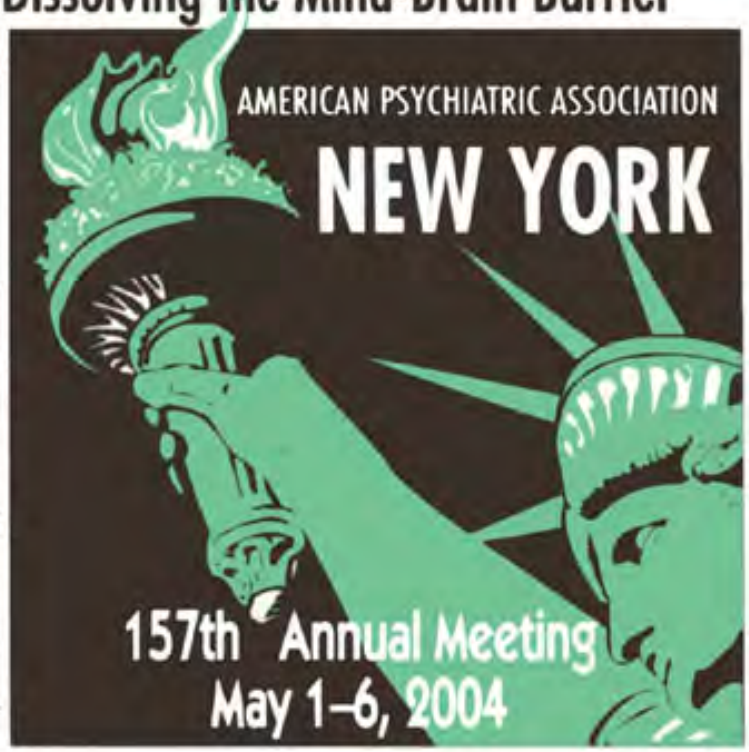
SYLLABUS &

SYLLABUS & PROCEEDINGS SUMMARY

AMERICAN PSYCHIATRIC ASSOCIATION

2004 ANNUAL MEETING

Psychotherapy and Psychopharmacology:
Dissolving the Mind-Brain Barrier



PROCEEDINGS SUMMARY

New York, NY ■ May 1-6, 2004

FOR YOUR RECORDS

This Certificate of Attendance is for your personal records.

the American Psychiatric Association certifies that

has participated in the
157th Annual Meeting of the APA
New York, NY, May 1-6, 2004
President's Theme: Dissolving the Mind-Brain Barrier

and is awarded _____ category 1 credits.

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

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

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

DAILY LOG FOR ATTENDANCE AT CME FUNCTIONS AT THE ANNUAL MEETING OF THE AMERICAN PSYCHIATRIC ASSOCIATION, May 1-6, 2004, New York, NY

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

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

American Psychiatric Association
Continuing Medical Education Requirement

APA Continuing Medical Education Requirement

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

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

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Obtaining an APA CME Certificate

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

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

Reciprocity with AMA

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

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

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

APA Report Form

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

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

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

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

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

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

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

SYLLABUS
AND
SCIENTIFIC PROCEEDINGS

IN SUMMARY FORM

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

New York, NY

May 1-6, 2004

Published by

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AMERICAN PSYCHIATRIC ASSOCIATION

1000 Wilson Boulevard, Suite 1825

Arlington, VA 22209

May 2004

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FOREWORD

This book incorporates all abstracts of the *Scientific Proceedings* in *Summary Form,* as have been published in previous years, and, additionally, information for continuing medical education purposes.

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

We wish to express our appreciation to the authors and other contributors for their cooperation in preparing the necessary materials so far in advance of the meeting. Our special thanks are also extended to Geralyn Trujillo, Kendra Grant, Sharita Morse, and Byron Phillips in the APA Annual Meetings Department.

Geetha Jayaram, M.D., M.B.A., *Chairperson*
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Full Texts

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

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Marcia Kraft Goin, M.D.

PAPER NO. 1: PRESIDENTIAL ADDRESS

DISSOLVING THE MIND-BRAIN BARRIER

The concept of a mind/body dichotomy is historically interesting, but clinically irrelevant in today's scientific world. Research in the past decade has demonstrated the molecular interaction of mind and brain, corroborating clinical experience. There is a re-awakening of the value of being mindful of the mind and its effect on brain functioning, both in the etiology of psychiatric disorders and in their treatment.

Our field is challenged to provide patients with effective and comprehensive treatment. Knowledgeable psychiatrists appreciate the virtue of psychotherapy integrated with an informed grasp of psychopharmacology. We are not far from that day when a computer will generate a patient's phenotype and link that information with specific details for appropriate use of psychopharmacologic agents. To peel back the layers of the psyche and affect therapeutic impact on the unconscious psychodynamic conflicts may take a while longer.

Neuroscientists recognize that stress has a major impact on neurocircuitry and gene expression. We psychiatrists have an intimate awareness that stress can be overwhelming and very often triggered by war, loss, death, and poverty. Stress also has personal individualized meaning depending upon a person's history and vulnerabilities. This delicate interplay between life experience, psychodynamic conflict, gene expression and developmental experience, filtered through our neurocircuitry makes all of us who we are, points to the diseases which affect us and recommends the treatments we use. Understanding the resultant idiosyncratic outcome of these interrelationships is the challenge and excitement of our specialty.

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INDUSTRY-SUPPORTED SYMPOSIUM 1—TREATMENT RESISTANCE: CONCEPTS AND MANAGEMENT IN MOOD AND ANXIETY DISORDERS

Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to 1) review leading-edge pharmacologic and somatic treatments for treatment-resistant mood and anxiety disorders, 2) describe rates of treatment for various mood and anxiety disorders in clinical trials, 3) present an overview of outcomes of cognitive behavior therapy for obsessive-compulsive disorder and posttraumatic stress disorder, and 4) optimally select treatments for treatment-refractory depression and anxiety disorders.

No. 1A
TREATMENT RESISTANCE IN MOOD AND ANXIETY DISORDERS: EVIDENCE FROM CLINICAL TRIALS

Ellen Frank, Ph.D., 3811 O'Hara Street, Pittsburgh, PA 15213-2593

SUMMARY:

More than a decade ago, it was recognized that confusion was rampant in the treatment outcome literature on major depression, with one person's "response" being another's "remission." Consensus definitions were proposed to characterize a variety of treatment outcomes, including "response," "remission," "relapse," and "recurrence," enabling investigators to better characterize outcomes from clinical trials and leading to the recognition that 30% to 40% of patients do not respond to the first treatment offered and typically less than 50% achieve a sustained remission. More recently, similar efforts have suggested similar rates of treatment resistance in anxiety disorders. It has long been understood that comorbid psychiatric disorders on both axis I and axis II contribute to treatment resistance; however, new efforts to describe and study softer forms of comorbidity indicate that these conditions contribute substantially to so-called treatment resistance. Thus, for example, patients with major depression and panic spectrum symptoms will include a lower proportion of patients with treatment response and will have a longer time to response and higher levels of residual impairment than patients without such comorbidity. Both the emotional and economic burden associated with such treatment resistance are enormous. Clearly, new treatment approaches are called for to address the suffering caused by these difficult-to-treat conditions.

No. 1B
PSYCHOTHERAPEUTIC APPROACHES FOR PATIENTS WITH TREATMENT-RESISTANT MOOD AND ANXIETY DISORDERS

Edna B. Foa, Ph.D., 3535 Market Street Suite 600 North, Philadelphia, PA 19104

SUMMARY:

This presentation discusses outcomes of cognitive therapy treatments for anxiety disorders, with special emphasis on obsessive-compulsive disorder and posttraumatic stress disorder, reviews the literature on predictors for failure to respond to cognitive behavior therapy for these disorders, and explores strategies to improve outcomes of patients with treatment-resistant disorders.

No. 1C
CLINICAL PATHWAYS FOR MOOD AND ANXIETY DISORDERS

Waguih W. Ishak, M.D., 8730 Alden Drive, W101, Los Angeles, CA 90048

SUMMARY:

Clinical pathways document potential steps in the diagnosis and treatment of a condition or procedure for individual patients. Their usefulness in guiding clinicians through the steps of non-response or partial response to interventions has been documented. These are predominantly management tools and are based on clinical information developed from evidence-based psychiatry, practice guidelines or expert consensus statements. Pathways may not be appropriate for use in all circumstances, nor are they a substitute for the practitioner's experience and judgment. Their applicability must be assessed by the responsible practitioner in light of relevant circumstances presented by individual patients in order to optimize treatment.

