally ill individuals in a variety of community settings, many of these assumptions do not hold true. Case managers and other clinicians are forced to make instantaneous, "on the spot" decisions when confronted with ethical dilemmas with little supervisory or "learned" guidance.

Issues ranging from personal boundaries between providers and homeless individuals, medication management, rationing of resources, transportation of "nonpatient" significant others, use of pharmaceutical industry resources, confidentiality of medical records and patient status, housing, and collaboration and competition between public and private community agencies working with the same individuals are just some of the areas where these arise.

Senior clinicians and trainees from different disciplines will begin by presenting some of their most intriguing ethical dilemmas. During the last hour of the workshop, participants will be encouraged to present their own clinical vignettes. Interactive discussion will serve both to demonstrate successful ways to navigate through the ethical mine fields of providing care to the homeless mentally ill and to present ongoing challenges for workshop participants to help solve.

TARGET AUDIENCE:

Psychiatrists, social workers, psychologists, case managers who are working with or interested in working with homeless mentally ill individuals.

REFERENCES:

1. American Psychiatric Association: The principles of medical ethics with annotations especially applicable to psychiatry. Washington, D.C., 1989.
2. Chafetz L: Why Clinicians Distance Themselves from the Homeless Mentally Ill, in Lamb HR, Bachrach LL, and Kass FI (eds.). Treating the Homeless Mentally Ill. Washington, D.C., American Psychiatric Association, 1992; pp. 95–108.

Workshop 13 **Wednesday, October 25**
1:30 p.m.-3:00 p.m.

WHAT'S GOING ON? GAY AND LESBIAN YOUTH AT RISK

1999–2001 APA/Bristol-Myers Squibb Fellows

William J. Resnick, M.D., *1999–2001 APA/Bristol-Myers Squibb Fellow, and Resident in Psychiatry, UCLA, Neuropsychiatric Institute, 500 Westbourne Drive, West Hollywood, CA 90048*; Steven Sokoll, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be familiar with the current literature on suicide risk among gay and lesbian youth and be comfortable treating these youth and providing them with appropriate resources.

SUMMARY:

Many have asserted that gay and lesbian youth are at increased risk for attempting suicide, though studies examining this risk have reached inconsistent conclusions. Recent authors who have looked at larger community-based samples have more clearly demonstrated that these youth are at greater risk. We will review the data from these newer studies, focusing in particular on what factors aside from sexual orientation increase the likelihood for many gay and lesbian youth to contemplate or attempt suicide, and we will discuss theoretical etiologies for the increased risk, including the role of societal and internalized homophobia. We will also look more broadly at the prevalence of other mental disorders in this population. Through clinical discussion and case presentation, the latter part of the presentation will focus on identifying and evaluating gay and lesbian youth in a variety of settings, and intervention and treatment approaches. We will discuss resources available to gay and lesbian youth in schools and local communities as well as national resources. This workshop should be of

interest to anyone who works with youth and young adults.

REFERENCES:

1. Fergussen DM, Horwood LJ: Is sexual orientation related to mental health problems and suicidality in young people? Arch Gen Psychiatry 1999; 56: 876–880.
2. Remafedi G, Furrow JA: Risk factors for attempted suicide in gay and bisexual youth. Pediatrics 1991; 87: 869–875.

Workshop 14 **Wednesday, October 25 3:30 p.m.-5:00 p.m.**

ARRESTING A PSYCHIATRIC INPATIENT: CLINICAL AND ADMINISTRATIVE ISSUES

Ali Khadivi, Ph.D., *Associate Director of Psychology, Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, 6th Floor, Bronx, NY 10456*; Merrill R. Rotter, M.D.; Harvey Bluestone, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to understand the clinical, legal, and administrative issues involved in arresting psychiatric inpatients from a hospital.

SUMMARY:

The number of psychiatrically ill patients who have had involvement with the criminal justice system is rising. Consequently, the incidents of arresting psychiatric patients who break the law during the course of their hospitalization has also increased. The purpose of this workshop is to explore the clinical and administrative issues that are involved in arresting a psychiatric inpatient.

The workshop will start with a brief review of relevant research on characteristics, patterns, and outcome of mentally ill patients arrested during their hospitalization. Then using case examples the presenters will discuss the clinical and administrative challenges involved in making a decision to arrest a psychiatric patient. Emphasis will be placed on how to protect the rights and the safety of the arrestee, while at the same time ensuring the safety of other patients and the staff. In addition, the psychodynamic issues, in particular the role of countertransferance reactions in the decision-making processes, will be discussed.

The workshop will be highly interactive; the audience will be invited from the start to share their experiences with arresting a psychiatric inpatient. At the end of the presentation there will be an open discussion between the participants and the presenters.

REFERENCES:

1. Norko MA, Zonana HV, Phillips RTM: Prosecuting assaultive psychiatric patients. Journal of Forensic Sciences 1992; 37: 923–931.
2. Volavka J, Mohammad Y, Vitrai J, Connolly M, Stefanovic M, Ford M: Characteristics of state hospital patients arrested for offenses committed during hospitalization. Psychiatric Services 1995; 46: 796–800.

Workshop 15 **Wednesday, October 25 3:30 p.m.-5:00 p.m.**

STRIVING AND SURVIVING: STRATEGIES FOR COMMUNITY HOSPITAL CARE

Ann K. Morrison, M.D., *Assistant Professor and Director of Community Psychiatry, Wright State University, P.O. Box 927, Dayton, OH 45401-0927*; Lisa M. Christensen, M.B.A.; Jerome J. Schulte, M.D.; Margaret S. Sisson, B.S.N.; Douglas A. Songer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should be able to describe training, programming, and system changes necessary to treat the more acutely ill patients now being admitted to inpatient psychiatric units of general hospitals.

SUMMARY:

The characteristics of inpatient psychiatric units in general hospitals have changed dramatically in the last decade. Lengths of stay have decreased, while patients present with more complex psychiatric, substance use, and general medical disorders. From 1996 to the present, opening of a county-wide crisis center and contracts between the mental health board and general hospitals accelerated these changes in our community. Adaptations described will include redesign of units, training for staff, new programming for patients, changes in staffing, linking with the community mental health system and probate court, and an outreach program bridging hospital discharge and community treatment. Reactions of staff to the changes in their work environment and effective administrative responses to these reactions will be described. Strategies that strive to provide both better care for our patients and professional satisfaction for staff will be emphasized. The participants include the clinical officer for the mental health board, nurse managers, and medical and training directors for the inpatient units. The target audience would be anyone practicing in a

community hospital inpatient setting. Ample time will be allotted for participation by the audience to both inquire about the programs described and share their own struggles and successes.

REFERENCES:

1. Mechanic D, et al: Changing patterns of psychiatric inpatient care in the United States, 1988–1994. Archives of General Psychiatry 1998; 55:785–791.
2. Grilo CM, et al: Controlled study of psychiatric comorbidity in psychiatrically hospitalized young adults with substance use disorders. Am J Psychiatry 1997; 154.

Workshop 16 **Wednesday, October 25**
3:30 p.m.-5:00 p.m.

CLINICAL RISK MANAGEMENT OF STALKING AT A CERTIFIED HOUSING PROGRAM

Scott R. Masters, M.D., *Department of Psychiatry, New York State Psychiatric Institute, and Assistant Clinical Professor, Inwood Clinic, Columbia University, 26 Sherman Avenue, New York, NY 10040*; Sabra Goldman, M.S., *Executive Vice President, Association for Rehabilitative Case Management and Housing, 588 Broadway, Suite 405, New York, NY 10012*; Daniel Johansson, M.Div.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, participants will be able to identify key strategies to effectively and safely work with the mentally ill client with a history of stalking.

SUMMARY:

Stalking is a crime involving acts of pursuit of an individual over time that are threatening and potentially dangerous. It is estimated that one million adult women and 0.4 million adult men are stalked annually in the United States. Some studies suggest that 63% of stalkers have a history of serious mental illness, and that stalking is not a crime typically committed by individuals with antisocial personality disorder or extensive criminal histories.

Managing such situations can present a formidable challenge to community organizations. In this workshop, participants will hear details of the clinical management of a mentally ill client who obsessively followed and threatened another client and several staff members. At several junctures, participants will be asked to suggest how they might handle the situation, including their countertransference, plans of action, and potential involvement of the criminal justice system or psychiatric hospital.

Suggestions on interventions from the growing literature on stalking will be offered and discussed in an informal manner. Guidelines from the literature on management of stalking and treatment for the victims of stalking will be distributed.

TARGET AUDIENCE:

Clinical and supervising psychiatrists, case managers, and program directors.

REFERENCES:

1. Meloy JR: The psychology of stalking, in The Psychology of Stalking, Clinical and Forensic Perspectives. Edited by Meloy JR. New York, Academic Press, 1998.
2. Meloy JR: The clinical risk management of stalking. Am J of Psychotherapy 1997; 51:174–184.
3. Zona M, Sharma K, Lane J: A comparative study of erotomanic and obsessional subjects in a forensic sample. J of Forensic Science 1993; 38: 894–903.

Workshop 17 **Wednesday, October 25**
3:30 p.m.-5:00 p.m.

UPDATE ON THE PRACTICE GUIDELINES FOR THE TREATMENT OF PATIENTS WITH BPD AND HIV/AIDS

APA Steering Committee on Practice Guidelines

John S. McIntyre, M.D., *Chair, Department of Psychiatry and Behavioral Health, Unity Health System, and Past President, American Psychiatric Association, 81 Lake Avenue, 3rd Floor, Rochester, NY 14608*; John M. Oldham, M.D.; J. Stephen McDaniel, M.D.

EDUCATIONAL OBJECTIVES:

The purpose of this workshop is to provide an update concerning the overall progress of the APA practice guideline effort and obtain feedback/answer questions on a wide variety of issues relating to the project in general and the development of the Borderline Personality Disorder and HIV/AIDS guidelines.

SUMMARY:

The APA practice guidelines project has moved forward using an evidence-based process designed to result in documents that are both scientifically sound and clinically useful to practicing psychiatrists. The foundation for treatment of each disorder is psychiatric management, which is combined with specific treatments in order to optimize patient outcome.

The borderline personality disorder practice guideline focuses on the evaluation, selection, and application of

both psychosocial treatments and pharmacologic interventions and provides a framework for clinical decision making. Formulating and implementing a treatment plan utilizing psychiatric management in conjunction with specific pharmacologic and psychosocial treatments will be discussed in the context of borderline personality disorder.

Additionally, workshop panelists will present the final draft of the HIV/AIDS Practice Guideline. By using case vignettes, practical application of the practice guideline and quick reference guide will be discussed.

Persons attending the session are 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 Psychiatry 1993; 150:2.
2. American Psychiatric Association: Practice Guideline for the Treatment of Patients with Panic Disorder Am J Psychiatry 1998; 155:5.

Workshop 18 **Wednesday, October 25**
3:30 p.m.-5:00 p.m.

MENTAL ILLNESS AND CULTURE: ANTHROPOLOGICAL AND INTERNATIONAL PERSPECTIVES

1999–2001 APA/Bristol-Myers Squibb Fellows

Ernest P. Alaimalo, M.D., *1999–2001 APA/Bristol-Myers Squibb Fellow, and Resident, Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, Honolulu, HI 96813-2548*; Sara K. Gardiner, M.D.; Leslie A. Horton, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be familiar with core anthropological and international psychiatric concepts in culturally diverse populations. In addition the participant should be able to appreciate the influence of culture on the presentation and treatment of patients with mental illness.

SUMMARY:

The concept of culture is central to fully understanding a patient's presentation, clinical course, and response to treatment in a psychiatric setting. Cultural norms and beliefs may influence a patient's decision to seek psychiatric treatment and also may affect treatment outcomes. Appreciating the influence of cultural beliefs on a patient's understanding of etiology and appropriate treatment of mental illness is crucial to providing competent care to culturally diverse populations. An awareness of these factors helps a mental health professional gain a more complete understanding of a patient's clinical presentation, strengthens the relationship with a mental health professional, and improves identification of non-psychiatric resources, which may benefit the patient. In this workshop we will examine the anthropological perspectives on mental illness by addressing the interaction between culture, the individual, emotion, and mental disorders. To elucidate the complex influence of culture on mental illness we will provide specific examples from the African continent and the South Pacific region. From Zambia and other sub-Saharan African countries, we will focus attention on the clinical presentations of patients to psychiatric services, explanatory models of mental illness, and the use of traditional healers. Similarly, we will look at the Polynesians (Maori, Hawaiians, and Samoans) in the South Pacific region and how culture influences the approach and utilization of psychiatric services.

TARGET AUDIENCE:

Psychiatrists, psychologists, social workers, anthropologists, and professionals with interest in international psychiatry.

REFERENCES:

1. Alarcon R (ed): The Psychiatric Clinics of North America: Cultural Psychiatry. WB Saunders, Philadelphia, 1995.
2. Patel V: Explanatory models of mental illness in Sub-Saharan Africa. Soc Sci Med 1995; 40(9): 1291–1298.

Workshop 19 **Wednesday, October 25**
3:30 p.m.-5:00 p.m.

WHAT THEY DIDN'T TELL YOU: ISSUES IN COMMUNITY PSYCHIATRY TRAINING

American Association of Community Psychiatrists

John J. Haggerty, Jr., M.D., *Associate Professor of Psychiatry, University of North Carolina School of Medicine, CB-7160, Chapel Hill, NC 27599*; Stephen M. Goldfinger, M.D.; David L. Cutler, M.D.; Kenneth S. Thompson, M.D.; Elizabeth M. Oudens, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to discuss current issues in community psychiatric education, including the relationship between training activities and training site characteristics; the concept of service-learning; typical deficiencies in residency training; supportive psychotherapy as a train-

ing activity; and support networks for community psychiatry trainers.

SUMMARY:

Attempts to provide high-quality psychiatric training experiences in community settings are simultaneously fraught with peril and laden with opportunity. The sometimes unstable nature of fiscal support for community programs, the concentration on patients with serious and persistent mental illness and frequent comorbid trauma histories and substance abuse, and the emphasis on multidisciplinary teamwork instead of solo or group practice can all lead to exciting but at times precarious training environments.

In this workshop, designed to meet the needs of educators, clinicians, and trainees working in public sector settings, we shall explore five aspects of such training: issues in the degree of fit between training program expectations and training site characteristics; the concept of "service-learning" as applied to community psychiatry training; deficiencies in residency training, which predictably lead to difficulties in the transition from residency to public sector practice; the use of supportive psychotherapy with chronically ill patients as a training activity; and a support network for community psychiatric educators, which has emerged under the aegis of the American Association of Community Psychiatrists. Participants will have ample opportunity to share their experiences regarding these and related issues in community psychiatry training.

REFERENCES:

1. Committee on Psychiatry and the Community, Group for the Advancement of Psychiatry: Resident's Guide to Treatment of People with Chronic Mental Illness, report #130. Washington, DC, American Psychiatric Press, 1993.
2. Cutler DL, Wilson WH, Pollack DA, et al: Training in community psychiatry, in Practicing Psychiatry in the Community: A Manual. Edited by Vaccaro JV, Clark GH. Washington, DC, American Psychiatric Press, 1996, pp. 461–474.

Workshop 20 **Thursday, October 26**
8:00 a.m.-9:30 a.m.

COLLABORATION BETWEEN RESEARCHERS AND CLINICIANS IN THE COMMUNITY

Scott R. Masters, M.D., *Department of Psychiatry, New York State Psychiatric Institute, and Assistant Clinical Professor, Inwood Clinic, Columbia University, 26 Sherman Avenue, New York, NY 10040*; Carole Siegel, Ph.D.; Cherie Makay, M.S.; Charles M. Barber, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, participants will be able to identify the components of an effective collaboration between researcher and community housing organization.

SUMMARY:

Increasingly, community organizations are being approached as sources of research ideas and as a source of research subjects in a more naturalistic setting. They can offer access to potential subjects with compliance problems, refractory illness, and history of homelessness. The training, expectations, and focus of involvement can be markedly different, however, between researcher and community worker. While there are several models of community agencies collaborating with academic research centers, there is little published on the effect of research done at smaller, unaffiliated community residences through informal collaborations. This workshop will bring together participants who have experience in forming alliances in the community to promote research and improved services in the community sector.