This presentation will focus on the use of clinical pathways in mood and anxiety disorders. The participants will become familiar with an example of an outcome monitored depression treatment pathway that has been implemented in a number of medical centers.

No. 1D
EMERGING TREATMENT OPTIONS IN TREATMENT-RESISTANT MOOD AND ANXIETY DISORDERS

Mark H. Rapaport, M.D., 8730 Alden Dr. Suite C301, Los Angeles, CA 90048

SUMMARY:

This presentation reviews the breadth of experimental treatment approaches that are available to aid clinicians treating patients with severe, treatment-resistant mood and anxiety disorders. This presentation has two related themes: 1) practical, new innovations that can be immediately employed in clinical practice and 2) new alternative somatic therapies such as vagus nerve stimulation and transcranial magnetic stimulation. By the end of the presentation the audience will have received an overview of the range of experimental options available for current and future use in patients with treatment-resistant disorders.

REFERENCES:

1. Frank E, Shear MK, Rucci P, Cyranowski JM, Endicott J, Fagiolini A, Grochocinski VJ, Houck P, Kupfer DJ, Maser JD, Cassano GB: Influence of panic-agoraphobic spectrum symptomatology on treatment response in patients with recurrent major depression. Am J Psychiatry 2000; 157:1101–1107.
2. Foa EB, Rothbaum BO: Treating the Trauma of Rape. New York, Guilford, 1998.
3. An Example of a Depression Treatment and Outcome Monitoring Pathway, IsHak WW, Merlino J, Trujillo M in Outcome Measurement in Psychiatry: A Critical Review, IsHak WW, Burt T, Sederer LI (editors), APPI, Washington, DC, 2002.
4. Fava ME, Davidson KG: Definition and Epidemiology of treatment-resistant depression, Psychiatr Clin North Am 1996; 19:179–198.

INDUSTRY-SUPPORTED SYMPOSIUM 2—PREVENTIVE PSYCHIATRY IN MOOD DISORDERS: A NEW FRONTIER
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1) understand the effects of early life trauma on neurobiology and the subsequent development of psychiatric illnesses, 2) provide patients and primary care providers with available information on medication use in pregnancy and lactation, 3) understand the emerging role of neuroimaging as it affects psychiatry, and 4) understand the ethical and study design difficulties for conducting prevention studies.

No. 2A
IDENTIFICATION OF RISK FACTORS FOR DEVELOPMENT OF DEPRESSION: FOCUS ON EARLY-LIFE TRAUMA

Charles B. Nemeroff, M.D., *1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

Numerous studies have confirmed that stressful or traumatic events during childhood predispose individuals to mood and anxiety disorders later in life. Examples of these events include, but are not limited to, physical and sexual abuse, parental loss, and neglect. Results of recent studies have linked adverse early-life experiences with profound changes in the central nervous system (CNS). Such traumas appear to permanently alter neurobiologic pathways, resulting in increased susceptibility to developing depression and anxiety. More specifically, this effect of early untoward life experience has been found to be mediated in part by increasing activity of the corticotropin-releasing factor (CRF) system. Identification of the precise CNS substrates and further elucidation of the mechanisms resulting in these neurobiological changes may lead to novel therapeutic targets to ameliorate or prevent the lifelong negative consequences of early-life stress and trauma. The effects of psychotherapy versus antidepressant therapy in depressed patients with early-life trauma are described.

No. 2B
ACHIEVING THE OPTIMAL BALANCE BETWEEN TREATMENT OF MATERNAL DEPRESSION AND INFANT MEDICATION EXPOSURE

Zachary N. Stowe, M.D., *1365 Clifton Road, Building B, # 6100, Atlanta, GA 30322*

SUMMARY:

Maternal stress and psychiatric illness during pregnancy have been shown to cause harmful neurobiologic and behavioral changes in the child, which continue into adulthood. Postpartum illness in the mother may cause further detriment to normal infant development. The incidence of mood and anxiety disorders in the female population appears to be increasing, therefore it is of great importance to understand how to adequately treat these women during pregnancy and lactation to prevent negative outcomes for the fetus and infant. At the same time, the clinician also must protect the infant from harmful medication exposure. The balance between therapeutic treatment of the mother and minimization of infant exposure is a complex and difficult responsibility, for which there are no existing guidelines. Recent data of placental passage and breast milk excretion of antidepressant medications are reviewed to provide physicians with current information on the safety and efficacy of the available treatment options for depression.

No. 2C
FUNCTIONAL BRAIN IMAGING: SUBTYPING DEPRESSION

Helen S. Mayberg, M.D., *3560 Bathurst Street, Toronto, ON Canada M6A 2E1*

SUMMARY:

Neuroscience research has advanced tremendously in recent years, and neuroimaging has been responsible in part for the logarithmic growth of our understanding of brain structure and function in depression in the last decade. Neuroimaging technology is approaching a role as an integral component of many neurobiologic studies, clinical trials, and diagnosis and therapeutic monitoring. Neuroimaging techniques, such as PET (positron emission tomography), SPECT (single photon emission computed tomography), and fMRI (functional magnetic resonance imaging) permit better understanding of neurotransmitter function and mapping of neural circuitry in health, psychiatric illness, and recovery. A theory is developing in which major depression is considered the result of maladaptive functional interactions of limbic-cortical regions, which are responsible for maintaining emotional control in response to cognitive and somatic stress. Results from PET studies examining regional metabolic and blood flow changes in depressed patients are reviewed. In addition, converging PET imaging findings that report subgroup-, state- and treatment-specific effects is discussed, with an emphasis on the variability in neural systems that may be relevant to the development of evidence-based diagnostic and treatment algorithms for patients with major depression.

No. 2D
GENETIC RESEARCH IN PSYCHIATRY: DIAGNOSTIC AND THERAPEUTIC IMPLICATIONS

Stephan Claes, M.D., *Universiteitsplein 1, Wilrijk, Belgium B-2610*

SUMMARY:

In a number of neuropsychiatric disorders, such as mental retardation and the dementias, relevant genetic factors have been identified. These findings have important consequences for disease classification and diagnosis.

In multifactorial diseases such as mood disorders, schizophrenia and anxiety disorders no causative genetic factors have been isolated beyond doubt, although several interesting findings are emerging. A polymorphism of the serotonin transporter gene has been associated with anxiety-related personality traits, aggression and increased excitability of the amygdala to emotional stimuli. Variations in the gene encoding for catechol-O-methyltransferase (COMT) have been implicated in the genetic vulnerability for schizophrenia, possibly through an impact on prefrontal dopamine signaling, executive cognition and the physiology of the prefrontal cortex. Several other genes associated with schizophrenia may have convergent effects on glutamatergic neurotransmission (1). A pleiotropic syndrome that includes panic disorder, bladder problems, severe headaches and mitral valve prolapse was linked to a region on chromosome 13q by two independent studies. In the field of psychopharmacogenetics, variations in metabolizing enzymes, in receptor and in transporter proteins have been shown to influence drug efficacy and side effects.

The consequences of these findings for pathophysiology, diagnosis and treatment will be discussed.

REFERENCES:

1. Penza KM, Heim C, Nemeroff CB: Neurobiological effects of childhood abuse: implications for the pathophysiology of depression and anxiety. Arch Women Ment Health 2003; 6:15–22.
2. Hendrick V, Stowe ZN, Altshuler LL, Hwang S, Lee E. Haynes D: Placental passage of antidepressant medications. Am J Psychiatry 2003; 160:993–996.
3. Mayberg HS: Modulating dysfunctional limbic-cortical circuits in depression: towards development of brain-based algorithms for diagnosis and optimized treatment. Br Med Bull 2003; 65:193–207.
4. Harrison PJ, Owen MJ (2003) Genes for schizophrenia? Recent findings and their pathophysiological implications. Lancet 361:417–9.

INDUSTRY-SUPPORTED SYMPOSIUM 3—BIPOLAR DISORDER AND ALCOHOLISM: DIAGNOSTIC CHALLENGES AND THERAPEUTIC INTERVENTIONS Supported by Ortho-McNeil Pharmaceuticals

EDUCATIONAL OBJECTIVES:

Upon completion of the program, participants should be able to discuss the neurobiology of alcohol withdrawal, dependence, and relapse prevention in patients with bipolar disorder; comprehend the effect of alcoholism on the presentation and course of bipolar disorder; address pharmacotherapy of alcohol dependence; determine the role of mood stabilizers in bipolar disorder alcohol comorbidity; and understand bipolar illness, substance abuse comorbidity, and their implications for the legal system.

No. 3A
NEUROBIOLOGY OF ALCOHOL WITHDRAWAL

Hugh Myrick, M.D., *109 Bee Street, Charleston, SC 29425*

SUMMARY:

The presentation focuses on the complex relationship between alcoholism and bipolar illness. Individuals with bipolar disorder have a higher prevalence of alcohol dependence than those with any other psychiatric disorder. There are many similarities between alcoholism and bipolar illness. The disorders can be linked on a phenomenological, neurobiological, and pharmacological basis. Phenomenological similarities include impulsivity and irritability. Impulsivity appears to be an underlying dimension that underlies both alcoholism and bipolar disorder. In addition, characteristics of protracted alcohol withdrawal such as sleep disturbance, anxiety, and mood instability are found in both alcoholism and bipolar disorder. Neurobiological similarities include kindling and neuronal loss. Kindling is known to occur in both alcohol withdrawal and bipolar illness. Kindling has the potential to affect the course and treatment of both illnesses. Neuronal loss in critical brain regions has also been found in individuals with alcoholism and bipolar illness. This neuronal loss is exacerbated in the comorbid condition. The presentation concludes by reviewing the rationale for the use of anticonvulsants as pharmacological agents to treat alcohol withdrawal and prevent relapse to alcohol use in bipolar disorder.

No. 3B
PHARMACOTHERAPY FOR ALCOHOLISM

Bankole A. Johnson, M.D., *7703 Floyd Curl Drive, MS 7793, San Antonio, TX 78229-3900*

SUMMARY:

New knowledge based in the neurosciences has improved understanding of the neurobiological underpinnings of alcohol dependence. Briefly, preclinical studies have identified several target neurotransmitters implicated in the expression of alcohol-related brain reward. Notably, neurotransmitters that interact with or modify the activity of dopamine-innervated mesocorticolimbic neurons have provided the foundation for developing medications to treat alcohol dependence. Of the medications to be reviewed, the mu-antagonist, naltrexone, has been approved in the United States for alcoholism treatment. Efficacy for naltrexone continues to be established by the majority of contemporary double-blind clinical trials. In Europe, the primary medication of interest has been the glutamate antagonist, acamprosate. While acamprosate failed to gain FDA approval for the treatment of alcohol dependence in the United States, additional evidence of efficacy from upcoming trials may improve its prospects for later acceptance. In a promising development, it has been demonstrated that the serotonin-3 antagonist, ondansetron, appears to be an effective treatment for alcoholics with a biological disease predisposition who develop problem-drinking behavior in their youth. In contrast, evidence is emerging that serotonin reuptake inhibitors may be a useful treatment for alcohol-dependent individuals who develop the disease as adults and who have little or no familial disease predisposition. A molecular hypothesis for explaining this differential effect of two types of serotonergic medication in these two subtypes of alcoholic is advanced. Another promising area of research is that the use of combinations of effective medications may prove to be superior to the use of single agents. This presentation reviews evidence of potential synergistic activity when ondansetron and naltrexone are combined for the treatment of alcoholics who develop the disease in their youth. Finally, new knowledge is presented showing that topiramate, a gamma-aminobutyric acid facilitator and glutamate antagonist, may be an effective treatment for alcohol dependence.

No. 3C
THE IMPACT OF ALCOHOLISM ON THE PRESENTATION AND COURSE OF BIPOLAR DISORDER

Susan L. McElroy, M.D., *MSB559-231 Albert Sabin Way, Cincinnati, OH 45267-0559*

SUMMARY:

It has long been recognized that bipolar disorder and alcoholism commonly co-occur. The Epidemiological Catchment Area (ECA) Study reported a 60.7% lifetime prevalence rate for substance abuse or dependence in persons with bipolar I disorder; alcohol was the most commonly abused substance. A subscale analysis of the ECA study showed that bipolar I disorder and bipolar II disorder populations had the highest lifetime prevalence rate of alcoholism (46.2% and 39.2%, respectively), followed by schizophrenia (33.7%), panic disorder (28.7%), unipolar depression (16.5%), and the general population (13.8%). Thus, by prevalence data alone, this comorbidity represents an enormous public health problem. Furthermore, this comorbidity has been associated with a greater illness burden, as represented by an increased number of past hospitalizations (predominantly for mania), and a higher prevalence rate of dysphoric mania, rapid cycling, suicidality, treatment noncompliance, health care utilization, and poor treatment response. This presentation reviews treatment strategies that are focused both on mood stabilization and alcohol withdrawal/relapse prevention.

No. 3D
THE ROLE OF MOOD STABILIZERS IN BIPOLAR DISORDER WITH COMORBID ALCOHOL DEPENDENCE

Joseph F. Goldberg, M.D., *79-59 263rd Street, Glen Oaks, NY 11004*

SUMMARY:

Although alcohol use disorders arise in more than half of patients with bipolar disorder, dual-diagnosis patients are routinely excluded from efficacy-based clinical trials. Prescribers must therefore draw inferences about mood-stabilizing drugs in comorbidly ill bipolar disorder patients in the relative absence of data from controlled treatment studies. Nevertheless, the field has increasingly come to recognize that alcohol use disorders are more common than rare in bipolar disorder patients and may even derive from common underlying factors such as impulsivity, sensation seeking, and mood dysregulation. Medications and psychotherapies that target domains such as these could provide inroads that might help to overcome the challenges of managing dual-diagnosis bipolar disorder patients. This presentation examines current information regarding psychopathology dimensions associated with the presence or absence of alcohol use disorders in bipolar disorder patients and reviews findings from existing pharmacotherapy trials as well as psychotherapy studies specific to dual-diagnosis bipolar disorder patients. Presumptive neurotransmitter systems involved in comorbid presentations are discussed relative to the rationale and clinical effectiveness of anticonvulsants and atypical antipsychotics in this distinct clinical population. Integrative pharmacotherapy psychotherapy strategies based on an emerging database from the literature are also discussed.

No. 3E
BIPOLAR ILLNESS, SUBSTANCE ABUSE COMORBIDITY, AND THE LEGAL SYSTEM

Cameron D. Quanbeck, Ph.D., *2230 Stockton Boulevard, Sacramento, CA 95817*

SUMMARY:

To determine illness factors associated with criminality, previous research identified clinical and legal correlates of inmates with bipolar disorder at the time of arrest and incarceration at Los Angeles County Jail. These inmates had a history of psychiatric treatment in the Los Angeles County community mental health system. Specifically, symptoms at arrest, criminal charges, substance abuse comorbidity and the nature of community mental health treatment preceding arrest were examined. Of the 66 inmates identified, most were experiencing manic (49/66, 74.2%) and psychotic (39/66, 59%) symptoms at the time of arrest. Manic arrestees were recently released from community inpatient treatment and failed to enter into outpatient care after release. Compared to a group of bipolar disorder patients who had been hospitalized but never arrested in Los Angeles County, the inmates with bipolar disorder had significantly higher rates of substance abuse comorbidity (75.8%, compared to 18.5%). The most common arresting charge was for violent crime. Most inmates had a criminal history (53/66, 80.3%) and were on parole or probation (40/66, 60.3%) at the time of their arrest. Patient characteristics and symptoms (particularly substance abuse) contributing to criminal behavior among bipolar disorder patients are discussed.