The workshop will explore the perspectives of the client, program directors, and the researcher. Issues to be covered include confidentiality issues, payment for participation, and the sharing of data and results. Participants will be encouraged to share their own experiences with similar collaborations.

REFERENCES:

1. Klein DF, Smith LB: Organizational requirements for effective clinical effectiveness studies. Prevention and Treatment 1999; 2, np.
2. Drake RE, Becker DR, Bartels SJ: Demystifying research: applications in community mental health settings, in Practicing Psychiatry in the Community: A Manual. Edited by Vaccaro JV et al. Washington, DC, American Psychiatric Press, 1996, pp. 475–484.

Workshop 21 **Thursday, October 26**
8:00 a.m.-9:30 a.m.

A COLLABORATIVE STUDY BETWEEN MANAGED CARE AND ACADEMIA TO ASSESS PRACTITIONER COMPLIANCE WITH APA TREATMENT GUIDELINES

1999–2001 APA/Bristol-Myers Squibb Fellows

Alan M. Langlieb, M.D., M.P.H., M.B.A., *1999–2001 APA/Bristol-Myers Squibb Fellow, and Department of Psychiatry, Johns Hopkins University School of Medicine, 600 North Wolfe Street, Meyer 131, Baltimore, MD 21287*; Michael R. Clark, M.D., M.P.H., *118 Hilltop Road, Silver Spring, MD 20910-5448*; Michael J. Kami-

nsky, M.D., M.B.A.; Paul R. McHugh, M.D.; Jonathan D. Book, M.D.; Andrew B. Rudo, M.D.; Laurence J. Pezor, Jr., M.D.; Robert G. Cumming, M.D.; Mary Botticelli; Gary W. Nyman, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to have a better understanding of compliance rate with APA treatment guidelines and the opportunities available for research in managed care.

SUMMARY:

The American Psychiatric Association (APA) has created practice guidelines for twelve psychiatric disorders to assist health professionals with the task of implementing specific treatments. Two of these, Major Depressive Disorder (MDD) and Substance Use Disorders represent unique and challenging problems for the clinician. Moreover, MDD has a lifetime prevalence of 5.8% in adults and is a leading cause of morbidity and mortality. Substance use disorders cost our society in excess of $300 billion annually.

In an effort to assess practitioner adherence to the APA Guidelines for MDD and Substance Use Disorders, the Johns Hopkins Department of Psychiatry and Magellan Behavioral Health, the nation's largest specialty managed care organization (MCO), have collaborated in a pilot study. The purpose of the study is to determine whether practitioner adherence to the guidelines can be influenced by written feedback from the MCO in an effort to improve the quality of patient care and the effectiveness with which psychiatric services are delivered.

An audit tool was developed to measure compliance in three separate but related areas of patient care: (1) assessment criteria of the patient's history and mental status exam, (2) diagnostic criteria, and (3) provider compliance with each of the treatment guidelines. Three groups were studied: (1) those receiving a "provider alert" newsletter containing the aggregate results of the study; (2) those who received (1) and their individual results; and (3) those who received neither. After receiving feedback, provider data were obtained by chart audit, one and two years later.

Preliminary results of our findings will be presented. In addition, the process of developing strategic partnerships between managed care and academic medicine will be explored in a panel discussion.

REFERENCES:

1. The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Quality first: Better health care for all Americans. Washington, DC; US Government Printing Office; 1998.
2. Practice Guideline for the Treatment of Patients With Major Depression and for Patients With Substance Use Disorders: Alcohol, Cocaine, Opioids. American Psychiatric Press, Inc., 2000.

Workshop 22 **Thursday, October 26**
8:00 a.m.-9:30 a.m.

PSYCHODYNAMIC PSYCHOTHERAPY AND MANAGED CARE

Steven S. Sharfstein, M.D., *Chief Executive Officer, President and Medical Director, Sheppard-Pratt Hospital, 6501 North Charles Street, Baltimore, MD 21204-6819*; Donald R. Ross, M.D., *Director, Education and Residency Training, Sheppard-Pratt Hospital, 6501 North Charles Street, Towson, MD 21204*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) discuss two areas of compatibility and two areas of conflict between psychodynamic psychotherapy and managed care, and (2) outline at least one adaptation within their practice setting where psychodynamic psychotherapy and managed care can be integrated.

SUMMARY:

The "integration" of psychodynamic psychotherapy and managed care is like an arranged marriage in which neither party is happy. However, the clinical needs of patients and the financial needs of third-party payers insist upon this union. Consequently, leaders of psychiatric institutions must find a way to help these two parties live together, if only for the sake of the children (or patients/clients/customers/trainees). Sheppard Pratt Health System has a long tradition, dating back to Harry Stack Sullivan, of using psychodynamic psychotherapy in flexible and innovative ways. Sheppard Pratt also has become a leader in behavior health care delivery in a managed care dominated marketplace. This has created tensions that have forced the leadership to confront and find ways to creatively adapt to this "marriage" of viewpoints. Two arenas in particular have served as crucibles within which Sheppard Pratt has forged new ways of defining its mission, vision, strategy, and tactics for delivering quality patient care in the 1990s. First, the long-term treatment of difficult patients with affective, dissociative, and borderline pathology (Sheppard Pratt's former long-term inpatients) has been redefined through a creative use of the continuum of care, including the formation of alternative housing on and off campus. Second, the training of today's psychiatric residents in psychodynamic psychotherapy has required a merger of programs with the University of Maryland Medical System (beginning in 1995) and a refocusing of re-

sources in the Residents Outpatient Clinic. By critically examining these solutions, including the tensions that remain, we hope to focus discussion on the challenges of integrating psychodynamic psychiatry and managed care.

REFERENCES:

1. Sharfstein SS: Psychotherapy and managed care: compatible or incompatible, in Janowsky DS, Ed. Psychotherapy: Indications and Outcomes. Am Psychiatric Press: Washington DC, 1999, pp 385–398.
2. Quaytman M, Sharfstein SS: Treatment for severe borderline personality disorder in 1987 and 1997. Am J Psychiatry 1991; 154:1139–1144.

Workshop 23 **Thursday, October 26**
8:00 a.m.-9:30 a.m.

DEVELOPING OUTCOME MEASURES IN COMMUNITY MENTAL HEALTH PROGRAMS

Linda Sacco, C.S.W., *Program Coordinator, Mobile Crisis Unit, Bronx Community Mental Health Services, Visiting Nurse Service of New York, 1601 Bronxdale Avenue, Bronx, NY 10462*; Neil Pessin, Ph.D.; David C. Lindy, M.D.; Carmen Tieso, C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should understand the principles of developing outcomes measures in community mental health programs, and design an outcome evaluation plan for community mental health programs.

SUMMARY:

Outcome evaluation in mental health programs has become of paramount importance due to managed care and the advent of performance-based contracts. The days of providing funding based upon "good intentions" will soon be replaced by funding for concrete results. Mental health programs are being required to prove the effectiveness of their interventions and services. This task is especially difficult for smaller, community-based programs whose resources, both in personnel and finances, are stretched to the limit. The question becomes, how to develop an outcome evaluation plan that is comprehensive, cost and time effective, yet is relatively painless to implement.

The Visiting Nurse Service of New York Division of Community Mental Health confronts this issue. It's 22 home-based programs provide outreach and mental health services to New York City's most vulnerable populations, including children, persons with AIDS, the elderly, the homeless, and the chronically mentally ill. The presentations will focus on both the administrative and clinical challenges in developing a system of evaluation that fits the needs of programs that work with diverse clientele where successful outcomes are equally diverse. This is especially true in our Mobile Crisis Program where a successful outcome might be in hospitalizing a client, or in diverting an unnecessary hospitalization, or getting a phobic child to return to school. Issues of concern include how to decide what is a successful outcome, utilizing instruments across diverse programs, and increasing staff investment in the process. Particular attention will be paid to the potential issues and problems in dealing with consumers who do not get better. Participant involvement will be encouraged in discussing innovative techniques and programs that are being developed to address the need for outcome evaluation.

REFERENCES:

1. Smith RG, Manderscheid RW, Flynn LM, et al: Principles for Assessment of Patient Outcomes in Mental Health. Psychiatric Services 1997; 48(8): 1033–1036.
2. Speer, David: Mental Health Outcome Evaluation. New York, Academic Press, 1998.

Workshop 24 **Thursday, October 26**
10:00 a.m.-11:30 a.m.

DEALING WITH ORGANIZATIONAL CHANGE: MERGER MANIA AND MAYHEM

Kathleen M. Fisher, Ph.D., *Assistant Professor of Nursing, Penn State University, 20 Briarcrest Square, Hershey, PA 17033*; Paul A. Kettl, M.D.; Nancy Bonalumi, R.N., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should understand that the change process and encouraging resilience are essential in successfully managing organizational change.

SUMMARY:

Dramatic changes in health care delivery have stimulated the health care industry to refocus and reorganize. Mergers and various alliances among health care delivery systems are commonplace as the industry responds to purchasers' demand for high-quality, low-cost health service products. Anxiety, conflict, confusion, resistance, and even hostility can be associated with such major organizational change. Concerns typically focus on job security (Will I stay employed?); role ambiguity (Will my role or responsibilities at work be different?); job satisfaction (Will the new organization provide threats or opportunities?); role conflict (Will this new

team be able to work together?); and time frame (When is this going to happen?).

Accepting change as inevitable and taking personal control and responsibility for it needs to be acknowledged by all in the health service industry today. Moving toward that position can best be achieved through an understanding of what change means to individuals.

The concept of resilience, which is the ability to absorb high levels of change while displaying minimal dysfunctional behavior, will be explored during this interactive workshop.

REFERENCES:

1. Bonalumi N, Fisher K: Health care change: challenge for nurse administrators. Nurs Admin Q 1999; 23:69–73.
2. Coner DR: Managing at the Speed of Change. New York, Villard Books, 1993.

Workshop 25 **Thursday, October 26**
10:00 a.m.-11:30 a.m.

COUNTERTRANSFERENCE REACTIONS IN THE TREATMENT OF THE BORDERLINE PATIENT

Philadelphia Association for Psychoanalysis

Isaiah A. Share, M.D., *Psychoanalyst, Philadelphia Association for Psychoanalysis, 1443 Hagys Ford Road, Narberth, PA 19072-1139*; Richard B. Cornfield, M.D., *Psychoanalyst, Philadelphia Association for Psychoanalysis, 8 East Newfield Way, Bala Cynwyd, PA 19004-2322*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize forms of countertransference that may develop in the treatment of the sicker patient; to understand the utility regarding treatment in the understanding and working with these often subtle, disguised reactions.

SUMMARY:

It is widely recognized that psychotherapy with the borderline patient mobilizes intensely hostile and negative affects within the therapist, responses about which the therapist is often only dimly aware. The nature of the conflict(s), which precipitate these quick and automatic-seeming reactions is initially hidden from the most knowledgeable and sophisticated psychotherapist or psychoanalyst.

It is the aim of this workshop to, first, describe and illustrate with clinical examples some of these ubiquitously occurring responses, and second, to demonstrate, also with clinical examples, the powerful positive therapeutic results that can be achieved when the therapist is able to acknowledge, understand, and work with his/her countertransference reactions.

Emphasis will be placed on the internal psychological processes where transferences from the patient to the therapist impinge on conflicts within the therapist to produce disruptive identifications and subtle, potentially damaging (to the therapeutic process) enactments, which stem from the therapist. They can affect recommendations for patient management including the use of psychopharmacologic agents. The wide range and variegated types of countertransference reactions will also be discussed in order to increase participants' familiarity with the phenomena.

REFERENCES:

1. Abend SM, Porder MS, Willick MS: Borderline Patients: Psychoanalytic Perspectives. New York, International Universities Press, 1983.
2. Jacobs TJ: On countertransference enactments. J Am Psychoanal Assoc 1986; 34:289–307.

Workshop 26 **Thursday, October 26**
10:00 a.m.-11:30 a.m.

REDUCING LIABILITY RISKS FOR THE CLINICIAN

Paul S. Appelbaum, M.D., *Vice President, APA Board of Trustees, A. F. Zeleznik Professor and Chair, Department of Psychiatry, and Director, Law and Psychiatry Program, University of Massachusetts Medical School, 55 Lake Avenue, North, Room S7-866, Worcester, MA 01655*; Debra A. Pinals, M.D.

EDUCATIONAL OBJECTIVES:

This workshop will review recent developments affecting some of the major liability risks for clinicians and to provide practical guidelines on reducing those risks.

SUMMARY:

The liability risks faced by psychiatrists and other mental health professionals are constantly evolving. This presentation is aimed at helping clinicians understand the parameters of malpractice and other forms of liability that they may face in today's evolving health care system. After a brief overview of legal rules governing clinicians' liability, the presenters will address several areas of special concern. First, the obligations of clinicians when managed care companies decline to authorize requested treatment are becoming increasingly clear, focusing on advocacy for patients' interests and involvement of patients in subsequent treatment decision making. Next, the duty to protect patients from self-injury will be considered, along with recent developments evidencing a willingness on the part of some courts to

recognize patients' responsibilities to act reasonably in regard to their own well-being. Finally, the management of dangerous patients will be addressed, with consideration of recent court decisions regarding the duty to protect third parties. Emphasis will be placed on practical steps that clinicians can take to reduce the risk of malpractice liability. Discussions about particular issues faced by audience members will be encouraged.

REFERENCES:

1. Gutheil TG, Appelbaum PS: Clinical Handbook of Psychiatry and the Law, 3rd edition. Baltimore, Williams & Wilkins, 2000.
2. Appelbaum PS: Patients' responsibility for their suicidal behavior. Psychiatric Services, 1:2000.

Workshop 27 **Thursday, October 26**
10:00 a.m.-11:30 a.m.

A COMMUNITY PILOT: TREATING WOMEN WITH MENTAL ILLNESS AND TRAUMA

Susan Caldwell, M.Ed., *Therapist, Horizon House, Inc., 120 South 30th Street, Philadelphia, PA 19104*; Ava Atzram, M.S.N., *Therapist, Horizon House, Inc., 120 South 30th Street, Philadelphia, PA 19104*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant should be able to: 1) recognize that inner city populations diagnosed with a major mental illness also have a high prevalence of past physical and sexual trauma; 2) assess trauma in the context of mental illness; and 3) develop and implement trauma recovery treatment in community settings.

SUMMARY:

This workshop will target community and hospital based mental health professionals interested in trauma recognition, treatment, and recovery. A history of physical and sexual trauma is common in women seen for the treatment of severe mental illness, especially in economically disadvantaged populations. We will report on the system-wide implementation of the Trauma Recovery and Empowerment (TREM) Model developed by Maxine Harris of Community Connections, Washington, D.C., at a community agency in Philadelphia. The training component of this pilot project consists of general training for staff from city-wide agencies, and intensive treatment training and supervision for the core team. The presentation will cover the results of the 36-week treatment pilot. Treatment methodology follows the prescribed curriculum developed by TREM. Outcomes will be discussed for client participants. We will show an increase in skill and a reduction in the use of unnessessary treatment and rehabilitation services. For clinicians, we will demonstrate increased competance in identifying trauma. Accurate identification leads to appropriate treatment. For a person with trauma experiences that remain undiagnosed and untreated, the consequences often are ineffective and expensive interventions. We hope to convey an alternative approach to trauma issues emerging in clinical practice, especially in disenfranchised populations.

REFERENCES:

1. Van der Kolk BA: Psychological Trauma. Washington, D.C. American Psychiatric Press, 1987.
2. Harris M: Trauma Recovery and Empowerment A Clinician's Guide For Working With Women in Groups. New York, NY, The Free Press, 1998.

Workshop 28 **Thursday, October 26**
1:30 p.m.-3:00 p.m.

FROM THE COUCH TO THE PARK BENCH: PSYCHOTHERAPY WITH HOMELESS PERSONS

Jaak Rakfeldt, Ph.D., *Associate Professor, School of Professional Studies, and Assistant Professor, Department of Psychiatry, Yale University, Lang Social Work Center, Southern Connecticut State University, 101 Farnham Avenue, New Haven, CT 06515*; Kenneth S. Thompson, M.D.; Deborah A. Fisk, M.S.W.; Diane Johnson, R.N.