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2. Johnson BA, Ait-Daoud N: Neuropharmacological treatments for alcoholism: scientific basis and clinical findings. Psychopharmacology 2000; 149:327–344.
3. Perugi G, Toni C, Frare F, et al: Effectiveness of adjunctive gabapentin in resistant bipolar disorder: is it due to anxious-alcohol abuse comorbidity? J Clin Psychopharmacology 2002; 22:584–591.
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INDUSTRY-SUPPORTED SYMPOSIUM 4—ADULT ADHD: CLINICAL UTILITY AND VALIDITY
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to 1) understand the magnitude and consequences of ADHD in adults based on empirical data in the United States and other countries around the world, 2) identify diagnostic instruments for screening people with possible ADHD in community and clinical settings, 3) recognize state-of-the art clinical assessments for ADHD diagnosis and differential diagnosis, and 4) understand the literature about possible treatment interventions to prevent the disability associated with ADHD.

No. 4A
PREVALENCE OF ADULT ADHD IN THE UNITED STATES: RESULTS FROM THE NATIONAL COMORBIDITY SURVEY REPLICATION (NCS-R)

Ronald C. Kessler, Ph.D., *180 Longwood Avenue, Boston, MA 02130*

SUMMARY:

This presentation will provide data from the recently completed National Comorbidity Survey Replication (NCS-R) on patterns and correlates of adult ADHD in the general population of the United States. The NCS-R is a national representative face-to-face household survey of nearly 10,000 Americans that was completed in the spring of 2003 to study the epidemiology of common DSM-IV disorders. The first national survey to include a diagnostic evaluation of adult ADHD, the NCS-R was based on fully structured questions that were calibrated in a subsample against blinded semi-structured follow-up clinical re-interviews. According to the NCS-R adult ADHD is a highly prevalent disorder in the general population that is typically associated with high comorbidity as well as substantial role impairment. Adult ADHD has a low rate of recognition and an even lower rate of treatment and, when undetected, it is implicated in a substantial proportion of the most severe and persistent cases of several other DSM-IV disorders. ADHD is almost always the temporally primary disorder in these comorbid cases. The presentation will close with a discussion of the public health implications of detecting and treating adult ADHD.detecting and treating adult ADHD.

No. 4B
ADULT ADHD DIAGNOSTIC AND SELF-REPORT SYMPTOM SCALES: DEVELOPMENT AND VALIDATION IN THE NATIONAL COMORBIDITY SURVEY REPLICATION (NCS-R) COHORT

Lenard A. Adler, M.D., *530 First Avenue HCC 5A, New York, NY 100166497*

SUMMARY:

The symptom assessment and diagnosis of adult ADHD remains controversial. This presentation will offer data on the development

and validation of diagnostic and symptom assessment measures in a study of adult ADHD in a national, well-characterized patient sample, the cohort from the National Comorbidity Survey (NCS).

Prior NCS studies examined ADHD through use of the childhood questions on the Composite International Diagnostic Interview (CIDI). Adult-specific scales were then developed and administered to those adult patients from the NCS who were identified as either likely or not likely of having ADHD, using diagnostic and symptomatic assessments of both childhood (retrospective Schedule for Affective Disorders and Schizophrenia [K-SADS]) and adult ADHD. The adult instrument consisted of a modified ADHD model of the K-SADS, with adult-specific prompts and a self-report, frequency-based scale symptoms assessment, and the Adult ADHD Self Report Scale (ASRS), which corresponded to the 18 items in DSM-IV.

This presentation will explain the process of rater training for this re-assessment of the NCS sample. The adult instruments were highly valid and accurate in diagnosing and assessing adult ADHD. Additionally, the actual scales will be described, along with the diagnostic predictive ranges based on scores for the ASRS. The implications of the utility of these instruments will also be explained.

No. 4C
CURRENT CONCEPTS IN THE NEUROBIOLOGY OF ADHD

Joseph Biederman, M.D., *15 Parkman Street, ACC—725, Boston, MA 02114*

SUMMARY:

Attention-deficit/hyperactivity disorder (ADHD) is an early-onset, clinically heterogeneous disorder of inattention, hyperactivity, and impulsivity. In contrast to the acceptance of ADHD as a childhood diagnosis, its prevalence in adults and its implications for clinical practice remain a source of controversy. Family studies consistently support the assertion that ADHD runs in families. Heritability data from twin studies of ADHD attribute about 80 percent of the etiology of ADHD to genetic factors. Adoption studies of ADHD implicate genes in its etiology. Molecular genetic data are bolstered by considerations suggesting that DRD4 and DAT genes may be relevant for ADHD. Independent of genes, prenatal exposure to nicotine and psychosocial adversity have been identified as risk factors for ADHD. Structural and functional imaging studies consistently implicate catecholamine-rich fronto-subcortical systems in the pathophysiology of ADHD. The effectiveness of stimulants, along with animal models of hyperactivity, point to catecholamine dysregulation as at least one source of ADHD brain dysfunction. Although not entirely sufficient, changes in dopaminergic and noradrenergic function appear necessary for the clinical efficacy of pharmacological treatments for ADHD, providing support for the hypothesis that alteration of monoaminergic transmission in critical brain regions may be the basis for therapeutic action in ADHD.

No. 4D
TREATMENT OPTIONS AND RESPONSE PATTERNS IN ADULT ADHD

Margaret D. Weiss, M.D., *C405A, 4480 Oak Street, Vancouver, BC Canada V6H 3V4*

SUMMARY:

ADHD in adults is associated with increased risk for smoking, drug use, traffic violations, motor vehicle accidents, marital problems, sexually transmitted diseases, unwanted pregnancy, occupational and educational impairment, and poor self-esteem. The disorder is often comorbid, which presents treatment challenges. Other important areas of functioning, such as parenting, have not yet been systematically investigated, but may be affected as well. Psychological treatment options include psychoeducation, environmental restructuring, coaching, and development of coping strategies to minimize the impairment associated with residual symptoms. Double-blind, placebo-controlled trials have demonstrated the safety and efficacy of methylphenidate, desipramine, mixed amphetamine salts, buproprion, and atomoxetine. The FDA recently approved atomoxetine for treatment of ADHD in adults. This presentation will review the current literature on treatment and provide a clinical guide to application and integration of psychological and pharmacological treatment principles. These new treatment options offer considerable new possibilities for improving the well-being of these patients. Given that this is a common and chronic disorder associated with serious functional impairment, these treatment options also hold a significant potential for ameliorating the serious public health difficulties that are associated with the disorder.

No. 4E
OUR NEW UNDERSTANDING OF THE PREVALENCE, IMPAIRMENTS, COMORBIDITY, AND TREATMENT OF ADULTS WITH ADHD

Thomas J. Spencer, M.D., *55 Fruit Street, Warren 705, Boston, MA 02114*

SUMMARY:

This presentation will explore the context of the existing controversies in adult ADHD. The existence and validity of adult ADHD was doubted until very recently. ADHD presents differently in adults, with less hyperactivity and relatively more inattention, and it may not be simple, but rather expressed as executive dysfunctions. The translation of the child-defined symptoms into adult equivalents has led to numerous corroborating discoveries. Rigorously defined, the national comorbidity study has now shown that 4% of a large adult epidemiological sample meets full criteria for ADHD. Like their childhood counterparts, many of these adults with ADHD suffer from antisocial, depressive, and anxiety disorders. They also show clinically significant impairments such as histories of school failure, occupational problems, and traffic accidents. These patterns of impairments and comorbidities are identical to those seen in referred adults patients with ADHD who are ascertained prospectively and retrospectively. These adults show familial aggregation, a characteristic profile of neuropsychological deficits, and an emerging neuroimaging literature suggests that abnormalities in the same brain regions underlie both the child and adult cases of ADHD. A number of large, controlled treatment studies have documented effective treatment of core symptoms as well as increased functional capacities.

REFERENCES:

1. Faraone SV, Biederman J, Spencer T, et al: Attention-deficit hyperactivity disorder in adults: an overview. Biological Psychiatry 2000; 48:9–20.
2. Adler LA, Chua HC: Management of ADHD in adults. J Clin Psychiatry 2002; 63(suppl 12):29–35.
3. Castellanos FX, Tannock R: Neuroscience of attention deficit/hyperactivity disorder: the search for endophenotypes. Nature Reviews Neuroscience 2002; 3:617–628.

INDUSTRY-SUPPORTED SYMPOSIUM 5—TOWARDS DSM-V: PHENOMENOLOGY, NEUROBIOLOGY, AND TREATMENT RESPONSE IN DEPRESSION
Supported by Cephalon, Inc.

EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium, the participant should be able to develop an understanding of neurobiology relevant to clinical

treatment issues to maximize likelihood of achieving remission in patients with major depression.

No. 5A
PATHOPHYSIOLOGY OF MAJOR DEPRESSION: MONOAMINES, PEPTIDES, AND NEUROTROPHINS

Kerry J. Ressler, M.D., *1639 Pierce Drive, Suite 4000, WMB Bldg., Atlanta, GA 30322*

SUMMARY:

Major depression is a common syndromal disorder that carries with it extreme morbidity and mortality. Recent discoveries are changing our understanding of the biological basis of depression. Evidence from basic to clinical research continues to reveal that norepinephrine and serotonin are crucial regulators of a myriad of behaviors ranging from stress response and emotional regulation to concentration and sleep. Historically, the roles of various neuropeptides, most notably corticotropin-releasing hormone, have been implicated in the dysregulation of the hypothalamic-pituitary-adrenal stress axis and depression. Recent evidence suggests that other peptides, including hypocretin, may have critical roles in depression, particularly in the regulation of the sleep-wake cycle. It has also been shown that neural growth factors, most notably brain-derived neurotrophic factor, are involved in neurogenesis within the normal brain, and that abnormalities with neurotrophins and neurogenesis contribute to depressive disorders. This presentation combines these different sets of data and somewhat disparate theories into an updated and more comprehensive overall view of the pathophysiological basis of major depression.

No. 5B
HOMOLOGY BETWEEN PATHOPHYSIOLOGY AND SYMPTOMS IN MAJOR DEPRESSION

Boadie W. Dunlop, M.D., *Mood and Anxiety Disorders Program, Emory University School of Medicine, 1841 Clifton Rd NE, 4th Flr, Atlanta, GA 30329*

SUMMARY:

The symptoms of major depression are multidetermined and are caused by overlapping neurochemical and neuropathyway dysregulations. While these dysregulations are complex, some homologous relationships exist between specific neurobiological alterations and symptoms. Classically, the hypothalamic-pituitary-adrenal (HPA) axis has been found to be abnormal in major depression, with persistently high levels of cortisol and resistance to suppression with exogenous dexamethasone. The net result is decreased neurogenesis and this may, in turn, account for some of the cognitive difficulties observed. Persistently high levels of cortisol in a subpopulation of depressed patients may also lead to abnormalities in inflammatory proteins and these may, in turn, lead to cardiovascular problems. Similar to alterations in the HPA axis are abnormalities in hypocretin that may explain some of the sleep difficulties in major depression. Dysregulation of serotonin may lead to irritability, aggression, increased eating, and insomnia. Dysregulation of norepinephrine can lead to decreased alertness and increased fatigue, selective attention, and arousal. Paradoxically, increasing serotonin function may lead to decreased dopamine in the frontal lobe, which can lead to apathy. These relationships are discussed with a focus on therapeutic interventions and diagnostic subtypes.

No. 5C
ENHANCING EMERGENCE OF ANTIDEPRESSANT BENEFIT

Charles DeBattista, M.D., *401 Quarry Road, #2137, Stanford, CA 94305-5723*

SUMMARY:

For the majority of patients with major depression (MD), there is considerable latency in achieving symptomatic remission on initiating antidepressant monotherapy. During this period, patients and psychiatrists often become frustrated or pessimistic, leading to non-evidence-based changes in medication or even discontinuation. The risk of suicide continues. The overall result is suboptimal outcome. Therapeutic options that result in remission more rapidly than currently available monotherapy are a major unmet need in the treatment of MD. There are several methodological challenges in demonstrating an earlier emergence of antidepressant benefit. These include considerable "technical" limitations inherent in clinical trials today. A focus on the initial point of separation from placebo is of limited value. The proportion of patients achieving remission during the initial weeks may be a more clinically relevant outcome measure. What are the options? Should initiating monotherapy continue to be the usual treatment strategy? When and for how long should augmentation or combination strategies be instituted to achieve rapid remission? What role do novel agents such as glucocorticoid receptor antagonists and wakefulness agents play in the goal of achieving remission? These issues are reviewed and clinical guidelines are derived based on the evidence.

No. 5D
PHARMACOLOGICAL APPROACHES TO MANAGEMENT OF RESIDUAL SYMPTOMS IN DEPRESSION

Maurizio Fava, M.D., *15 Parkman Street, WACC-812, Boston, MA 02114*

SUMMARY:

Fatigue and sleep problems are among the most common residual symptoms associated with antidepressant therapy. These symptoms likely persist despite adequate antidepressant therapy because they are mediated by different areas of the brain than the core mood-related symptoms of depression (core symptoms mediated by multiple areas of the brain, including the orbital and medial prefrontal cortex, the amygdala, and related parts of the striatum and thalamus; fatigue and sleep problems largely mediated by the frontal cortex). Comorbid conditions and concomitant medications often contribute to the development of residual symptoms and should be considered when designing subsequent treatment strategies. Various adjunct therapies have been studied for use in patients who fail to achieve complete response on optimal antidepressant mono- or combination therapy, including therapies that target different areas of the brain than antidepressants, such as lithium, thyroid hormone, pindolol, psychostimulants, and modafinil. This presentation reviews the rationale for the use of these agents and discusses the results of clinical trials of their safety and efficacy in this patient population.

No. 5E
MIND: LESSONS FROM THE BRAIN

Philip T. Ninan, M.D., *1841 Clifton Road, 4th Floor, Atlanta, GA 30329*

SUMMARY:

Human experiences and behaviors are driven by modules of brain function such as internal representations, emotions, and cognition.

Executive functions based on prefrontal cortical function allow emergent capacities that define our humanity. Consciousness permits willful choice of behavior, while implicit or preconscious brain activity result in more automatic responses. Normality is the capacity to flexibly shift behavioral strategies in response to evolving situations. Psychopathology is the limitation of such choice where behavior is perseverated based on an inappropriately dominant brain region or neurocircuit. The mind becomes captive, and behavior deterministic. The mechanisms of action of the different psychotherapies and pharmacological agents can be examined in the light of this synthesis. Time-sequenced activation of brain regions can be examined and broadly categorized as top-down or bottom-up. Psychotherapeutic treatments are postulated to influence top-down processing. The mediating effects of different psychotherapies such as cognitive behavioral and psychodynamic treatments are likely very different and can be explored neurobiologically. The mechanisms of action of pharmacological agents, on the other hand, are largely bottom-up. Such a conceptual scaffold can intelligently target the use of different treatment modalities based on the individual patient. We can welcome the mind back into psychiatry.

REFERENCES:

1. Ressler KJ, Nemeroff CB: Role of serotonergic and noradrenergic systems in pathophysiology of depression and anxiety disorders. Depress Anxiety 2000; 12:2–19.
2. De Souza EB, Grigonadis DE: Corticotropin-releasing factor: physiology, pharmacology, and role in central nervous system disorders, in Neuropsychopharmacology: The Fifth Generation of Progress, Edited by Davis KL, Charney D, Coyle JT, Nemeroff C. Philadelphia, Lippincott Williams and Wilkins, 2002.
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4. Fava M: Augmentation and combination strategies in treatment-resistant depression. J Clin Psychiatry 2001; 62 (suppl 18):4–11.
5. Ninan PT, Feigon SA, Knight B: Neurobiology and mechanisms of antidepressant treatment response in anxiety. Psychopharm Bull 2002; 36(suppl 3):67–78.

INDUSTRY-SUPPORTED SYMPOSIUM 6—THE ROLE OF DOPAMINE IN HEALTH AND ILLNESS: SCIENCE TO PRACTICE

Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium, the participant should be able to describe the role dopamine plays in mental health and illness by discussing the effects dopamine exerts on different regions of the brain and subsequent influences on behavior, review implications "good and bad" when the dopamine system is manipulated for therapeutic goals (e.g., antipsychotics) or for other reasons (i.e, cocaine abuse).

No. 6A
THE ROLE OF DOPAMINE AS A MEDIATOR OF NORMAL HUMAN REWARD

Nora D. Volkow, M.D., *6001 Executive Boulevard, Room 5274, Bethesda, MD 20892*

SUMMARY:

The neurotransmitter dopamine plays a key role in the function of reward in the human brain and in modifying mental and physical activity. Dopamine also figures prominently in the pathophysiology and treatment of several disorders. Understanding the role of dopamine in normal human reward will provide attendees with insights into the numerous effects dopamine exerts in the human brain and the consequences associated with departures from normal dopamine function.

No. 6B
FROM DOPAMINE TO SALIENCE TO PSYCHOSIS: WHY ANTIPSYCHOTICS ARE ANTIPSYCHOTIC

Shitij Kapur, M.D., *250 College Street, Toronto, ON Canada M5T 1R8*

SUMMARY:

The clinical hallmark of schizophrenia is psychosis—an experience at the "mind" or phenomenological level. Yet, the most prominent theories about psychosis relate to dopamine, a chemical. How does one unite these different levels of analysis? It is proposed that dopamine firing has a role in detection of novel unpredicted rewards (Schultz et al.) and that dopamine release, particularly within the mesolimbic system, has a central role in mediating "salience" of the environment and its internal representations (Berridge et al). We propose that in the context of psychosis a dysregulated hyperdopaminergic state, whatever its primary origins, leads to a process of heightened novelty and aberrant assignment of salience to environmental stimuli and their internal representations. Delusions are a cognitive effort by the patient to make sense of these aberrantly salient experiences and associations, whereas hallucinations reflect a direct experience of the aberrant salience of internal representations. The antipsychotics exert their anti-"psychotic" effect by "dampening" the motivational salience of these abnormal experiences and associations and, by doing so, provide a platform for psychological resolution of symptoms. Other predictions of this hypothesis, particularly regarding the possibility of synergy between psychological and pharmacological therapy, will be presented.

No. 6C
DOPAMINE AND NEUROLEPTIC DYSPHORIA IN PRACTICE

Peter J. Weiden, M.D., *450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203*

SUMMARY:

Many of the disorders treated with antipsychotic medications require long-term or even life-long treatment. Therefore, adverse effects of medications become crucial in maintaining long-term compliance. Neuroleptic dysphoria is a subjectively unpleasant response that can heighten patients' already negative attitudes toward treatment. Understanding the mechanism that dopamine plays in neuroleptic dysphoria and using that understanding in selecting antipsychotic medications that may have lower risk of neuroleptic dysphoria could help increase patient compliance.

No. 6D
THE ROLE OF DOPAMINERGIC/CHOLINERGIC INTERACTION IN COGNITION AND PSYCHOSIS

Rajiv Tandon, M.D., *1500 East Medical Center Drive, Ann Arbor, MI 48109-0120*

SUMMARY:

Dopamine has a critical role in the working memory functions of the prefrontal cortex. These functions can be impacted by age, substance abuse, and disorders such as Parkinson's disease and schizophrenia. Cognitive dysfunction seems to be a core domain of

schizophrenia and may account for low functioning level with impact to the quality of life of schizophrenia patients. The preponderance of serotonin in 5 HT-2A antagonists over dopamine D2 blockade exerted by atypical antipsychotics may contribute to their cognitive enhancing effect. The specific mechanisms that mediate the cognitive-enhancing effect of atypical antipsychotics will be explored. The choice of atypical antipsychotics should, therefore, include an understanding of the specific cognitive deficit and the knowledge of those domains of cognition that can most be modified to benefit from an atypical.

No. 6E
THE ROLE OF DOPAMINE IN THE NEUROBIOLOGY OF SEXUAL DYSFUNCTION

Abdelouahed Elmouchtari, M.D., *450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203*

SUMMARY:

One of the key challenges is how to distinguish those sexual difficulties arising from the social hardships inherent in having schizophrenia, with those arising from disruption of normal dopamine function from schizophrenia or its treatment. The topic of sexuality and sexual functioning in schizophrenia has been relatively neglected in research, but is of considerable interest to our patients. Surveys of patient satisfaction to antipsychotic medications consistently show that patients often attribute their sexual dysfunction to their antipsychotic medications. Not surprisingly, our patients find sexual dysfunction attributed to antipsychotics to be very distressing. This talk will present new data on rates and severity of reported sexual dysfunction in a prospective study of first-episode schizophrenia.

The neurobiology of normal sexual functioning is essential to understanding of sexual issues in schizophrenia. Normal sexual functioning is divided in three phases: desire, arousal, and orgasm. Many of the neurotransmitter pathways associated with these phases are affected by schizophrenia or its treatment. The most salient pathways are the disruption of normal cortical dopamine neurotransmitter functioning, and of abnormal release of prolactin. This talk will review the literature on the clinical effects of disrupting these systems. Finally, the clinical implications of such disruptions will discussed within the context of having a diagnosis of schizophrenia, and the types of clinical presentations of sexual problems seen in patients with schizophrenia.

REFERENCES:

1. Volkow ND, et al: Reinforcing effects of psychostimulants in humans are associated with increases in brain dopamine and occupancy of D2 receptors. J Pharmacol Exp Ther 1999; 291:409–15.
2. Kapur S: Psychosis as a state of aberrant salience: a framework linking biology, phenomenology, and pharmacology in schizophrenia. Am J Psychiatry 2003; 160:13–23.
3. Gerlach J: Improving outcome in schizophrenia: the potential importance of EPS and neuroleptic dysphoria. Ann Clin Psychiatry 2002; 14(1):47–57.
4. Gao WJ, Goldman-Rakic PS: Selective modulation of excitatory and inhibitory microcircuits by dopamine. Proc Natl Acad Sci USA 2003; 100(5):2834–41.
5. Melis MR, Argiolas A: Dopamine and sexual behavior. Neuroscience and behavioral reviews, 19(1):19–38, 1993.
6. Meston CM, Frohlich, PF: The neurobiology of sexual functioning. Archives of General Psychiatry, 57:1012–1030, 2000.

INDUSTRY-SUPPORTED SYMPOSIUM 7—IMPULSIVITY: EMERGING CLINICAL PERSPECTIVES
Supported by Ortho-McNeil Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the various presentations of impulsivity, understand when impulsivity becomes pathological, be aware of its basic neurobiology, and effectively treat such patients.

No. 7A
NEUROBIOLOGY OF IMPULSIVE BEHAVIOR

Alan C. Swann, M.D., *1300 Moursund Avenue, Room 270, Houston, TX 77030*

SUMMARY:

Impulsivity results from a failure in the balance between the initiation and screening of behavior. Normally, prospective behavior undergoes a filtering process, lasting less than 0.5 seconds, that consists of a rapid screening of environmental conditions and relevant memories. This process takes place outside of consciousness. If the prospective behavior is not rejected in this process, the individual can then reflect and decide whether to carry out the behavior. This process requires that several important areas of brain function be intact, including activation/arousal, attention, working memory, and the balance between behavioral activation and inhibition. Several neurotransmitter balances are essential, including those between excitatory and inhibitory amino acid function, and dopamine and serotonin. Impulsivity has state-and trait-dependent aspects, illustrated best by bipolar disorder, where impulsivity as a personality trait is chronically increased but performance impulsivity is increased only during mania or if substance abuse is present. Rapid changes in risk of impulsivity may be associated with impairment of prefrontal cortical function by increased noradrenergic transmission associated with conditions like stress, mania, overstimulation, and substance abuse. Pathological impulsivity is prominent in a range of psychiatric disorders and leads to rapid unplanned actions with severe long-term consequences. Integrated treatment strategies for pathological impulsivity can be developed by using these principles.

No. 7B
WHEN DOES IMPULSIVE BEHAVIOR BECOME PATHOLOGIC?

Ernest S. Barratt, M.D., *301 University Boulevard, Galveston, TX 77550-0189*

SUMMARY:

Impulsivity is a pervasive construct present in a wide range of impulse control disorders. Why? The answer proposed here assumes that 1) impulsivity is multidimensional from both a clinical (e.g., DSM-IV) and a research viewpoint, 2) the substrata of the subdimensions of impulsivity are significantly related to the substrata of these disorders, 3) impulsivity is defined and measured differently within the different disciplines that study impulsivity, and 4) a major impediment to understanding impulsivity is the lack of a model to synthesize research data on impulsivity across disciplines. Within a general systems theory personality model, impulsivity is defined as a function of sequential information processing that relates to performance of everyday behaviors that have timing and rhythm requirements. The model outlines the following four categories of measurements used in defining impulsivity: 1) biological (e.g., neurotransmitters or event-

related potentials, 2) behavioral (e.g., reading and fine motor skills), 3) cognitive (e.g., attention deficits), and 4) social (e.g., learning emotional qualities of stimuli). Impulsivity subdimensions are categorized as attention, nonplanning, and motor. Brain functions that play a key role in impulsivity include sensory gating of information and working memory. Impulsivity leads to pathological behaviors when cut-off points for the subdimension measurements are exceeded.