EDUCATIONAL OBJECTIVES:

At the end of this workshop, participants should be able to integrate psychotherapeutic techniques into their clinical work with homeless persons with mental illness, as well as recognize the important role of psychiatrists in implementing clinical case management programs in community settings.

SUMMARY:

The clinical services provided to homeless persons with mental illness through assertive outreach programs have been largely unconventional, prompting clinicians and psychiatrist to redefine psychotherapy in their clinical work on the streets. Clinicians engage in various nontraditional activities with homeless persons in an effort to build a trusting and therapeutic relationship with them. This relationship provides the foundation for ongoing clinical contacts with clients in various community settings, such as soup kitchens, shelters, under highway bridges, or on park benches. The goals of the relationship and ongoing clinical contact are to help clients gain insight into their illness and their homelessness, and

to help clients make steady progress toward accepting the clinical and support services that they need. In this workshop, a multidisciplinary staff from two homeless outreach teams draw from clinical cases to explore the following: the dynamic process involved in the clinical engagement of homeless persons with mental illness, the theoretical concepts and techniques of psychodynamic psychotherapy and relate these to clinical work on the streets with homeless persons with mental illness and specific strategies that can help individuals receive the clinical, rehabilitative, and housing supports that they need.

TARGET AUDIENCE:

Mental health professionals and administrators.

REFERENCES:

1. Fisk D, Rakfeldt J, Heffernan K, Rowe M: Outreach worker's experiences in a homeless outreach project: issues of boundaries, ethics, and staff safety. Psych Quart 1999; 70(3):231–246.
2. Sledge WH, Astrachan B, Thompson K, Rakfeldt J, Leaf P: Case management in psychiatry: an analysis of tasks. The American Journal of Psychiatry 1995; 152(9):1259–1265.

Workshop 29 **WITHDRAWN**

Workshop 30 **Thursday, October 26**
1:30 p.m.-3:00 p.m.

PSYCHIATRIC ILLNESS AND THE WORKPLACE

Steven E. Pflanz, M.D., *Chief, Mental Health Services, F.E. Warren U.S. Air Force Base, 408 West First Avenue, Cheyenne, WY 82001*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should understand the relationship between work stress and mental health and the role of the mental health professional in minimizing the impact of job stress on the emotional health of workers.

SUMMARY:

Increasingly, both industry and mental health professionals are recognizing that work stress is a major factor in the mental health of employees. Psychiatrists and other mental health professionals are often faced with patients suffering from emotional distress that is attributed to job stress. Importantly, 15% of American workers experience at least one episode of psychosocial disability every year. Mentally ill workers exhibit decreased productivity, increased workforce turnover, higher absenteeism, and increased medical care utilization. These combined factors cost industry $150 billion annually. The relationship between the work environment and the mental health of employees has received little research attention. Nonetheless, 30% of U.S. workers report exposure to mental stress at work and 14% believe that their experience of work stress could be deleterious to their mental health. Both exposure to acute traumatic events and chronic daily stress at work can produce or exacerbate psychiatric symptoms. In this workshop, we will discuss the complex relationship between the work environment and mental health. We will examine the common sources of job stress and the mechanisms by which work stress can lead to psychiatric illness. Lastly, we will explore how the mental health professional can forge a partnership with patients and employers to reduce work stress and ameliorate or eliminate psychiatric illness in working patient populations.

TARGET AUDIENCE:

General psychiatry, occupational psychiatry.

REFERENCES:

1. Pflanz SE, Skop B: Occupational stress & mental illness in the military. Southern Medical Journal 1998; 91 (10):S63.
2. Pflanz SE: Psychiatric illness & the workplace. Military Medicine 1999; 164 (6):401–406.

Workshop 31 **Thursday, October 26**
1:30 p.m.-3:00 p.m.

FROM ALIENATION TO ALLIANCE: ENGAGING THE MENTALLY DISORDERED OFFENDER

Merrill R. Rotter, M.D., *Director, Division of Law and Psychiatry, Albert Einstein College of Medicine, and Bronx Psychiatric Center, 1500 Waters Place, Bronx, NY 10461*; Michael F. Steinbacher, M.A.; Jack Carney, D.S.W.; Alan D. Felix, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the unique challenges that exist in treating the mentally disordered offender, to recognize these challenges as opportunities for engagement, and to use the approaches presented to take advantage of these opportunities.

SUMMARY:

Increasingly the treatment of the mentally disordered offender is a routine practice of community psychiatry. Individuals who suffer from mental illness and who have

a history of offending behavior present with a clinical picture that is often complicated by substance abuse, character pathology, and the behaviors that result from exposure to environmental stressors such as homeless and correctional incarceration. Each of these so-called complications presents challenges to as well as opportunities for therapeutic engagement. In this workshop, we present approaches to therapeutic engagement that take advantage of these opportunities: a cognitive-behavioral approach that targets criminal recidivism, based on principles of dialectical-behavior therapy; a cultural competence approach that targets the impact of correctional incarceration; and a case management approach that targets the effects of social dislocation and homelessness, which has its roots in both outreach principles of public psychiatry as well as such dynamic concepts as resistance repetition, the "holding environment," and associated transference and countertransference issues. The presentations emphasize practical tools of engagement while addressing underlying theoretical ideas. Clinical case discussions and structured exercises will allow participants to respond to the presentations and to hone their therapeutic skills.

REFERENCES:

1. Lamb HR, Weinberger LE, Gross BH: Community Tx. of severely mentally ill offenders under the jurisdiction of the criminal justice system: a review. Psy Services 1999; 50: 907–913.
2. Beauford JE, Dale EM, Bincer RL: Utility of the initial therapeutic alliance in evaluating psychiatric patients' risk of violence. American Journal of Psychiatry 1997; 154: 1272–1276.

Workshop 32 **Thursday, October 26**
1:30 p.m.-3:00 p.m.

WHAT'S IN THE PSYCHIATRIST'S DOCTOR'S BAG? CAREERS IN PSYCHIATRY

APA Committee on Medical Student Education

Tana A. Grady-Weliky, M.D., *Associate Dean of Undergraduate Medical Education, University of Rochester School of Medicine and Dentistry, 601 Elmwood Avenue, P.O. Box 601, Rochester, NY 14642*; Michael J. Vergare, M.D.; Edward K. Silberman, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop, the participant should be able to 1) recognize the myriad of career opportunities in psychiatry; 2) understand the important factors in selecting residency training programs in general and child psychiatry; and 3) enhance their knowledge of combined residency training programs and the special opportunities that such programs offer.

SUMMARY:

This is an exciting time for psychiatry. As we enter the 21st century we are learning more about the interaction of neurobiological and psychological factors in the etiology of psychiatric illnesses. Additionally, a broad spectrum of more specific treatments for these maladies is emerging. In spite of these remarkable advances, medical students are less likely to consider careers in psychiatry. There has been a decrease in the number of U.S. medical graduates entering psychiatry over the past decade. A recent study (Feifel et al., 1999) demonstrated negative attitudes toward psychiatry among medical students, which may account, in part, for the continued decline in interest. With these factors in mind, this workshop will address the myriad of career opportunities in psychiatry. We will briefly present background information about psychiatric careers and then present up-to-date information about training and career options available for students with an interest in psychiatry. In addition to a review of general and child psychiatry residency programs, we will discuss combined residency training programs, including internal medicine/psychiatry, family medicine/psychiatry, and pediatrics/psychiatry/child psychiatry. Specifically, special career opportunities in these combined specialty areas will be addressed. There also will be discussion of advanced residency opportunities in geriatric and addiction psychiatry. This overview of psychiatric training opportunities will take no more than 45 minutes, which will leave the remaining 45 minutes for open discussion with the audience. The emphasis of this workshop is twofold: (1) to convey the excitement of careers in psychiatry, and (2) to help interested medical students understand the best career path for them among the many opportunities that our field has to offer.

TARGET AUDIENCE:

Medical students and junior residents, medical student education directors, residency education directors, and other mental health professionals interested in psychiatric education.

SPECIAL BACKGROUND REQUIREMENTS:

None

REFERENCES:

1. Ferfed D, et al: Attitudes toward psychiatry as a prospective career among students entering medical school. Am J Psychiatry 1999; 156:123-146.
2. Johns BV, et al.: Choosing the Right Psychiatry Residency & How to Get it to Choose You. Int Proc Psych 1996; 5:263–299.

Workshop 33 **Thursday, October 26**
1:30 p.m.-3:00 p.m.

OPERATIONALIZED PSYCHODYNAMIC DIAGNOSIS

Manfred Cierpka, M.D., *Medical Director, and Chair, Department of Family Therapy, University of Heidelberg, Germany, Bergheimer Street 54, Heidelberg, Germany 69115*; Gerd Rudolf, M.D.; Wolfgang Schneider, M.D., Ph.D.; Gerhard Schuessler, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand operationalized psychodynamic diagnoses and apply these techniques in patient care.

SUMMARY:

OPD is the outcome of intensive cooperation of German university departments of psychosomatics and psychotherapy in order to construct a psychodynamically oriented assessment tool. The reasons for developing OPD were both the present state of psychoanalytic diagnostics and a general dissatisfaction with the purely phenomenological classification found in ICD-10 and DSM-IV. Whereas psychodynamic psychotherapy classifies mental phenomena by means of very abstractly formulated metapsychological constructs, descriptive classification systems are very limited in their use for guiding psychodynamic therapy.

OPD consists of four psychodynamic axes and one descriptive one:

I Experience of Illness and Prerequisites for Treatment
II Relation
III Conflict
IV Structure
V ICD-10

The essential points of the first four axes coincide with central psychoanalytic concepts like transference and countertransference processes, intrapsychic conflicts, and personality structure. A guideline for the initial interview covers the dimensions and items of OPD. A manual serves as a basis for the clinicians' judgments.

In this workshop, the conceptualizations of the five axes will be presented. Reliability scores derived from various studies will be shown. Results of validation studies with respect to OPD constructs will be discussed. An outline of clinical applications will be given.

REFERENCES:

1. Arbeitskreis OPD (Hrsg.): Operationalized Psychodynamic Diagnosis. (in press) 1999 Huber.
2. Arbeitskreis OPD (Hrsg.) (1998): Operationalisierte Psychodynamische Diagnostik. Huber.
3. Schauenburg H, et al: (1998): OPD in der Praxis. Huber.
4. Cierpka M, et al: Die erste Version einer operationalisierten Psychodynamischen Diagnostik, in Psychotherapeut 1995; 40: 69–87.

Workshop 34 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

PREVENTING INCARCERATION OF MENTALLY ILL ADULTS

J. Steven Lamberti, M.D., *Associate Professor of Psychiatry, Strong Ties, University of Rochester, and Director of Project Link, 1650 Elmwood Avenue, Rochester, NY 14620*; Robert L. Weisman, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to: 1) identify risk factors for incarceration of persons with severe mental illness; 2) discuss current models for prevention of jail and hospital recidivism; and 3) describe the structure and operation of Project Link.

SUMMARY:

Jails and prisons have become a final destination for persons with severe mental illness in America. Addiction, homelessness, and cultural barriers have contributed to the problem, and have underscored the need for new service delivery approaches. This workshop will present Project Link, recipient of the American Psychiatric Association's 1999 Gold Award. Project Link is a university-led consortium of community agencies that spans health care, social service, and criminal justice systems. It features three primary components: a mobile treatment team with a forensic psychiatrist and culturally diverse case advocates, a dual-diagnosis residence, and integration with the criminal justice system. The goal of Project Link is to prevent jail and hospital recidivism among multicultural populations with severe mental illness through outreach and linkage with community services.

This workshop will discuss risk factors for incarceration among the severely mentally ill, current models of prevention, and the structure and operation of Project Link. The importance of assertive outreach, cultural competence, and service integration will be emphasized. Results of a recent program evaluation of Project Link will be presented. Audience participation will be encouraged through the use of discussion questions and clinical vignettes.

REFERENCES:

1. Lamberti JS, Weisman RL, Schwarzkopf SB, Mundondo-Ashton R: Prevention of jail and hospital re-

cidivism among outpatients with schizophrenia. Schizophrenia Research 1999; 36:(1) 344.
2. Torrey EF: Out of the Shadows: Confronting America's Metal Illness Crisis. John Wiley and Sons, New York, NY, 1997.

Workshop 35 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

CULTURALLY COMPETENT TREATMENT FOR MINORITY WOMEN

APA Council on Professional Values and Human Dignity

Debbie R. Carter, M.D., *Department of Psychiatry, University of Colorado Health Services Center, 4200 East Ninth Avenue, Denver, CO 80262*; Theresa M. Miskimen, M.D., *Assistant Professor of Psychiatry, University Medical and Dental of New Jersey, 215 South Orange Avenue, Newark, NJ 17103*; Silvia W. Olarte, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the impact of culture on psychotherapeutic and psychopharmacological interventions. In addition, the audience will gain knowledge on best-care managed practices for minority women's mental health.

SUMMARY:

The need for culturally competent mental health services has been widely documented in the literature. This workshop will address and discuss how cultural factors influence treatment in clinical practice including managed care settings. The core presentations will include case vignettes covering the following topics: application of best-managed-care practices for minority women, culturally competent psychopharmacology, and depression in Latino women, a cultural perspective.

Workshop participants will be encouraged to participate actively.

TARGET AUDIENCE:

Psychiatrists, residents, and psychologists.

REFERENCES:

1. Zhou HH, Koshakji RP, Siberstein DJ: Racial differences in drug response. N England J of Med 1989; 320(9): 565–570.
2. Canino IA, Canino GJ: Psychiatric Care of Puerto Ricans. Edited by Gaw A. Washington, D.C., APA press, 1993 pp.467–99.

Workshop 36 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

PERSONALITY STYLE AND ENGAGEMENT IN CRISIS INTERVENTION

Erik J. Roskes, M.D., *Assistant Professor of Psychiatry, University of Maryland, 22 South Greene Street, P.O. Box 291, Baltimore, MD 21201*; Sharon Lipford, L.C.S.W.; Tiffany Thomas, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) demonstrate an understanding of the variety of client personality types presenting for crisis intervention, and (2) develop an appreciation for the need to approach clients of different personality styles in an individualized way, with an understanding of the psychodynamics underlying each individual's personality.

SUMMARY:

Little is known about the utility of psychodynamic principles in approaching, assessing, and meeting the needs of the client in crisis. Baltimore Crisis Response, Inc., has been working in the area of mobile and residential crisis intervention for the past seven years. Axis I diagnoses include mood disorders, psychotic disorders, and anxiety disorders, often with co-occurring addictive and/or medical disorders. Our average length of stay is under five days in the residential program, and somewhat longer for clients treated in their homes. Integral to the work of our agency is the case management process, which occurs from the beginning of the assessment process and continues until, and at times, after, discharge. We have identified several client types that determine the clinical approach we take in the case management process. These client types include (1) the narcissistic/independent client, (2) the passive-dependent client, (3) the overanxious client, (4) the passive-aggressive client, and (5) the "never will succeed" client. As we have refined our approach, we have determined what types of case management interventions should be applied to these various types of client. This workshop will present our work with these client types and will foster open and lively discussion.

TARGET AUDIENCE:

Crisis interventionists, clinical personnel and program administrators.

REFERENCES:

1. Patterson V, O'Sullivan M: Three perspectives on brief psychotherapy. American Journal of Psychotherapy 1974; 28(2):265–277.

2. Aguilera DC: Crisis Intervention: Theory and Methodology. St. Louis, CV Mosby Company, 1997.

Workshop 37 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

DEINSTITUTIONALIZATION OF TRAINING: FROM INPATIENT TO COMMUNITY

David M. Band, M.D., *Clinical Director, Mobile Community Outreach Treatment Team, District of Columbia Commission on Mental Health Services, 3849 Alabama Avenue, S.E., Washington, DC 20020*; Julia B. Frank, M.D., *Director, Psychiatric Clerkship, and Associate Professor, Department of Psychiatry and Behavioral Sciences, George Washington University School of Medicine, 2150 Pennsylvania Avenue, N.W., Washington, DC 20037*; Roger Peele, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to identify some of the trends and benefits of moving mental health training experiences from the inpatient setting to community-based assertive community treatment programs.

SUMMARY:

Beginning in the 1960s, through the process of deinstitutionalization, the vast majority of psychiatric inpatients were transferred from inpatient settings to community mental health systems. Many inpatient hospitals/units were closed, including entire inpatient systems.