No. 7C
CLINICAL ISSUES OF IMPULSIVITY IN PSYCHIATRY

Dan J. Stein, M.D., *Francis S. Key Medical Center, Baltimore, MD 21224*

SUMMARY:

DSM-IV-TR includes a section on impulse-control disorders not otherwise classified, where diagnostic criteria are provided for intermittent explosive disorder, kleptomania, pathological gambling, pyromania, and trichotillemania. Nevertheless, impulsivity is a core feature of a number of other disorders, including sustance-related disorders, attention-deficity/hyperactivity disorder, eating disorders, and cluster B personality disorders. Furthermore, evaluation and treatment of impulsivity is a crucial aspect of the management of a broad range of conditions, including mood and psychotic disorders. Is it possible to formulate a general approach to clinical impulsivity that is useful across this wide range of diverse conditions? Certainly, any such approach would need to recognize that impulsivity is a multidimensional construct, with both cognitive and affective components. This talk attempts to outline some additional issues and principles that inform theoretical and practical approaches to impulsivity in the clinical context.

No. 7D
ADDRESSING IMPULSIVE BEHAVIOR IN EATING DISORDERS

Renu Kotwal, M.D., *231 Albert Sabin Way, Cincinnati, OH 45267*

SUMMARY:

Although eating disorders share considerable overlap with obsessive-compulsive disorder, they are also characterized by impulsive behavior. Indeed eating disorders share considerable overlap with impulse-control disorders (ICDs). Impulsivity in eating disorders has important clinical and theoretical considerations. In this presentation, the phenomenologic, comorbidity, biological, and treatment response implications of impulsivity in anorexia nervosa, bulimia nervosa, and binge eating disorder are addressed. In particular, the implications between impulsivity, on the one hand, and the use of atypical antipsychotics in anorexia nervosa and antiepileptics in bulimia nervosa and binge eating disorder, on the other hand, are discussed.

No. 7E
IDENTIFYING THE SPECTRUM OF IMPULSE-CONTROL DISORDERS

Eric Hollander, M.D., *One Gustave Levy Place, Box 1230, New York, NY 10029*

SUMMARY:

The impulse-control disorders are a group of conditions characterized by an irresistible impulse to engage in behavior associated with pleasure, or gratification; intense arousal that is dissipated by engaging in the impulsive behavior; and guilt, shame or humiliation afterwards. Existing impulse-control disorders not otherwise specified include pathological gambling, intermittent explosive disorder, trichotillomania, kleptomania, and pyromania, and newly emerging ones include compulsive shopping, Internet addiction, sexual compulsions, and binge eating disorder. These behaviors can be conceptualized as behavioral addictions, obsessive-compulsive spectrum disorders, or impulsive disorders. They may lie along a continuum from compulsivity to impulsivity and may share basic features of altered frontal-limbic circuitry and neurotransmitter/peptide function. Specific aspects of pathological gambling, sexual compulsions, and Internet addiction will be highlighted, including phenomenology, comorbidity, neurobiology, and treatment response. Common themes across the impulse-control disorders, impact of comorbidity, and future issues regarding classification will be highlighted.

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INDUSTRY-SUPPORTED SYMPOSIUM 8—BIPOLAR DISORDER: IMPROVING OUTCOMES WHEN THEORY, SCIENCE, AND CLINICAL PRACTICE CONVERGE
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium, the participant should be able to incorporate evidence-based studies into clinical practice for the effective treatment management of patients with bipolar disorder.

No. 8A
THE CONVERGENCE OF PHARMACOTHERAPY AND PSYCHOTHERAPY IN MAINTENANCE TREATMENT OF BIPOLAR DISORDER

Paul E. Keck, Jr., M.D., *231 Albert Sabin Way, ML559, Cincinnati, OH 45267-0559*

SUMMARY:

For the first time since the advent of lithium prophylaxis in bipolar disorder, studies of new medications in the maintenance treatment of bipolar disorder have provided important new evidence of efficacy in the long-term treatment of this often lifelong recurrent illness. Convergent with these developments, a number of controlled studies have also begun to shed light on the efficacy of specific forms of psychotherapy on relapse prevention uniquely tailored to bipolar disorder. The time, thus, appears ripe to attempt to synthesize the results of these studies into pharmacological and psychotherapeutic approaches designed to prevent relaspe and optimize functioning for patients with bipolar disorder.

This presentation will review the latest data and clinical implications from randomized, controlled trials of medications in the maintenance treatment of bipolar disorder, including lithium, carbamazepine, divalproax, olanzapine, lamotrigine, and aripiprizole. In addition, studies of group, psychoeducational, interpersonal, and family psychotherapeutic interventions on relaspe prevention will be discussed. Finally, the relative efficacy of these strategies in preventing manic

vs depressive relaspe and possible synergies based on illness presentation and prior course of illness will be reviewed.

No. 8B
CONSIDERATIONS IN THE FEMALE PATIENT OF CHILDBEARING YEARS

Adele C. Viguera, M.D., *15 Parkman Street/WACC 815, Boston, MA 02114*

SUMMARY:

Women with bipolar disorder require special consideration with respect to treatment. Several of the major mood stabilizers are known teratogens. Moreover, some anticonvulsants can have a negative impact on fertility, contraceptive efficacy, and pregnancy outcome. Despite this, in clinical practice, anticonvulsants are often used as first-line mood stabilizers in women.

Management of bipolar disorder in women who plan to conceive or those who are pregnant or puerperal poses significant challenges for clinicians who care for these patients. Recent data suggest that pregnancy is not protective against relapse of a psychiatric disorder and that for women with bipolar disorder specifically, relapse is common after lithium discontinuation.

This presentation will review the major clinical dilemmas associated with the management of patients with bipolar disorder during the childbearing years. Treatment guidelines for the management of bipolar illness for women trying to conceive will be presented, as well as recent prospective data on the course of bipolar disorder during pregnancy and the postpartum period.

An algorithm for assessment of the risks and benefits of using older and newer antipsychotics and mood stabilizers will be presented. This presentation will conclude with a review of the risks-benefit decision process for managing patients during the childbearing years.

No. 8C
CHOOSING TREATMENTS IN BIPOLAR DEPRESSION: WHAT, WHEN, AND WHY?

Roy H. Perlis, M.D., *15 Parkman Street, WACC-812, Boston, MA 02114*

SUMMARY:

Despite the historical focus on mania as the defining feature of bipolar disorder, the depressive phase of illness is increasingly recognized as a major contributor to morbidity and mortality. The risk of suicide among untreated bipolar patients is up to 30 times greater than that of the general population, but is substantially less among treated patients. Data will be discussed from two large longitudinal studies of patients with bipolar disorder that indicate patients may experience depressive symptoms for a third or more of days in a given year.

Treatment approaches in bipolar depression also continue to evolve, as evidenced in the 2002 revision of the American Psychiatric Association bipolar treatment guidelines. In particular, the potential risks and benefits of standard antidepressants, alone or in combination with mood stabilizers, are debated. Studies with newer strategies for the treatment of bipolar depression, including novel anticonvulsants and atypical antipsychotics, also require a reevaluation of standard treatment approaches. The place of psychosocial interventions, understudied in bipolar depression but shown to be effective in major depressive disorder, also remains unclear.

Despite the varied strategies available, many patients fail to achieve complete or persistent antidepressant response. The application of evidence-based techniques for better sequencing of interventions, from algorithms to pharmacogenetics, may help to improve outcomes.