This trend continues not only in psychiatry, but in primary care as well. The general locus of medical and surgical care has moved from inpatient to ambulatory settings. However, training of physicians and mental health professionals has not always kept pace with this vast transition. It is sometimes difficult to integrate training into an ambulatory setting. Overcoming issues such as patient refusal to participate, confidentiality, stigma, and less frequent follow up than with inpatient care are obstacles to providing a meaningful training experience. The daily intensive contact between patients and the assertive community treatment team reduces these barriers and makes an intensive training experience possible in an outpatient setting.

The public Assertive Community Treatment Program (ACT), Mobile Community Treatment Team has developed relationships with several training programs to offer community-based psychiatry and mental health clinical training to medical students, residents, externs, nursing students, and psychology interns.

A clerkship director, ward teaching attending, medical director of an ACT team, and trainees from different disciplines will each present their perspectives on this unique training experience. During the last half of the workshop, these participants will engage in an open discussion with the attendees to help enhance community-based public-academic partnerships for mental health trainees from multiple disciplines.

TARGET AUDIENCES:

Mental health professionals, trainees, and others interested in community-based mental health training and public-academic community partnerships.

REFERENCES:

1. Brown DB, et al: Training residents for community psychiatric practice guidelines for curriculum development. Community Mental Health Journal 1993: 29(3):271–283.
2. American Psychiatric Association: A Guideline for a Medical Student Curriculum in Psychiatry and Behavioral Science, Washington, D.C., 1994.

Workshop 38 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

APPLYING SANCTUARY CONCEPTS: PROJECTS FOR COMMUNITY HEALING

APA Alliance

Paula G. Panzer, M.D., *Member, APA Institute Scientific Program Committee, and Associate Chief Psychiatrist for Adult Trauma Services, Jewish Board of Family and Children Services, Inc., 500 West End Avenue, Suite GR-J, New York, NY 10024*; Sandra L. Bloom, M.D.; Brian Barger

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should recognize the fundamental tenets of a trauma-based approach to healing communities scarred by family violence.

SUMMARY:

In May 1998, Brian Barger, then an established investigative reporter for CNN, went to Juarez, Mexico, to cover a story involving a five-year string of brutal rapes and murders of more than 200 women along the U.S. border. In response, he organized the first rape crisis center in the city and launched community organizing programs to empower survivors to become involved in anti-violence programs. In May 1998, Dr. Sandra Bloom, an experienced trauma psychiatrist and author, was asked to chair a task force on family violence for Mike Fisher, Attorney General of Pennsylvania. The task force focused on six working groups representing the major social institutions. By the end of 1998, their paths

crossed, and Bloom and Barger began sharing their unique experiences. Bloom has continued developing her concepts of applying trauma theory to the building of healthy communities, be they inpatient units, schools, entire cities, or states—a notion she describes as "creating sanctuary." Barger has left his journalistic career to create a nonprofit organization, the International Trauma Resource: A Project for Community Healing, which applies the concepts of trauma theory to develop new models for community organizing in the developing world. In this workshop, Bloom and Barger will summarize their work and discuss how new understandings of the psychobiology of trauma can be translated into effective violence prevention programs. The audience will be asked to share their own experiences and discuss how these concepts can be applied to other settings.

REFERENCES:

1. Bloom SL: Creating Sanctuary: Toward the Evolution of Sane Societies, 1997.
2. Bloom SL, Reichert M: Bearing Witness: Violence, & Collective Responsibility, 1998.

Workshop 39 **Thursday, October 26**
3:30 p.m.-5:00 p.m.

SLEEPING WITH THE ENEMY: PSYCHIATRIC LEADERSHIP IN A MODEL, NONPROFIT MEDICAID BEHAVIORAL MANAGED HEALTH CARE COMPANY

Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute, Assistant Professor of Psychiatry, University of Pennsylvania Medical Center, and Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Room E-516, Pittsburgh, PA 15213*; Wesley E. Sowers, M.D.; Kenneth C. Nash, M.D.; Safdar I. Chaudhary, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to recognize the role of both psychiatric advocacy, leadership, and authority in the creation of community responsive models of medicaid managed behavioral health care.

SUMMARY:

The role of psychiatrists in the leadership and management of managed behavioral health care has been a topic of contention in the profession. Some believe that such participation is tantamount to selling out the profession. Others see it as essential to ensuring that psychiatry has any future at all. This workshop will consider these issues by elucidating the role of psychiatrists in creating, leading, and managing a model nonprofit, locally controlled Medicaid behavioral managed health care company in Pittsburgh, Pa. Presenters will describe (1) the context for the creation of the company, (2) role psychiatrists played in advocating for fundamental principles in its development and mission, and (3) the evolving role psychiatrists have played in managing both care and the company. The efforts of a joint Pennsylvania Psychiatric Society/State of Pennsylvania project to delineate the role of managed care medical directors will be described. Discussion will consider the issues of professionalism in this new era. It will focus on the necessity and means of incorporating leadership/advocacy skills, as well as administrative/management skills, into the repertoire of the profession.

REFERENCES:

1. Bodenheimer T, Casalino L: Executives with white coats—the work and world view of managed-care medical directors. NEJM 1999; 341:1945–1948.
2. Andrulis DP, Carrier B: Managed Care & the Inner City: The Uncertain Promise for Providers, Plans & Communities. San Francisco, Josey-Bass, 1999.

Workshop 40 **Friday, October 27**
8:00 a.m.-9:30 a.m.

CONTINUUM OF CARE FOR THE SERIOUSLY MENTALLY ILL IN RURAL SOUTHERN ILLINOIS

Jagannathan Srinivasaraghavan, M.D., *Professor of Psychiatry, Southern Illinois University School of Medicine, and Medical Director, Choate Mental Health and Development Center, 1000 North Main Street, Anna, IL 62906*; Thomas Richards, B.S.; Rebecca L. Gates, M.S., L.C.P.C.; Dana M. DeLong, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to learn and reflect on (1) effective continuum of care for the seriously mentally ill living in sparsely populated rural areas, (2) delivery of assertive community treatment and psychosocial rehabilitation for a small number of patients by several mental health centers working collaboratively, and (3) initiation and maintenance of patient centered Dialectical Behavior Therapy (DBT).

SUMMARY:

The state of Illinois is home to nearly 12 million people. However, the southern 28 counties covering almost one fourth of the state have less than 600,000 population served by one public psychiatric hospital and 16 mental health centers in the southern network. The

sparsity of population and vast distances necessitate innovative methods. The care for the seriously mentally ill is delivered in cooperation and collaboration between inpatient and outpatient teams and between different outpatient mental health centers. Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR) are modalities offered to eligible seriously mentally ill adults meeting specific criteria aimed at decreasing hospitalization, maximizing functioning in community, improving linkage, enhancing ability of independent living, mobilizing support network, engaging in treatment and encouraging self management, improving community integration, and developing social skills and safe social-recreational events. Specific data regarding outcome of the modalities cooperatively provided by several mental health centers will be discussed. Dialectical Behavior Therapy (DBT) is a novel therapy for borderline personality disorder based on strong relationship between therapist and patient, structured in stages with clear hierarchy of targets aimed specifically at the management of parasuicide. Continuum of therapy from inpatient to outpatient will be described. Audience participation will be encouraged.

REFERENCES:

1. McGrew JH, Bond GR, Dietzen LL, McKasson M, Miller LD: A multi-site study of client outcomes in assertive community treatment. Psychiatric Services 1995; 46:696–701.
2. Bond GR, McGrew JH, Fekete D: Assertive outreach for frequent users of psychiatric hospitals: a meta-analysis. Journal of Mental Health Administration 1995; 22:4–16.
3. Koerner K, Miller AL, Wagner AW: Dialectical Behavior Therapy: Part I: principle-based intervention for patients with multiple problems. Journal of Practical Psychiatry and Behavioral Health 1998; 4:(1)28–36.

Workshop 41 **Friday, October 27**
8:00 a,m.-9:30 a.m.

PROGRAM EVALUATION: EAT THE BEAR BEFORE THE BEAR EATS YOU

Jules M. Ranz, M.D., *Director, Public Psychiatry Fellowship, New York State Psychiatric Institute, Columbia University, 1051 Riverside Drive, P.O. Box 111, New York, NY 10032*; Susan M. Deakins, M.D.; Elizabeth M. Oudens, M.D.; Steven J. Lee, M.D.; Silviu M. Burcescu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will learn why it is important for psychiatrists serving as program managers to initiate program evaluations. They will also learn how clinician managers, without extra resources, can design and carry out useful program evaluations.

SUMMARY:

Few clinicians find evaluations by either inside (CQI) or outside (JCAHO) surveyors to be programmatically productive or relevant. Since the parameters of the evaluation have been determined by outside forces (at least from the clinicians' perspective), the evaluation is experienced as being done "to" rather than "for" the program.

Clinicians, especially those serving as program managers, can take charge of the CQI or JCAHO survey process by initiating program evaluations that use measures that accurately reflect the particular program's goals and are meaningful to the program's operations and outcomes. By being proactive in this manner, clinical program managers can create the necessary data to use the survey process to support program development.

The Columbia University Public Psychiatry Fellowship requires fellows to design and carry out program evaluations at their field placements and encourages them to continue this process after they complete their fellowship. Three alumni of the fellowship will present program evaluations they designed and carried out at their field placement or current agencies.

TARGET AUDIENCE:

Psychiatrists and other clinicians working in organizational structures, especially those with management responsibility.

REFERENCES:

1. Posavec EJ: Toward more information uses of statistics: alternatives for program evaluators. Evaluation and Program Planning 1998; 21:243–254.
2. Rossi PH, Freeman HE, Lipsey MW: Evaluation—a systematic approach, sixth edition. Thousand Oaks, Sage Publications, 1999, pp 29–33.
3. Ranz JM, Rosenheck S, Deakins S: Columbia University's Fellowship in Public Psychiatry. Psychiatric Services 1996; 47:512–516.

Workshop 42 **Friday, October 27**
8:00 a.m.-9:30 a.m.

ASSESSMENT AND MANAGEMENT OF DANGEROUSNESS IN THE HOMELESS POPULATION

APA New York County District Branch's Study Group on the Mentally Ill Homeless

Katherine Falk, M.D., *Assistant Clinical Professor of Psychiatry, Columbia University, President and*

Founder, Project for Psychiatric Outreach to Homeless, Inc., and New York State Psychiatric Institute, 141 East 88th Street, New York, NY 10128-2248; Howard W. Telson, M.D.; Alan D. Felix, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants will have better understanding of how to assess and predict violence and how to manage dangerous homeless mentally ill persons.

SUMMARY:

Issues of dangerousness in the population of homeless mentally ill persons have become a serious concern in recent years as the prevalence of violence has increased in this population. The following characteristics have been shown to be associated with risk for future violence: the presence of substance abuse, antisocial personality disorder, criminal and violent history, younger age, and association with antisocial peers. Clinicians, public-policy makers, and the police often deny the existence as well as the seriousness of the risk of violence in this population. Clinicians who are involved in the treatment of these individuals must become more aware of how to assess for risk of dangerousness and violence in their patients and know how to better manage these patients.

REFERENCES:

1. Harris GT, Rice M: Risk appraisal and management of violent behavior. Psychiatric Services 1977; 1168–1174.

Workshop 43 **Friday, October 27**
8:00 a.m.-9:30 a.m.

STAGES IN THE DEVELOPMENT OF A VETERANS AFFAIRS NETWORK-WIDE MENTAL HEALTH SERVICE LINE

James J. Nocks, M.D., M.S.H.A., *Network Director, Veterans Integrated Service Network 5, VA Capitol Network, 849 International Drive, Suite 275, Linthicum Heights, MD 21090-2229*; Stephen I. Deutsch, M.D., Ph.D., *Director, Mental Health Service Line, Veterans Integrated Service Network 5, VA Capitol Network, 50 Irving Street, N.W., Room 3A-154, Washington, DC 20422-0001*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to define a mental health service line and its potential advantages, as well as identify challenges to implementation.

SUMMARY:

The Veterans Health Administration has reorganized its medical facilities into 22 geographic units termed Veterans Integrated Service Networks (VISNs). VISN 5 is composed of three integrated Maryland hospitals, and hospitals located in D.C. and Martinsburg, W.Va. In 1995, the VISN Director appointed a task force (TF) to plan a VISN-wide continuum of mental health and substance abuse services, and identify economic inefficiencies.

Because of its effectiveness, the VISN director converted the TF to a permanent mental health committee (MHC).

The MHC evolved into the final stage with implementation of a mental health service line (SL) in August 1999. A SL approach was adopted because it offered the prospect of tighter integration across management structures than a committee or TF. The SL could effect significant improvement in three major areas: assurance of consistent and high-quality service across the VISN, budget/cost effectiveness, and planning and marketing.

The SL is essential to effect necessary changes in the level and mix of staff, as well as changes in the scope and alignment of specialized programs across sites. The SL has challenged members of mental health staffs aligned according to discipline within facilities to blend into a single SL across facilities. Moreover, the SL has created administrative challenges and tension between the leadership at each of the individual medical facilities and the SL director. Challenges that will be faced by the SL include adoption of an organizational structure that transcends facilities, while remaining responsive to local facility needs and participating in local activities. Unlike the MHC, the SL is empowered to monitor and assure that uniform high-quality psychiatric services are delivered in the most clinically effective and cost efficient manner across the VISN.

REFERENCES:

1. Charns MP: Organization design of integrated delivery systems. Hospital & Health Services Administration 1997; 42:411–432.
2. Dittbrenner H: Ensuring survival into nontraditional services. Caring Magazine 1994; 13:54–58.

Workshop 44 **Friday, October 27**
8:00 a.m.-9:30 a.m.

GENDER-SPECIFIC DRUG TREATMENT: A COMPREHENSIVE APPROACH

Aline B. Wommack, R.N., M.S., *Assistant Director for Addiction Services, San Francisco General Hospital, 1001 Potrero Avenue, 7M-24, San Francisco, CA 94110*; Anna M. Spielvogel, M.D., Ph.D., *Director, Psychiatric*

Residency Training, San Francisco General Hospital, 1001 Potrero Avenue, 7M-26, San Francisco, CA 94110-3518; Matilda M. Mengis, M.D.; Stephanie Casal, R.N., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe five core problems of women seeking treatment for alcohol and drug treatment; to describe five comprehensive gender-specific treatment interventions that will broaden and strengthen services to pregnant substance-using women.

SUMMARY:

This past decade has seen a dramatic rise in the use of heroin in the United States. Urban areas such as Baltimore and San Francisco lead the nation in opiate-related emergency room visits and opiate-related deaths. Injection drug use is often accompanied by multiple addictions to alcohol, cocaine, or other drugs. Increasingly, patients enter treatment with serious comorbid psychiatric and/or physical conditions. These conditions include: sexually transmitted diseases (STDs), bacterial infections (cellulitis, necrotizing fasciitis), tuberculosis, hepatitis B and C, and human immunodeficiency virus (HIV). The problem of multi-drug dependence accompanied by psychiatric and physical conditions creates pressures on providers to work with patients using more intensified approaches.

Historically, alcohol and other drug treatment programs have been designed to serve adult males. Few services have been designed to meet the needs of women. Even fewer services have been designed to address the needs of pregnant women. Reliable national estimates of the prevalence of alcohol and other drug use by pregnant women are not available. Yet, one of the best opportunities afforded practitioners to approach and intervene with a substance-using woman is during her pregnancy. Motivation to have a healthy baby, role normalization, and prenatal intervention afford the patient an opportunity to successfully complete alcohol and other drug treatment.

Through the presentation of a case study, this workshop examines the changing characteristics of injection drug users and the need for comprehensive psychiatric/drug treatment. The case study describes the introduction of assertive case management interventions with psychotherapy and methadone maintenance for high-risk pregnant women treated in an opiate-replacement outpatient program. This case study will serve as a beginning point for discussion regarding the changes needed to develop gender-specific services.

REFERENCES:

1. Bernstem AL, Lenhart SA: The Psychodynamic Treatment of Women. American Psychiatric Press, Washington D.C., 1993.
2. Jessup M: The treatment of perinatal addiction: identification, intervention, and advocacy. Western Journal of Medicine (Special Issue-Addiction Medicine) 1990; 152:553–558.

Workshop 45 **Friday, October 27**
10:00 a.m.-11:30 a.m.

COUNTERTRANSFERENCE IN ADDICTION AND PERSONALITY DISORDER TREATMENT

Wesley E. Sowers, M.D., *Medical Director, Center for Chemical Dependency Treatment, and Chief Corporate Officer, Center for Addiction Services, Department of Psychiatry, St. Francis Medical Center, 400 45th Street, Pittsburgh, PA 15201*; Kenneth S. Thompson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize common countertransferential issues encountered in the treatment of persons with co-occurring addictions and characterologic disturbances and the interaction between transference and countertransference in projective identifications.

SUMMARY:

This workshop will consider common countertransferential issues in the treatment of persons with addictive disorders and characterologic disturbances. To provide a context for this discussion, a historical overview of the origins of the concepts of transference and countertransference will be presented. Transference reactions commonly displayed by persons with addictions and characterologic disturbances will be considered in terms of their sustaining mechanisms and the defensive styles associated with them. A broadly defined concept of countertransference will be used to consider the wide spectrum of emotions and reactions therapists frequently experience when they attempt to engage this population, and the implications these reactions have for development of successful treatment planning. The use of countertransference to inform psychotherapeutic interventions will be discussed as well. The final portion of the workshop will consider "projective identification" as an interaction of transferential and countertransferential manifestations and as a constellation of defenses used to ward off feelings of inferiority and rejection. Participants will be asked to contribute their own perspectives and experience of working with this population, and effective therapeutic management of persons with these co-occurring disorders will be discussed.

REFERENCES:

1. Imhof, JE: Countertransference issues in alcoholism and drug addiction. Psychiatric Annals 1991; 21:292–306.
2. Kaufman ER: Countertransference and other mutually interactive aspects of psychotherapy with substance abusers. American Journal on Addictions 1992; 1:185–202.

Workshop 46 **Friday, October 27**
10:00 a.m.-11:30 a.m.

MERGING ADMINISTRATIVE AND ACADEMIC CAREERS IN PSYCHIATRY

American Association of Psychiatric Administrators

Louis J. Mini, M.D., *Associate Medical Director, Tinley Park Mental Health Center, 7400 West 183rd Street, Tinley Park, IL 60477*; Mary Ellen Foti, M.D.; Marc D. Feldman, M.D.; S. Atezaz Saeed, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to more effectively combine a formal administrative position with any desired academic interests and pursuits. Participants will also develop a clearer understanding of how to integrate separate behavioral health care systems in a mutually beneficial way.

SUMMARY:

In recent years, more psychiatrists have gravitated toward assuming administrative positions as their primary function in an ever-changing behavioral health-care environment. At the same time, many such psychiatrists have also wished to further establish or preserve professional identities as academicians. The ability to combine these two pursuits successfully often results in a very diverse, challenging, and satisfying career path. This workshop will focus on strategies to develop this type of personal career path, as presented by a panel of psychiatrists—each a high-level medical administrator from a different mental health care system, who also maintains a highly active university faculty appointment with significant teaching and/or research responsibilities. The target audience of this workshop is the administrative psychiatrist who similiarly wishes to embellish academic pursuits in his/her career.

Different models of such career development will be presented, followed by questions and discussion. Input from the participants about their own experiences and insights will be strongly encouraged. Additionally, there will be presentation and discussion about creative ways to merge academic or university mental health services with other types of behavioral health-care organizations in a harmonious fashion, which adds value to both systems.

REFERENCES:

1. Mogul KM, Dickstein LJ: Career Planning for Psychiatrists. Washington, DC, American Psychiatric Press, Inc., 1995.
2. Douglas EJ, et al: Administrative relationships between community mental health centers and academic psychiatry departments: a 12 year update. Am J Psychiatry 1994; 151:722–7.

Workshop 47 **Friday, October 27**
10:00 a.m.-11:30 a.m.

CONTROVERSIES OF CHARACTER: A SYNTHESIS OF *DSM-VI* AND PSYCHOANALYSIS

Charles J. Franchino, M.D., *Department of Psychiatry, Albert Einstein Medical Center, 676 West Johnson Street, Philadelphia, PA 19144-3706*; Daniel A. Monti, M.D., *Assistant Professor of Psychiatry, Albert Einstein Medical Center, 706 South Washington Square, #1-W, Philadelphia, PA 19106-3517*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: describe comorbidity of Axis I and II, the discrepancy between diagnosis rates of structured instruments and clinical interview methods, the unitary model integrating Axis I and Axis II, and show improved rates of diagnosis of Axis II disorders.

SUMMARY:

Numerous epidemiologic studies have documented the co-occurence of Axis I and Axis II disorders and the impact of the presence of character pathology on the successful treatment of Axis I disorders. However, this literature also reveals a striking discrepancy in diagnostic rates between clinician-interview-based diagnosis and structured-instrument-based diagnosis. Attendees of the workshop will gain an understanding of the scope of comorbidity of Axis I and II, as well as an understanding of various hypotheses, from technical to psychodynamic and psychocultural orientations, for the discrepancy between clinical interview and structured instruments.

A unitary model integrating Axis I and II will be presented as an alternative approach to conceptualizing "comorbidity" as interpenetrant, rather than as superimposed phenomena.

Clinical features of Axis II disorders, based on psychoanalytic theory will be presented to allow participants to enhance diagnostic sensitivity to the detection of char-

acter pathology. Active participation and discussion will be encouraged throughout the presentation.

TARGET AUDIENCES:

Psychiatrists, psychologists, and residents with a basic understanding of *DSM-IV* and psychoanalytic theory will benefit.

REFERENCES:

1. Westen D, Shedler J: Revising and assessing Axis II and I: developing a clinically and empirically valid assessment method. J Psychiatry 1999; 156:258–272.
2. Siever LJ, Davis KL: A psychobiologic perspective on the personality disorders. Am J Psychiatry 1991; 148:1647–1658.

Workshop 48 **Friday, October 27**
10:00 a.m.-11:30 a.m.

OUTSIDE THE BOX: CREATING A NEW KIND OF DIALOGUE BETWEEN CONSUMERS AND SYSTEMS OF CARE

Michael J. Vergare, M.D., *Consultant, APA Institute Scientific Program Committee, Professor and Chair, Department of Psychiatry and Human Behavior, Jefferson Medical School, and Professor and Chair, Department of Psychiatry, Albert Einstein Medical Center, 841 Chestnut Street, Suite 1001, Philadelphia, PA 19107*; Joseph A. Rogers; Greg Mungan

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the peer-support model and its usefulness in helping people with serious mental illness learn to advocate for themselves and to successfully negotiate systems of care.

SUMMARY:

This workshop will describe a model program whose objective is to make involuntary hospitalization and the court commitment process less overwhelming to the consumer. The program is based on the peer-support model, which minimizes or eliminates distinctions between staff and clients. The program is staffed by an ombudsperson/care coordinator (OCC) who engages consumers in the emergency room and inpatient units at two Philadelphia psychiatric facilities and in mental health court. He builds a rapport with consumers, provides them with information about their options, and offers assistance based on their needs and wishes.

The OCC provides a nontraditional alternative to the professional staff in the emergency room. He also meets with consumers attending mental health court to ensure that they are aware of their rights and options and familiarizes them with the court process. In addition, he conducts weekly advocacy/education presentations on the inpatient units, during which consumers gain information on the mental health system and can discuss their concerns in a nonclinical setting.

This presentation will be of interest to a broad audience (professionals, consumers, family members), who will gain a better understanding of the philosophy, methods, and importance of alternative approaches to mental health services.

REFERENCES:

1. Borkman TJ: Understanding Self-Help/Mutual Aid: Experiential Learning in the Commons. Piscataway, NJ, Rutgers University Press, 1999.
2. Mowbray CT, Moxley DP, Jasper CA, Howell LL: Consumers as Providers in Psychiatric Rehabilitation. Columbia, Md, International Association of Psychosocial Rehabilitation Services, 1997.

Workshop 49 **Friday, October 27**
1:30 p.m.-3:00 p.m.

BLUES, SADNESS, DEPRESSION AND MUSIC: IS THERE SOMETHING IN COMMON?

David L. Cutler, M.D., *Director, Public Psychiatry Training Program, Oregon Health Sciences University, 3181 S.W. Sam Jackson Park Road, Portland, OR 97201-3011*; Dave Van Ronk

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant will be able to appreciate the overlapping interface between American folk and blues music and the clinical experience of despair, grief, and depression.

SUMMARY:

Many of us commonly assume when we listen to music that it must be some sort of a reflection of the inner spirit of our human experience. We all attach some sort of affective meaning to it, and often it strikes a sensitive chord in us. In particular the form we think of as blues stimulates thoughts of sadness or grief, yet these pieces may have a haunting beauty to them and often have the paradoxical effect of lifting our spirits instead. What is there about this music that does this? Is there a cultural button that gets pushed or is there something universal here? Where does this music really come from? Who sang it first and under what circumstances? Finally what can we learn about ourselves and each other when we listen?

Mr. Dave Van Ronk has spent his career writing and singing in this genre. He has had first-hand contact with

some of the legendary blues artists of the early 20th century and can both play and describe the roots of this music perhaps as well as anyone around these days. He is one of the great acoustic blues musicians of our time and has consented to share his music and insights with us as well as answer questions about the mentors who influenced his style such as Mississippi John Hurt, Brownie McGhee, and Rev. Gary Davis and early century historical legends such as Jelly Roll Morton and Billie Holiday. Dr. Cutler who has worked with Mr. Van Ronk in the past will serve as chair of the panel, which will feature Mr. Van Ronk playing guitar, singing, demonstrating, answering questions, and discussing the topic.

REFERENCES:

1. Campbell D: The Mozart Effect.™ New York, NY: Avon Books, 1997.
2. Rauscher, F., Shaw, G., Ky K: Music and spatial task performance. Nature 1993; 364:611.

Workshop 50 **Friday, October 27**
1:30 p.m.-3:00 p.m.

THE ETHICS OF CASE PRESENTATIONS

Stephen B. Levine, M.D., *Clinical Professor of Psychiatry, Case Western Reserve University School of Medicine, 23200 Chagrin Boulevard, Suite 350, Beachwood, OH 44122-5404*; Susan J. Stagno, M.D., *Clinical Assistant Professor, Department of Psychiatry, Case Western Reserve University School of Medicine, 23200 Chagrin Boulevard, Suite 350, Beachwood, OH 44122-5404*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to explain the psychology of consent, appreciate the skewing of cases away from psychodynamics due to editorial policy, and recognize the magnitude of the ethical problem of requesting consent for case publication or presentation.

SUMMARY:

Editorial policies for medical journals and ethical guidelines from the AMA and APA require informed consent by the patient for publication of a case history or presentation of cases at scientific meetings. These policies discourage detailed psychiatric case reports, particularly of the psychotherapeutic process. Whether in psychotherapy or not, transference should be expected to affect every therapist's request for permission to present his or her patient. There is an inherent coercive quality to the request, which can have a variety of evolving meanings to the patient, some of which may prove harmful. Further, the request for permission results in an intrusion of the therapist's agenda into the patient's therapy.

This workshop, intended for those who present cases, will explore the many facets of this dilemma. We seek to provoke a more flexible approach to the inherent tensions between patients' right to privacy and the professional obligation to advance the field of psychotherapy. There are no specific background requirements.

REFERENCES:

1. International Committee of Medical Journal Editors: Protection of patients' right to privacy. BMJ 1995; 311:1272.
2. Wilkinson G, Fahy T, Russell G, et al: Case reports and confidentiality: opinion is sought, medical and legal. Br J Psychiatry 1995; 166:555–8.

Workshop 51 **WITHDRAWN**

Workshop 52 **Friday, October 27**
1:30 p.m.–3:00 p.m.

PUBLIC MENTAL HEALTH SECTOR MANAGED CARE: THE ARIZONA EXPERIENCE

Mario Cruz, M.D., *Clinical Assistant Professor and Associate Head of Clinical Services, Department of Psychiatry, University of Arizona, 1501 North Campbell Avenue, Tucson, AZ 85724*; Glenn Lippman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate an historical appreciation of the evolution of managed care in the public mental health system and identify the improvements as well as the failings in the public mental health system in the era of managed care.

SUMMARY:

The transformation of cottage-industry public mental health care to large integrated service delivery systems has renewed hope that troubling issues of access to and quality of care for the serious and persistent mentally ill can be resolved. It has also resulted in many community psychiatrists recognizing that the healing tools that have been traditionally taught in residency training need to be augmented by population-based treatment strategies and business acumen. Nowhere within the United States has this transformation been more active than in the state of Arizona.

The two presenters, who have held key administrative positions throughout the implementation of managed

care concepts in Arizona, will share their experiences in this process. They will present both the improvements in the public mental health system as a result of this shift to managed care and the problems that persist and have been created as a result of this service delivery paradigm shift. It is hoped that the presentation will lead to a discussion of managed care's effect on public mental health services in other states.

REFERENCES:

1. Shortell S, Gillies R, Anderson D: The new world of managed care: creating organized delivery systems. Health Affairs 1994.
2. Santiago J: The evolution of systems of mental health care: the Arizona experience. American Journal of Psychiatry 1990; 147:148–155.

Workshop 53 **Friday, October 27**
1:30 p.m.–3:00 p.m.

MANAGING VIOLENT BEHAVIOR IN COMMUNITY SETTINGS

Alan D. Felix, M.D., *Associate Professor of Clinical Psychiatry, Columbia University, 622 West 168th Street, New York, NY 10032*; Scott R. Masters, M.D.; Charles M. Barber, M.S.; Anne Pedersen, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to better recognize risks of violent behavior in community settings, set appropriate levels of tolerance for violence, and respond effectively when violence occurs.

SUMMARY:

The differing levels of tolerance and management of violence at two community settings, a New York City shelter and community residence, will be addressed in this workshop. Both settings serve the homeless mentally ill, but with different expectations and requirements. Clinicians in each setting must evaluate and respond to violent behavior within its context. Specific topics to be covered are attempts at engaging clients with a history of violence, predictors for violence, paranoia as a prominent factor in violent behavior, the role of behavioral contracts and restrictions, efforts at medication compliance, appropriate use of police intervention, and discharge criteria for violent behavior. Staff and client "burn-out" to ongoing perceived threats of violence and concerns of the larger community will also be addressed. Participants will be encouraged to share their experiences in managing violence in their own programs. Target audience will include clinicians and administrators of community programs of at-risk populations.

REFERENCES:

1. Reed J: Risk assessment and clinical risk management: the lessons from recent inquiries. Brit J of Psychiatry 1997; 170:4–7.
2. McNiel DE: Empirically based clinical evaluation and management of the potentially violent patient, in Emergencies in Mental Health Practice: Evaluation and Management. Edited by Kleespies PM, et al. New York, Guilford Press, 1998, pp. 95–116.

Workshop 54 **Friday, October 27**
3:30 p.m.–5:00 p.m.

MANDATORY OUTPATIENT TREATMENT: BACKGROUND, PILOT DATA AND RECOMMENDATIONS

APA Council on Psychiatry and Law

Jagannathan Srinivasaraghavan, M.D., *Professor of Psychiatry, Southern Illinois University School of Medicine, and Medical Director, Choate Mental Health and Development Center, 1000 North Main Street, Anna, IL 62906*; Paul S. Appelbaum, M.D., *Vice President, APA Board of Trustees, and A. F. Zeleznik Professor and Chair, Department of Psychiatry, and Director, Law and Psychiatry Program, University of Massachusetts Medical School, 55 Lake Avenue, North, Room S7-866, Worcester, MA 01655*; Kenneth J. Tardiff, M.D.; Thomas A. Simpatico, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the controversies related to mandatory outpatient treatment, recent pilot projects from New York and Illinois, and the specific rationale and recommendations made by the American Psychiatric Association's Council on Psychiatry and Law.

SUMMARY:

Successful deinstitutionalization over the last four decades and brief, recurrent hospitalizations have resulted in large numbers of seriously mentally ill individuals living and being cared for in the community. While at least 40 states have commitment statutes permitting mandatory outpatient treatment, many states have not utilized this authority. The American Psychiatric Association's Council on Psychiatry and Law has developed a resource document that delineates possible uses for mandatory outpatient treatment. This workshop is aimed at providing historical background, studies on the efficacy of mandatory outpatient treatment, and the suggested criteria for a successful and efficient implementation of mandatory outpatient treatment. Dr. Jagannathan Srinivasaraghavan will provide the background and introduce the subject. Dr. Kenneth Tandiff will present

data on the Bellevue Hospital Center Outpatient Commitment Pilot Program and New York's recent "Kendra's Law." Dr. Thomas Simpatico will present data from the Outpatient Commitment Project of Metro Northern Chicago. Dr. Paul Appelbaum will discuss the recommendations of the Council regarding controversial issues such as patients' competency status, specific procedures in case of noncompliance, and forced medications.

REFERENCES:

1. Appelbaum PS: Outpatient commitments: the problems and the promise. Am J of Psychiatry 1985; 36:265–267.
2. Fulop NJ: Involuntary outpatient civil commitment. International Journal of Law and Psychiatry 1995; 18(3):291–303.
3. Swartz MS, Burns BJ, et al.: New directions in research on involuntary outpatient commitment. Psychiatric Services 1995; 46(4):381–385.
4. Telson H, Glickstein R, Trujillo M: Report of the Bellevue Hospital Center Outpatient Commitment Pilot Program, 1999.

Workshop 55 **Friday, October 27**
3:30 p.m.-5:00 p.m.

TOWARDS A RATIONAL INTEGRATED TREATMENT APPROACH TO THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED

Harvey Stabinsky, M.D., J.D., *15 Boulder Trail, Armonk, NY 10504-1008*; Susan Stabinsky, M.D.; Michael M. Scimeca, M.D.; Sheldon Travin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will be made aware of efficacious methods of treating the MRDD population.

SUMMARY:

Until recently, questions had been raised about the efficacy of specific psychiatric treatments, including psychotherapeutic and psychopharmacologic interventions, for people with mental retardation and developmental disabilities. Most psychiatric treatments for this population were focused on decreasing aggression, and the primary therapeutic tool for decades was sedation. This workshop will review the rapidly growing focus on actually diagnosing and then appropriately treating a wide range of accompanying psychiatric disorders, often affective in nature, in this population.

The experiences of the panelists in treating the MRDD population on both an inpatient and outpatient basis will be reviewed, as will the growing literature in this field. The difficulties in incorporating a significant MRDD population into an existing general psychiatric inpatient unit and the special needs of the coexisting outpatient population will be reviewed. Workshop participants will be asked to share their experiences in this type of treatment. Finally, the impact of countertransferential factors in this treatment will be evaluated.

REFERENCES:

1. Masi G, et al: Psychiatric illness in mental retardation: an update on pharmacotherapy. Pan Minerva Medica 1997; 39:299–304.
2. Bepil N: Psychoanalytic psychotherapy with men with intellectual disabilities: a preliminary outcome study. British Journal of Medical Psychology 1998; 71:1–11.

Workshop 56 **Friday, October 27**
3:30 p.m.-5:00 p.m.

RECOGNIZING AND DEALING WITH SECONDARY TRAUMA: A TEAM MODEL

Jewish Board of Family and Children's Services, Inc.

Libbe Madsen, C.S.W., *Senior Associate, Center for Trauma Program Innovation, Jewish Board of Family and Children's Services, 428 Broome Street, New York, NY 10013*; Janet A. Geller, Ed.D., C.S.W., *Director, Family Violence Prevention Center, Jewish Board of Family and Children's Services, 65 West 95th Street, New York, NY 10025*; Lynn Ohrenstein, D.S.W.; Paula G. Panzer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the impact of trauma on him/herself as a clinician, and to experience the alleviating effects of structured discussion in a team context.

SUMMARY:

Bearing witness to trauma stories can evoke in us the confusion and emotional turmoil we see in our patients. Guided by a team model and structured-case discussion, therapists can use their understanding of the impact of trauma on complex cognition and affect regulation to help each other and move the clinical work forward. Safety is an essential component of trauma work for patients and clinicians. This presentation demonstrates an innovative model designed to foster safety for the therapist and improve the effectiveness of the work.

The model is based in theory and research on the biology and psychology of traumatic stress reactions. Secondary trauma is seen as a product of empathic en-

gagement with the patient's traumatic material. It is a normal, nonpathological effect that can be understood and alleviated. The model structures case discussion, thus helping to counterbalance the overwhelming cognitive and affective impact of trauma. The team process helps staff to develop community responsibility for the work, which can increase safety for the therapist and thereby enhance the clinical process. The workshop is for clinicians working with trauma in agency or other group settings. The model will be demonstrated; audience participation is invited.

REFERENCES:

1. van der Kolk BA, McFarlane AC, Weisaeth L: Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society. New York, Guilford Press, 1996.
2. Bloom S: Creating Sanctuary: Toward an Evolution of Sane Societies. New York, Routledge, 1997.

Workshop 57 **Friday, October 27**
3:30 p.m.-5:00 p.m.

ADVANCES IN COGNITIVE THERAPY FOR SEVERE MENTAL DISORDERS

Judith S. Beck, Ph.D., *Clinical Assistant Professor of Psychology, University of Pennsylvania Beck Institute for Cognitive Therapy and Research, One Belmont Avenue, Suite 700, Bala Cynwyd, PA 19004*; Aaron T. Beck, M.D., *Professor of Psychiatry, University of Pennsylvania Beck Institute for Cognitive Therapy and Research, One Belmont Avenue, Suite 700, Bala Cynwyd, PA 19004*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to conceptualize patients according to the cognitive model, vary therapy according to a patient's disorder, and link the formulation of disorders and the conceptualization of patients to treatment planning.

SUMMARY:

This interactive workshop will emphasize advanced cognitive case formulation and treatment planning for patients with severe mental disorders. Over 350 randomized trials have demonstrated the efficacy of cognitive therapy for the range of psychiatric disorders. In the past decade, researchers have been studying the efficacy of cognitive therapy for severe mental illnesses such as bipolar disorder, schizophrenia, treatment-resistant depression, and personality disorders.

The cognitive model states that people's perceptions and interpretations of situations influence their emotional, behavioral, and physiological reactions. Teaching patients to identify and modify their distorted thinking leads to improvement in their mood, behavior, and physiology. For enduring improvement, patients learn to modify their dysfunctional beliefs, or basic understandings of themselves, their worlds, and other people.

This basic model has now been elaborated for severe mental disorders, and sophisticated strategies have been developed. The process by which a clinician conceptualizes an individual patient and plans treatment has been refined for patients with challenging disorders. An emphasis on developing a sound therapeutic alliance and/or restructuring the meaning of childhood experiences is frequently required. Cognitive, behavioral, psychodynamic, and experiential techniques are commonly used.

TARGET AUDIENCE:

This workshop is designed for clinicians interested in learning how cognitive therapy has been adapted for a wide range of psychiatric disorders.

REFERENCES:

1. Beck JS: Cognitive Therapy: Basics and Beyond. New York, Guilford, 1995.
2. International Handbook of Cognitive and Behavioral Treatments for Psychological Disorders. Oxford, Pergamo, 1999.

Workshop 58 **Saturday, October 28**
8:00 a.m.–9:30 a.m.

THE DEFENSIVE USE OF RACISM

Philadelphia Association for Psychoanalysis and Philadelphia Psychoanalytic Institute

Kelly M. Reid, M.D., *Assistant Faculty, Philadelphia Association for Psychoanalysis, and Faculty, Albert Einstein Center for Psychoanalysis, 505 Bay Avenue, Suite 202, Somers Point, NJ 08244*; Larry Blum, M.D., *Faculty, Philadelphia Psychoanalytic Institute, East Mall Drive, Suite 940, Cherry Hill, NJ 08002*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1) recognize the mechanism of the typical defenses involved in racial hatred; 2) recognize the psychodynamic relationship between a person's racial hatred and their own intrapsychic conflicts; 3) to demonstrate a knowledge of how to work with a patient's defensive use of race in the therapeutic setting; 4) to demonstrate an understanding of how a therapist can recognize his/her own "blind spots" regarding racial issues; and 5) to demonstrate a knowledge of how to handle one's own countertransference issues regarding race.

SUMMARY:

The purpose of this workshop is to demonstrate how racial difference can be used defensively by patients and to help clinicians identify the defensive use of race in the clinical setting. Clinicians will also learn how to approach interpretation, in order to help resolve the patients' conflicts, which underlie this defense.

We will begin by examining the "meaning of a difference," culturally as well as intrapsychically. Then, clinical examples will be used to illustrate: 1) how racial difference is used defensively by a patient, 2) the intrapersonal and interpersonal conflicts that most often underlie this defensive use of race, and 3) how to approach this psychotherapeutically. The issue of the therapist's own "blind spots" regarding race will be discussed in the context of countertransference feelings that can emerge when racial issues arise in same-race and mixed-race analyses.

It is important for all clinicians engaged in psychodynamic psychotherapy to be knowledgeable of how racial difference can be used as a defense for the purpose of protecting against one's own intrapsychic conflicts. If a clinician cannot recognize and handle this psychotherapeutically, then an important and pervasive externalizing defense mechanism will go untreated in that patient. The use of this defense threatens to become more prevalent as our world becomes more diverse, and it is the job of every psychodynamic psychotherapist to be knowledgeable, aware, and educated about this important defense. Only then will the therapist be positioned to optimally help their patients resolve the underlying conflicts that spurn the use of this prevalent externalizing mechanism.

REFERENCES:

1. Holmes DE: Race and transference in psychoanalysis and psychotherapy. Int J Psychoanal 1992; 73:1–10.
2. Fischer N: An interracial analysis: transference & countertransference significance. J Amer Psychoanal Assoc 1971; 19:736–745.

Workshop 59 **Saturday, October 28**
8:00 a.m.–9:30 a.m.

NURSING HOME PSYCHIATRY: PROBLEMS AND SOLUTIONS

New Jersey Psychiatric Association

Marc I. Rothman, M.D., *Medical Director, Hampton Behavioral Health Center, 650 Rancocas Road, Westampton, NJ 08060*; Istvan J.E. Boksay, M.D., Ph.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 psychotrophic medicines in the nursing home within federal guidelines; manage marital and intimacy issues in nursing home residents; and intervene with families experiencing a crisis due to the nursing home experience.

SUMMARY:

The workshop will address difficult challenges commonly encountered by psychiatrists working in nursing home settings. These are: 1) enhancing the psychiatric assessment and management skills of all levels of personnel interacting with nursing home residents to increase problem prevention and make psychiatric consultation efforts more effective; 2) understanding 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 encouraged and discussed.

REFERENCES:

1. Streim JE, Katz IR: Federal regulations and the care of patients with dementia in the nursing home. Med Clin North Am 1994:78:895–909.
2. Reichman WE, Katz IR. Psychiatric Care in the Nursing Home. New York: Oxford University Press, 1996.

Workshop 60 **Saturday, October 28**
8:00 a.m.–9:30 a.m.

FROM HOMELESS TO HOUSED: MODELS FOR DEVELOPING SAFE, AFFORDABLE AND SUPPORTIVE RESIDENTIAL OPTIONS FOR HOMELESS MENTALLY ILL/DUALLY DIAGNOSED INDIVIDUALS

Marilyn Seide, Ph.D., *Consultant, Los Angeles Department of Mental Health, 7660 Beverly Boulevard, Los Angeles, CA 90036*; Suzanne Wagner, M.S.; Carol Wilkins; Monique Lawshe; Geoffrey Gilbert, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to develop a program that demonstrates a continuum of care from homelessness through transi-

tional services, resulting in placement of mentally ill/dually diagnosed clients in safe, affordable housing with appropriate supportive services.

SUMMARY:

As recent events have shown, homelessness has become one of the critical social problems of the decade. A significant number of these people have severe mental illness or substance abuse problems. In order to effectively address the needs of this population with the aim of eventual placement in a permanent, appropriate residential setting, different models and approaches have been developed by organizations around the country and varying strategies conceived and attempted in different settings.

This workshop will include presentations by representatives from several programs that have successfully implemented such strategies, and will discuss such issues as funding, colloboration, strategies for addressing NIMBY issues, special needs of patients, and types of housing/programs found to be most relevant and appropriate in meeting these needs. Audience members will be encouraged to share their experiences attempting similar initiatives, whether as policymakers in public or nonprofit organizations or as direct service providers.

REFERENCES:

1. Understanding Permanent Supportive Housing. Corporation for Supportive Housing, New York, April 1997.
2. Minnesota Supportive Housing Demonstration Program. Corporation for Supportive Housing, New York, June 1998.

Workshop 61 **Saturday, October 28**
8:00 a.m.–9:30 a.m.

THE CLINICAL EVALUATION OF COGNITIVE DYSFUNCTION

Raymond A. Faber, M.D., *Professor of Psychiatry and Neurology, University of Texas Health Science Center, San Antonio, and Chief of Neuropsychiatry, Audie Murphy VA Hospital, 7400 Merton Minter (116A), San Antonio, TX 78284*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to efficiently assess the nature and extent of cognitive dysfunction in psychiatric and neuropsychiatric patients.

SUMMARY:

This workshop will present the essential elements that comprise the clinical evaluation of cognitive functioning. The organization of cognitive functioning will be explained. This is best understood as a hierarchy starting with the fundamental foundations of consciousness and attention then ranging to specialized abilities such as language and visuospatial skills. Practical methods of easily assessing cognitive functions will be demonstrated. Particular emphasis will be given to the assessment of memory and executive functions as understood from recent research. Two practical batteries will be presented in detail. These are the "Cognistat" exam and the "7 Minute Screen" for Alzheimer's disease. The advantages of these instruments over the better known Mini-Mental State exam will be highlighted.

TARGET AUDIENCE:

This workshop is intended for clinicians who must efficiently determine the nature and extent of cognitive dysfunction in patients with psychiatric and neuropsychiatric disorders. No special background is required other than a license in a mental health profession.

REFERENCES:

1. Solomon PR, Hirsckoff A, Kelly B, et al: A 7-minute neurocognitive screening battery highly sensitive to Alzheimer's disease. Arck Neurol 1998; 55:349–355.
2. Kiernan RJ, Mueller J, Langston JW, et al: The Neurobehavioral Cognitive Status Examination: a brief but quantitative approach to cognitive assessment. An Intern Med 1987; 107:481–485.

Workshop 62 **Saturday, October 28**
8:00 a.m.–9:30 a.m.

TEACHING BRIEF DYNAMIC PSYCHOTHERAPY

Lisa A. Mellman, M.D., *Associate Clinical Professor of Psychiatry, Columbia University, 1051 Riverside Drive, Box 103, New York, NY 10032*; Alan S. Barasch, M.D., *Clinical Assistant Professor of Psychiatry, COR, 1148 Fifth Avenue, New York, NY 10128*; Susan Swick, M.D.; Eve Caligor, M.D.; David A. Gutman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand a method for teaching brief dynamic psychotherapy through individual and group supervision emphasizing selection criteria, focus, transference, and termination.

SUMMARY:

Psychodynamic psychotherapy is an important tool for psychotherapists, yet teaching time for this modality has been gradually eroded in many residencies. Brief psychotherapy is the modality most psychotherapy patients initially expect, and it has been further promoted by current health care economics and a culture de-

manding rapid response. This workshop will familiarize participants with a unique method for training residents in brief dynamic psychotherapy. This method—a didactic seminar, individual supervision, and a weekly group seminar for all trainees and supervisors—has become a key part of psychodynamic teaching in the Columbia University residency.

After an initial orientation to the clinical theory and technique for brief dynamic psychotherapy and overview of the structure of this program, participants will observe one of the weekly group seminar classes of trainees and supervisors and will listen to the presentation and discussion of case material. Participants will be invited into the process of the seminar through questions and discussion in order to refine their understanding of this model.

REFERENCES:

1. Barasch A: Psychotherapy as a short story: selection and focus in brief dynamic psychotherapy. J Am Acad Psychoanalysis 1999; 27:47–59.
2. Strupp H, Binder J: Clinical illustration of the assessment process and the development of a focus, in Psychotherapy in a New Key. New York, Basic Books, 1984, pp. 110–134.

Workshop 63 **Saturday, October 28**
10:00 a.m.–11:30 a.m.

CULTURAL DIVERSITY IN RESIDENCY TRAINING

APA Center for Mental Health Services Zeneca Minority Fellows

Varanise C. Booker, M.D., *Member, APA Board of Trustees, APA Center for Mental Health Services Zeneca Minority Fellow, and Department of Psychiatry, University of Louisville, 14308 Willow Grove Circle, Louisville, KY 40245*; Victoria Barnes, M.D., *APA Center for Mental Health Services Zeneca Minority Fellow, and Department of Psychiatry, Tufts University, 98 Charles Street, #4, Boston, MA 02114*; Gabrielle F. Beaubrun, M.D.; Brett N. Murphy-Dawson, M.D.; Rajendra A. Morey, M.D.; Francis G. Lu, M.D.; Lisa D. Green-Paden, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will have an increased awareness of how a culturally diverse curriculum provides more culturally competent physicians who provide competent care. The participants will also have a greater appreciation of how a multicultural training system is the most suitable method of integrating and developing culturally appropriate services.

SUMMARY:

Medical training has traditionally focused on diagnosis and treatment of disease with the expectation that if these two factors are satisfactorily managed, the desired outcome will inevitably follow. Most programs do not include teaching or supervision specific to students and physicians of color. They do not routinely incorporate factors such as lifestyle, family and living circumstances, and an awareness of cultural uniqueness. Most nonwhite physicians in a standard residency program are faced with discrimination at several levels, as well as special problems of professional development and productivity. In this workshop we will explore racial and cultural diversity in the academic setting. Affirmative action efforts continue to be challenged as lowering standards and depriving better-qualified students admission to medical school. Affirmative action should not be seen as lowering standards, but instead as a measure to ensure that all available information in the selection process for medical school and residency training be utilized to ensure that the medical profession more closely mirrors the diverse and ethnic background of the U.S. population. The psychodynamic and cultural dimensions of this topic will be explored through discussion and multimedia presentations. The audience will be encouraged to share their own experiences and to generate discussion on ways to eliminate racial and ethnic health disparities and to prepare culturally competent practitioners. Obtaining racial and cultural diversity in the medical profession should be a national imperative.

REFERENCES:

1. Survey of the cross-cultural content of U.S. psychiatry residency training programs. Cultural Diversity & Mental Health 1997; 3(3):215–8.
2. Promoting diversity in the medical school pipeline: a national overview. Academic Medicine 1999; 74(4):312–4.

Workshop 64 **Saturday, October 28**
10:00 a.m.–11:30 a.m.

ABPN UPDATE: REQUIREMENTS FOR ABPN EXAMINATION

American Board of Psychiatry and Neurology

Stephen C. Scheiber, M.D., *Executive Vice President, American Board of Psychiatry and Neurology, 500 Lake Cook Road, Suite 335, Deerfield, IL 60015-4939;* Glenn C. Davis, M.D.; James H. Scully, Jr., M.D.; Elizabeth B. Weller, M.D.; Pedro Ruiz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to assist resident, young career psychia-

trist, and other members in learning the policies and procedures of the ABPN for certification, recertification, and subspecialization.

SUMMARY:

An overview of the policies and procedures of the American Board of Psychiatry and Neurology will be presented followed by a dialogue about the necessary conditions for admission to the certification examination, the examination process, and the current status of recertification and subspecialization. Material will focus on resident members and young career psychiatrists. Resident and early career psychiatrists will be encouraged to ask questions about certification, recertification, and subspecialization in addition to the specifics of the Part I and Part II written and oral examinations for certification. Participants will be urged to discuss child and adolescent psychiatry, addiction psychiatry, forensic psychiatry, geriatric psychiatry, clinical neurophysiology, and pain management.

REFERENCES:

1. Shore J, Scheiber SC: Certification, Recertification and Lifetime Learning. Washington, D.C., APPI Press, 1994.
2. American Board of Medical Specialties: Recertification for Medical Specialists. Evanston, IL, ABMS 1987.

Workshop 65 **Saturday, October 28**
10:00 a.m.–11:30 a.m.

TRANSFORMING PSYCHIATRIC EMERGENCY SERVICES TO TREAT A CO-OCCURRING POPULATION: THE PHILADELPHIA EXPERIENCE

Philadelphia Behavioral Health System

Carolyn Ulmer, *Director of Acute Services, Philadelphia Behavioral Health System, 1101 Market Street, Suite 700, Philadelphia, PA 19107*; Daniel Winterstein, *Philadelphia Behavioral Health System, 1101 Market Street, Suite 700, Philadelphia, PA 19107*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should have a working knowledge of the process of transforming a traditional hospital-based psychiatric emergency service into a behavioral health care model that has the capacity to evaluate and assess individuals in crisis from mental health, substance use, or co-occurring disorders.

SUMMARY:

Psychiatric emergency services have traditionally been designed to be hospital based and treat only individuals suffering from a psychiatric crisis. Therefore, psychiatric emergency staff have been trained and supported only in treating the target population. In reality, psychiatric emergency staff are faced with individuals suffering from mental illness, substance use disorders, and co-occurring disorders. Over the past three years the Philadelphia Behavioral Health System has been a national leader in transforming services to effectively treat individuals with co-occurring mental health and substance use disorders. Their first large-scale initiative has been to transform psychiatric emergency services into a behavioral health care emergency services model. Our two presenters have been key personnel in that process of transformation. They can knowledgeably discuss the clinical and administrative issues involved in such a change.

TARGET AUDIENCE:

Psychiatrists and residents involved in emergency psychiatry treatment and clinicians interested in issues of dual diagnosis of mental illness and substance use disorders.

REFERENCES:

1. Currier G (Ed.): New Developments in Emergency Psychiatry: Medical, Legal and Economic. New Directions in Mental Health Services; no. 82, San Francisco, Jossey-Bass, 1999.
2. Drake PE, Muosser KT (Eds): Dual Diagnosis of Major Mental Illness and Substance Abuse Volume 2: Recent research and clinical implications. New Directions for Mental Health Services; no 70 San Francisco, Jossey-Bass, 1996.

Workshop 66 **Saturday, October 28**
10:00 a.m.–11:30 a.m.

RECENT ONSET PSYCHOSIS PROGRAMS: MOVING FROM RESEARCH TO COMMUNITY SETTINGS

Ramanbhai C. Patel, M.D., *Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456*; John M. Kane, M.D.; Delbert G. Robinson, M.D.; Vania Concolino, C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should understand the administrative and clinical issues involved in starting treatment programs for patients with recent onset psychosis.

SUMMARY:

There is increasing interest in the treatment needs of patients with recent onset psychosis. Until now, specialized treatment programs for these patients have been primarily located in research centers. This workshop will explore the administrative and clinical challenges involved in setting up programs for these patients in community-based treatment settings.

The workshop will start with a brief review of clinical research findings relevant to the treatment of recent onset psychosis patients. The next presentation will focus upon the administrative planning required to set up a specialized clinical program for recent onset psychosis patients in a community setting. Presenters will discuss clinical challenges involved in working with these patients from both psychiatric and psychosocial perspectives. Emphasis will be placed on the long-term care of these patients with special focus on pharmacological intervention and strategies to enhance adherence to treatment.

After the presentations, the audience will be invited to discuss their experiences treating recent onset psychosis patients. This will be followed by a discussion between the presenters and audience members.

REFERENCES:

1. Robinson D, Woerner M, Alvir JM, et al: Predictors of relapse following response from a first episode of schizophrenia schizoaffective disorder. Arch Gen Psychiatry 1999; 56:241–247.
2. Robinson D, Woerner M, Alvir JM, et al: Predictors of treatment response from a first episode of schizophrenia or schizoaffective disorder. Am J Psychiatry 1999; 156:544–549.

Workshop 67 **Saturday, October 28**
1:30 p.m.–3:00 p.m.

LISTENING FOR A CHANGE: CREATING CONSUMER-PROVIDER ALLIANCES IN PSYCHIATRY

Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute, Assistant Professor of Psychiatry, University of Pennsylvania Medical Center; and Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Room E-516, Pittsburgh, PA 15213*; Wesley E. Sowers, M.D.; Linda Morrison, M.S.W., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to appreciate the importance of consumer/provider alliances and understand the nature of the "dialogue process."

SUMMARY:

Promoting alliances between consumer and provider organizations in psychiatry is not a simple matter. Such efforts are hampered by stigmatization and dependency as well as by the traditional social control function and institutional contexts of psychiatric treatment. We will discuss efforts to create a consumer-provider alliance in Allegheny County based on two key elements. First, we will describe the use of a dialogue process in which participants move "outside the box" of traditional roles to a) relate as respected equals and develop new communication patterns; b) recognize and expand mutual areas of interest and concern in mental health care; and c) lay the groundwork for personal and organizational alliance formation. Second, as mutuality and alliances develop in continuing dialogues, we will describe how the alliance might focus on a) shared objectives for intervention related to service allocation, quality of care, accountability, and/or ethical practice; b) planned interventions designed to engage the alliance and impact the managed care system; and c) effective use of these organizational alliances to improve mental health services.

REFERENCES:

1. Bodenheimer T, Casalino L: Executives with white coats-the work and world view of managed care medical directors. NEJM 1999; 341:1945–1948.
2. Andrulis DP, Carrier B: Managed Care and the Inner City. The Uncertain Promise for Providers, Plans and Communities. San Francisco, Jossey-Bass, 1999.

Workshop 68 **Saturday, October 28**
1:30 p.m.-3:00 p.m.

REBUILDING BRIDGES: REUNITING THE HOMELESS WITH THEIR FAMILIES

Scott R. Masters, M.D., *Department of Psychiatry, New York State Psychiatric Institute, and Assistant Clinical Professor, Inwood Clinic, Columbia University, 26 Sherman Avenue, New York, NY 10040*; Anne Pedersen, M.A.; Sarah Seung, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, participants will be able to identity and apply techniques that facilitate the reunion of the homeless with family members. Participants will appreciate the perspectives of clients, family members, and the care team members in order to anticipate and meet needs as they arise.

SUMMARY:

After a period of time in a stable housing environment, it is not uncommon for individuals with a history of homelessness to desire contact and reunion with their

family members. This process of reunion can be a powerful emotional experience for everyone involved. Increasingly, the strengthening of ties with family is becoming an objective of community-based case-management programs. Case managers and psychiatrists can facilitate this process of successful reunion by understanding the challenges that must be overcome, including confidentiality concerns, fears of increased family burden, guilt, and helplessness, and a sense of shame and rejection in the client.

This workshop will encourage participants to discuss their experiences with homeless clients and their families. Two short scenarios of reunion attempts will be presented by case managers to facilitate discussion. The perspectives of the client, family members, case managers, and consulting psychiatrists will be explored. Summaries of exploratory interviews with formerly homeless individuals and their family members will be discussed.

REFERENCES:

1. Wood PA, Hurlburt MS, Hough RL, Hofstetter RC: Longitudinal assessment of family support among homeless mentally ill participants in a supported housing program. J of Community Psychology 1998; 26:327–344.
2. Zipple AM, Langle S, Tyrell W, et al: Client confidentiality and the family's need to know; strategies for resolving the conflict, in Ethical and Legal Issues in Professional Practice with Families. Edited by Marsh DT, Magee, RD. New York, John Wiley & Sons, 1997, pp. 238–253.

Workshop 69 **Saturday, October 28**
1:30 p.m.–3:00 p.m.

THE CONTINUUM OF CARE: VARIATIONS ON A THEME

Association for Ambulatory Behavioral Health Care

Lawrence L. Kennedy, M.D., *Director, Partial Hospitalization Services, The Menninger Clinic, 5800 S.W. 6th Avenue, Topeka, KS 66601*; Enrique G. Bernardo, M.D., *Medical Director, San Miguel Clinic, Madrid, Spain, Orellano 4-1o Doha, Madrid, Spain 28004*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand basic concepts of a continuum of care in psychiatric treatment, define the components of an integrated behavioral health care system, recognize the variations of complexities possible in the continuum of care, gain knowledge of how a continuum of care varies from one culture to another and how this knowledge can be useful in thinking about innovative program planning.

SUMMARY:

Psychiatric care is shifting to a model that includes short periods of hospitalization, usually for management of crises, followed by a continuum of services gradually diminishing in intensity. Components of an integrated system may include, in addition to hospitalization, residential care, partial hospital, intensive outpatient, psychosocial rehabilitation, outpatient, home health, and services by primary care physicians. There are many possible variations depending on the types of illnesses, age of the patients, and whether the services are all part of the same system. Many such continuums of care are emerging in the United States and other countries. Though they may make sense clinically, there are many problems. Models of the continuum of care in the united States and Spain will be presented. This will offer an opportunity to examine systems in the two countries. The goal of the workshop is not to provide solutions or answers but, instead, to promote an awareness of issues. The workshop should be useful to all mental health disciplines since all psychiatric disciplines need to alter and change their ways of functioning.

REFERENCES:

1. Lefkovitz PM: The continuum of care in a general hospital setting. General Hospital Psychiatry 1995; 17:260–267.
2. Kiser LJ, Lefkovitz PM, Kennedy LL, Knight MA. Continuum 1994; 1:7–13.

Workshop 70 **Saturday, October 28**
1:30 p.m.–3:00 p.m.

ONGOING RESIDENT PSYCHODYNAMIC THERAPY DEMONSTRATION SEMINARS: PATIENT BENEFITS

Leah J. Dickstein, M.D., *Associate Dean and Chair of Academic Affairs, and Director, Division of Attitudinal and Behavioral Medicine, Department of Psychiatry and Behavioral Science, University of Louisville, 500 South Preston Street, #214, Louisville, KY 40292*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand that patients may benefit from observers in the room with patients during their psychodynamic psychotherapy led by senior clinicians.

SUMMARY:

Since 1978, the presenter has conducted an educational seminar for second-year psychiatry residents to

learn through observation how to conduct psychodynamic psychotherapy. The residents are assigned readings from an assembled monograph, sit silently in the room for the 50-minute session, and after the patient leaves, participate in a 40-minute discussion of that patient session, plans for the next session, and the reading assignments.

Patients are carefully selected by the faculty member. In recent years they have been referred by the senior staff social worker in our university outpatient psychiatry clinic. The patients may be female or male, are generally the former and have life issues related to poor relationships, history of abuse, low self-esteem, and depressive and anxiety disorders. The patients are initially understandably anxious, are told all will be held in confidence, but as early as the second session react positively to the resident's presence, i.e., "I must have something to say they can learn from to help others." Thus, in addition to the usual benefits of therapy, the patients are pleased to make strong ongoing efforts to be present and to be forthright about all issues to be shared.

Finally, in any emergency situation, if they come to the emergency psychiatry service they may be seen by one of the residents who already knows them.

The residents definitely appreciate the opportunity to observe psychodynamic psychotherapy as opposed to simply reading or hearing second hand what should does occur.

REFERENCES:

1. Freud A: The Ego and the Mechanisms of Defense. International University Press, 1996.
2. Fromm-Reichmann F: Principles of Intensive Psychotherapy. Chicago, University of Chicago Press, 1950.

Workshop 71 **Saturday, October 28**
1:30 p.m.–3:00 p.m.

PSYCHODYNAMIC SUPERVISION OF SUPERVISORS: THE PURPOSE OF PROCESS

David C. Lindy, M.D., *Clinical Director and Chief Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York, and Associate Clinical Professor of Psychiatry, College of Physicians and Surgeons, Columbia University, 1250 Broadway, 3rd Floor, New York, NY 10001*; Neil Pessin, Ph.D., *Director, Community Mental Health Services, Visiting Nurse Service of New York, 1250 Broadway, 3rd Floor, New York, NY 10001*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand ways in which a psychodynamically oriented supervision group can be an effective supervisory modality, and to have an experience of dynamic group process through discussion in the workshop group.

SUMMARY:

Supervisors of community-based mental health programs must frequently deal with complicated clinical situations presented by front-line staff of variable training, skill, and experience. Supervisors hear these reports "second hand" which can be confusing, frustrating, or even frightening. However, a supervisor's *experience* with staff can, if understood as such, provide valuable clues toward understanding the *client's* experience. Furthermore, the specific interactions comprising the behavioral aspects of that experience stimulate ideas, affects, and fantasies that can lead to confusion or to clarity, depending on how the supervisor handles them. Process is a descriptive term for the interplay of these dynamics over time. Dynamics can be taught as they occur between supervisor and staff, between staff and client, so that the most appropriate assessment and treatment approach with the client can be employed.

As psychoanalytically trained directors of a large community mental health service, we have attempted to teach these dynamics in a psychodynamically oriented supervision group we have conducted with eight program supervisors for the past two years. Through informal presentations of their supervisory work to the group, we have been able to demonstrate the utility of identifying dynamic process at play. In this workshop, we will describe the group, some of the theoretical underpinnings of psychodynamics, and representative group members will present illustrative cases. We will also invite workshop participants to present their experiences with supervisees in an attempt to recreate the experience of group process in the workshop.

TARGET AUDIENCE:

Mental health supervisors and supervisees.

REFERENCES:

1. Altman N: Analyst in the Inner City: Race, Class, & Culture Through a Psychoanalytic Lens. Hillsdale, NJ, Analytic Press, 1995.
2. Freud, S: Group Psychology and the Analysis of the Ego. The Standard Ed 1955; 18:67–143.

Workshop 72 **Saturday, October 28**
3:30 p.m.–5:00 p.m.

SOUTH ASIAN PATIENTS: MULTICULTURAL CLINICIANS

Anand Pandya, M.D., *Resident, Department of Psychiatry, New York University School of Medicine, 215 East*

24th Street, #322, New York, NY 10010-3804; Juhi Chawla, M.D.; Linda Chokroverty, M.D.; Nalini V. Juthani, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify some common problems facing South Asian patients and their clinicians, namely issues of stereotyping, stigmatization, and transference/countertransference. Through appreciation of these phenomena, the participant will gain insight into strengthening the therapeutic alliance in the psychiatric setting.

SUMMARY:

One-fifth of the world's population comes from the nations of South Asia. The subcultures derived from this part of the world suggest a different normative developmental course and different normative psychodynamics. These differences affect the expectations of South Asian patients in their attitude and trust of the health care system as well as their general approach to mental health and mental illness. Using a psychoanalytic and historical perspective along with patient vignettes, our panel aims to elicit audience participation in exploring what occurs when South Asians seek psychiatric care in the United States. Also, the perceptions of South Asian patients by the medical and mental health system in the West will be explored. Finally addressed will be the experiences of clinicians who share or lack common ethnicity with South Asian patients, particularly with respect to the psychodynamics involved.

REFERENCES:

1. Kakar S: The Inner World: A Psychoanalytic Study of Childhood & Society in India. New Delhi, Oxford University Press, 1978.
2. Roland A: In Search of Self in India and Japan. Princeton, N.J, Princeton University Press, 1988.

Workshop 73 **Saturday, October 28**
3:30 p.m.-5:00 p.m.

USING GUIDED ROLE PLAYS TO TEACH OUTPATIENT ASSESSMENT

Julia B. Frank, M.D., *Director, Psychiatric Clerkship, and Associate Professor, Department of Psychiatry and Behavioral Sciences, George Washington University School of Medicine, 2150 Pennsylvania Avenue, N.W., Washington, DC 20037*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to implement a role-play curriculum to teach medical students, residents, other trainees, and staff the fundamental principles of assessment and treatment planning for psychiatric outpatients.

SUMMARY:

Since 1997, third-year students at the George Washington University School of Medicine have participated in structured, unscripted role plays that teach assessment and treatment planning for psychiatric patients in primary care settings. Each student receives a role in advance—patient, primary care physician, psychiatric consultant, or observer. After an interview between the naïve physician and the patient, who knows his/her diagnosis, observers ask questions, comment on the interview, and discuss medical and psychiatric differential diagnosis. The "consultant" then reviews the condition at hand, outlining a treatment plan for the particular patient presented.

This method balances learning by doing with the presentation of factual information. Students refine their interviewing skills and practice communicating mental health information. The use of role plays compensates for the unpredictable patient flow, lack of time for teaching, and concerns about confidentiality that complicate education in real ambulatory-care settings.

Workshop participants will work through one role play and discuss their reaction to this method of instruction. Student evaluation data will be presented. Each participant will receive a copy of the full curriculum. The workshop should interest anyone involved teaching mental health assessment skills, whether to medical students, residents, other trainees, or new staff.

REFERENCES:

1. Sasson VA, et. al: Teach 1 do 1...better: superior communication skills in senior medical students serving as patient-examiners for their junior peers. Acad Med 1999; 74:932–37.
2. Bordage G, et al: Education in ambulatory settings: developing valid measures of educational outcome and other research priorities. Acad Med 1998; 73:743–50.

Workshop 74 **Saturday, October 28**
3:30 p.m.-5:00 p.m.

HOUSEHOLDS, NOT HOSPITALS: HOMESHARE A PROVEN ALTERNATIVE

John J. Connery, M.A., *Director of Community Mental Health Services, South Carolina Department of Mental Health, 2414 Bull Street, Columbia, SC 29202*; Gail N. Mattix, M.S.W.; Mary B. Curlee, M.S.W.; David A. Rosin, M.D., P.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to to describe the Homeshare program model, to outline an implementation strategy for Homeshare program, to identify multiple uses of the Homeshare program model, and to determine replication possibilities and resource contacts.

SUMMARY:

The South Carolina Department of Mental Health is developing a mental health system of care, built around quality community-based services with less reliance on hospitals for acute and long-term psychiatric care. The workshop will highlight a model program, Homeshare, which offers the flexibility to tailor residential placement and service delivery to an individual's desires and needs for a successful community-living experience. The presenters will describe how to plan and implement this program model and the multiple applications of this model. Participants will receive information on program and client data gathered from eight years of program operation. The workshop exposes participants to a proven, effective, community-based program that can address the needs of people young and old, who are psychiatrically impaired and/or addicted, in crisis or in need of long-term rehabilitation. Ongoing evaluation shows success in the goals of decreasing hospital-bed utilization, cost-effective programming, positive quality-of-life outcomes, and customer satisfaction. The planning methods and outcomes are potentially replicable in a small or large system of care. There will be opportunity throughout the workshop for questions and sharing of experiences and ideas on the information presented.

TARGET AUDIENCE:

Clinicans, program administrators and program planners.

REFERENCES:

1. Deci PA, Bevilacqua JJ, Morris, JA, Dias JK:, Community service development for consumers in long-stay psychiatric hospitals in SC. International Journal of Law & Psychiatry 1996; 19:265–287.
2. Deci PA, Mattix, GN: Homeshare: The forgotten alternative, in S.H. Henggeler & A.B. Santos (Eds.) Innovative Services for Difficult to Treat Populations. Washington, DC, American Psychiatric Press, 1997.

Workshop 75 **Saturday, October 28**
3:30 p.m.-5:00 p.m.

MULTIDISCIPLINARY TRI-LEVEL TREATMENT MODEL

Katherine G. Levine, M.S.W., *Program Director, Community Mental Health Services, Visiting Nurse Service of New York, 1250 Broadway, New York, NY 10001*; Nicolás Dávila-Katz, M.D.; Yvette C. Miller, R.N.; Aida Cruz

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify three levels of treatment and the tasks applicable to each level; to gain expertise required to complete each task.

SUMMARY:

This workshop presents a multidisciplinary tri-level treatment model useful for treating children and adolescents. This model has been used by the Visiting Nurse Service of New York's Mobile Community Support Service (MCSS). The MCSS operates in New York City's Mott Haven Section of the South Bronx and serves seriously emotionally ill youth at risk of psychiatric hospitalization. To date more than 350 youngsters have been served. This program makes use of a varied group of service providers including natural supports, respite workers, parent advocates, case aides, and social work assistants, as well as master-level social workers, a community mental health nurse, and a psychiatrist. The presenters represent the multidisciplinary nature of the service. The presentation will first discuss the model, which consists of three levels—support, logical, and meta-logical. Each level contains six treatment tasks ranging from assuring safety, to meeting concrete needs, establishing treatment alliances, teaching cognitive-behavioral medication, environmental structuring, and psychodynamic treatment. The model is not linear and allows for flexible movement between levels. Demographic and outcome data will then be presented. Finally, several cases will be presented for discussion.

REFERENCES:

1. Steiner H: Treating Adolescents. San Francisco, Jossey Boss, 1996.
2. Berlin SB, Marsh JC: Informing Practice Decisions. New York, Macmillan Publishing Company.

Workshop 76 **Saturday, October 28**
3:30 p.m.–5:00 p.m.

THE EFFECT OF KENDRA'S LAW ON THE ROLE OF INTENSIVE CASE MANAGEMENT AND ASSERTIVE COMMUNITY TREATMENT STAFF

Howard W. Telson, M.D., *Director, Outpatient Commitment Program, Department of Psychiatry, Bellevue Hospital, New York University School of Medicine, 215 East 24th Street, Apt. 321, New York, NY 10010-3804*; Neil Pessin, Ph.D.; David C. Lindy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the traditional functions of intensive case management and assertive community treatment, and understand how New York's Assisted Outpatient Treatment Statute of 1999 has affected the theory and practice of these services.

SUMMARY:

Intensive case management (ICM) and assertive community treatment (ACT) are clinical interventions that are designed to promote compliance with community psychiatric treatment and psychosocial rehabilitation among individuals with serious and persistent mental illness. Outpatient commitment is a legal intervention to compel patients to accept mental health services in the community and thereby prevent adverse outcomes.

ICM and ACT staff of the Visiting Nurse Service of New York's Community Mental Health Division have had the opportunity to provide court ordered outpatient services since 1995. They have worked collaboratively with the state's Outpatient Commitment Pilot Program, but have had no statutorily defined responsibility.

Under New York's 1999 Assisted Outpatient Treatment (AOT) statute, all patients receiving an outpatient commitment order must receive either a case manager or an ACT team. Furthermore, the state's program coordinators must insure that each AOT program has a mechanism for case managers and ACT teams to "report the assisted outpatient's compliance, or lack of compliance with treatment."

This workshop will focus on the clinical experiences of community mental health workers in facing the new roles required by the law. It will emphasize audience participation in the discussion of ethical dilemmas in the field.

REFERENCES:

1. Lidz CW: Coersion in psychiatric care: What have we learned from research? J Am Acad Psychiatry Law 1999; 26:631–7.
2. Swartz MS, Swanson JW, Wagnier HR, Burns BJ, Hiday VA, Borum R: Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. Am J Psychiatry 1999; 156:1968–75.

Workshop 77 **Sunday, October 29 8:00 a.m.-9:30 a.m.**

ALTERNATIVE MEDICINE AND PSYCHIATRY: EDUCATING OURSELVES AND THE PATIENTS

Group for the Advancement of Psychiatry's Committee on Psychopharmacology

Satyanarayana Chandragiri, M.D., *Senior Resident in Psychiatry, Temple University School of Medicine, and Former APA/Bristol-Myers Squibb Fellow, 3401 North Broad Street, Philadelphia, PA 19140*; Lawrence S. Gross, M.D.; Satyajit Satpathy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the importance of educating ourselves and patients about alternative medicines in psychiatry; understand the training needs of psychiatrists in the area of alternative medicine or in assisting patients in making informed decision about alternative medicine.

SUMMARY:

The growing use of alternative therapies in the United States is a trend that a responsible psychiatrist cannot ignore. With several factors motivating this trend, including a desire to avoid toxicity, a sense of being in control, ward off social stigma, failure of conventional treatment, cultural and belief systems, etc, it becomes prudent to get beyond "Don't ask, Don't tell" attitudes. Psychiatrists are often confronted with a situation where their knowledge is minimal, and both the patient and the psychiatrist grope with ignorance about the potential effect, side effect, or interactions these agents have.

The workshop will review some of the key issues to be dealt with in educating ourselves regarding assisting patients to make informed decisions and the current status of psychiatry residency curriculum with regard to alternative medicine. The participants will have an opportunity to discuss their practice experiences and contribute to what must go into an ideal curriculum.

REFERENCES:

1. Eisenberg DM, Davis RB, Ettner SL, et al: Trends in alternative medicine use in the US, 1990–97, JAMA 1997; 280:1569–1575.
2. Sugarman J, Burk L: Physicians ethical obligations regarding alternative medicine. JAMA 1998; 280:1623–1625.

Workshop 78 **Sunday, October 29 8:00 a.m.-9:30 a.m.**

ASSESSING COMPETENCY IN PSYCHOTHERAPY TRAINING

Donald R. Ross, M.D., *Director, Education and Residency Training, Sheppard-Pratt Hospital, 6501 North Charles Street, Towson, MD 21204;* Hinda F. Dubin, M.D., *Director of Psychotherapy Training, Department of Psychiatry, University of Maryland, Baltimore, 701 West Pratt Street, 4th Floor, Baltimore, MD 21201-1023*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to 1) discuss the role of outcome measures

in psychotherapy education, 2) discuss the importance of sustaining a "holding environment" in psychotherapy supervision, and 3) outline a program for psychotherapy competency assessment.

SUMMARY:

Assessing competency in psychotherapy soon will be a requirement of all psychiatric residency training programs. This creates a serious challenge to traditional methods of teaching, supervision, and assessment of psychotherapy, which have largely been subjective and based upon supervisor reports about the resident's work. Even the definition of competency in psychotherapy is problematic insofar as it is partly dependent upon inner qualities of the resident/therapist. As the emphasis shifts to more accountability, the nature of the supervisory relationship may be threatened, even to the point of losing some essential functions such as providing a safe holding environment for the resident to explore countertransference issues. Recognizing the importance and complexity of this challenge, the University of Maryland/Sheppard Pratt residency program formed a task force consisting of core faculty, clinical supervisors, and residents. The task force has designed a competency assessment protocol that uses supervisor assessments, objective testing of knowledge, and a comprehensive case write up of a patient in psychotherapy. Each component measures certain facets of "competency." No component stands alone. Furthermore, this multifocal approach has a specific goal of protecting the holding environment of the supervisory relationship. We believe that a discussion of the problems of assessing competency in psychotherapy, using our work as a springboard, would be very useful to psychiatrists involved in resident education and psychotherapy supervision.

REFERENCES:

1. Ross DR: Training residents in the era of managed care, in Schreter RK, Sharfstein SS, Schreter CA, Eds. Managing Care, Not Dollars: The Continuum of Mental Health Services. Washington DC, Am Psychiatric Press; 1997, pp 299–315.
2. Beitman BD, Yue D: A new psychotherapy training program: description and preliminary results. Academic Psychiatry 1999; 23:95–102.

Workshop 79 **Sunday, October 29**
10:00 a.m.-11:30 a.m.

PREVENTING SUICIDE: PSYCHIATRY, PRIMARY CARE AND PUBLIC HEALTH

Annelle B. Primm, M.D., M.P.H., *Assistant Professor and Director, Community Psychiatry Program, Johns Hopkins University School of Medicine, 600 North Wolfe Street, Meyer 144, Baltimore, MD 21287-7180;* Kenneth S. Thompson, M.D.; Lisa Cooper, M.D., M.P.H.; David A. Pollack, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify several strategies for the improvement of diagnosis and treatment of depression and prevention of suicide in the primary care setting.

SUMMARY:

This workshop will address the issue of suicide prevention through the collaboration of psychiatry with the primary care sector and will present strategies that provide psychiatric education and consultation to primary care providers to improve recognition and treatment of depression in the primary care setting. We will discuss how to set up a consultation relationship with a primary care provider group with emphasis on training in recognizing and treating depression as well as looking out for signals of suicidal risks. A description of a collaborative effort of primary care physicians and psychiatrists following the release of the Surgeon General's Report on Suicide Prevention will be presented. Research data show that African Americans are less likely than whites to be recognized as depressed or to be offered pharmacotherapy in primary care settings. In an effort to address these disparities, we will discuss the critical elements that need to be incorporated in the design of new primary care-based intervention strategies aimed at eliminating barriers to adequate care of African Americans with depressive illness.

TARGET AUDIENCE:

Mental health and primary care practitioners, and trainees.

REFERENCES:

1. Pollack DA: The Integrated System's View. Advancing Mental Health and Primary Care Collaboration in the Public Sector. New Directions for Mental Health Services. San Francisco, Jossey-Bass Publishers, 1999.
2. Cooper-Patrick L, Crum R, Ford DE. Identifying suicidal ideation in general medical patients. Journal of the American Medical Association 1994; 272: 22:1757–1762.

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