No. 8D
COGNITIVE FUNCTIONING OUTCOMES: FROM FIRST EPISODE TO FUNCTIONAL RECOVERY

Deborah Yurgelun-Todd, Ph.D., *115 Mill Street, Belmont, MA 02478*

SUMMARY:

Neuropsychology focuses on the reliable objective assessment of higher cortical brain functions. Arising from the disciplines of neurology and psychology, neuropsychological science relies heavily on the interrelationships between behavioral function and neuroanatomy. Although early investigations emphasized the role of the nondominant hemisphere in bipolar disorder, neuropsychological theories have evolved in accordance with neurobiological findings, leading to new study approaches. Recent investigations have reported that patients with bipolar disorder demonstrate diffuse cognitive deficits involving executive control, attention, memory, and psychomotor speed, although general intellectual functioning appears relatively unaffected. Nearly one-third of patients diagnosed with bipolar disorder will demonstrate persistent cognitive deficits that remain despite clinical improvement of the affective symptoms. Previous investigations have primarily focused on changes in mood and clinical state when assessing treatment and recovery of patients with bipolar disorder. Assessment of neurocognitive function provides a more valid indicator of functional recovery, rehabilitation, and reintegration than pure measures of mood. Studies of first-episode patients report the presence of cognitive deficits early in the course of illness, underscoring their roles as primary factors in the disorder.

Additionally, the functional improvement noted following the administration of atypical antipsychotics suggest the cognitive abnormalities evident in bipolar disorder may be treated and warrants closer examination.

No. 8E
TRANSLATING RESEARCH INTO CLINICAL PRACTICE: FROM THE BENCH TO THE TRENCHES

Joseph F. Goldberg, M.D., *79-59 263rd Street, Glen Oaks, NY 11004*

SUMMARY:

The vast majority of individuals with bipolar disorder carry multiple psychiatric diagnoses, take multiple psychotropic medications, see multiple practitioners of different modalities, and have outcomes that fall short of optimal results described in randomized controlled trials. Drug class and antimanic efficacy alone are neither robust nor sufficient criteria by which to judge which pharmacological monotherapies or combination therapies are in fact mood-stabilizing.

"Breadth of spectrum of activity" has become an increasingly relevant and useful concept in choosing from among existing treatment options for bipolar disorder, both short-term and long-term. This presentation will draw on the controlled trial literature to enhance clinical decision-making for practitioners when customizing pharmacotherapy for patients with bipolar disorder, both straightforward and complex. Longitudinal information essential to this process includes recognizing key features such as age at onset, past medication responses, cycle frequency, and predictors of drug response for distinct patient subtypes, such as mixed states, rapid cycling, or bipolar II forms of the illness. Skills for interpreting randomized clinical trials and their generalizability will be discussed in order to help practitioners fit the literature to the patient, rather than the patient to the literature.

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off CB. American Psychiatric Publishing, Inc: Washington, DC, 2003.
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INDUSTRY-SUPPORTED SYMPOSIUM 9—GAD: EVIDENCE-BASED CONSIDERATIONS FROM PATHOPHYSIOLOGY TO LONG-TERM MANAGEMENT
Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss the prevalence of GAD and its comorbidities as well as the impact of GAD on patient quality of life; review the molecular and cellular pathophysiology of GAD; Recognize the clinical characteristics of GAD; assess the importance of psychotherapy in the treatment of GAD and realize how to incorporate it into the treatment regimen; and compare the available and impending pharmacotherapies used in the management of GAD and review links to the underlying GAD pathophysiologies.

No. 9A
PREVALENCE OF GAD IN THE U.S.: RESULTS FROM THE NATIONAL COMORBIDITY SURVEY REPLICATION

Ronald C. Kessler, Ph.D., *180 Longwood Avenue, Boston, MA 02130*

SUMMARY:

Preliminary data are presented on the prevalence and correlates of ICD-10 and DSM-IV generalized anxiety disorder (GAD) as well as sub-threshold GAD from the recently completed National Comorbidity Survey Replication (NCS-R). NCS-R is a nationally representative household survey of 9,645 respondent 18 years of age and older that was carried out between April 2001 and October 2002. Results show that GAD is a common disorder in the general population. Prevalence is higher when ICD criteria are used rather than DSM criteria, due to the fact that ICD, unlike DSM, requires the anxiety to be "prominent" but not necessarily "excessive" (i.e., substantially greater anxiety than other people in the same objective situation). The clinical profile of the additional cases included in the broader ICD definition is equivalent to that of the DSM cases in terms of age at onset, course, comorbidity, symptom severity, and impairment. The socio-demographic profile of the additional ICD cases differs from that of DSM cases, though, in that the former have more objective disadvantage. This result makes sense in that extreme objective disadvantage makes it less likely that any given level of anxiety will be "excessive" in relation to objective circumstances. The presentation closes with a discussion of the implications of retaining or deleting the requirement for anxiety being "excessive" in DSM-IV.

No. 9B
DISTINGUISHING GAD: UNIQUE CHARACTERISTICS

Wei Zhang, M.D., *Box 3812, Durham, NC 27710*

SUMMARY:

GAD is classified by several key diagnostic criteria as defined by DSM-IV in 1994. The key feature is excessive, uncontrollable worry of at least six months duration about a number of life events or activities, accompanied by at least three of six associated symptoms of negative affect or tension (that is, restlessness or feeling keyed up or on edge, fatigability, concentration difficulties, irritability, muscle tension, sleep disturbance). The disorder is frequently difficult to diagnose because of the variety of presentations and the common occurrence of comorbid medical or psychiatric conditions.

This presentation will review the current diagnostic criteria and how to differentiate GAD from other disorders in the clinical setting. Discussion will also center around what has been learned about diagnosing GAD in the years since the publication of DSM-IV and the possible changes that could come about in DSM-V.

No. 9C
THE MOLECULAR AND CELLULAR PATHOPHYSIOLOGY OF GAD

Carl Salzman, M.D., *Department of Psychiatry, Mass Mental, 74 Fenwood Road, Boston, MA 02115*

SUMMARY:

A better understanding of the GABA system and its role in anxiety disorders has focused on specific subunits of the GABA-A receptor.

In addition, several new molecular targets are being investigated for the treatment of anxiety and will be reviewed during this symposium. First, antidepressants such as selective serotonin reuptake inhibitors and serotonin/norepinephrine reuptake inhibitors are effective in anxiety–even in nondepressed patients. Second, the role of peptides such as adenosine, substance P and CRF in anxiety has provided new targets for anxiolytic medications. Third, modulation of a subtype of calcium ion channel in the central nervous system appears effective in treating anxiety without the withdrawal symptoms associated with the benzodiazepines, although the exact mechanism of action in treatment is unknown.

REFERENCES:

1. Jetty PV, Charney DS, Goddard AW, Neurobiology of generalized anxiety disorder. *Psychiatr Clin North Am.* 2001; 24: 75–97.
2. Pande AC, Crockett JG, Feltner DE, et al. Pregabalin in generalized anxiety disorder: a placebo-controlled trial. *Am J Psychiatry.* 2003; 160: 533–540.
3. Gorman JM. New molecular targets for antianxiety interventions. *J Clin Psychiatry.* 2003: 64(suppl3): 28–35.

No. 9D
COGNITIVE-BEHAVIOR THERAPY FOR THE TREATMENT OF GAD

Michelle G. Newman, Ph.D., *310 Moore Building, University Park, PA 16802*

SUMMARY:

Cognitive behavioral therapy (CBT) for generalized anxiety disorder is based on the theory that the disorder stems from constant perceptions of the world as a dangerous place, resulting in a process of maladaptive and habitual interactions among cognitive, behavioral, and physiological response systems. Maladaptive cognitive responses include a preattentive bias to threat cues, negatively va-

lenced images, worrisome thinking, and cognitive avoidance of some aspects of anxious experience. Maladaptive behavioral responses include subtle avoidance and slowed decision making. Physiological responses entail excessive muscle tension and a deficiency in parasympathetic tone. The interaction of these systems leads to a process of spiraling intensification in anxiety. CBT attempts to replace these reactions with multiple adaptive coping responses targeting each domain of dysfunction.

Research shows that CBT produces greater improvement than no treatment, analytic psychotherapy, pill placebo, nondirective therapy, and placebo therapy. When compared with pharmacologic treatments, CBT is associated with significantly stronger effects on depression severity and a clear maintenance of treatment gains. This presentation will review research on CBT for GAD and using a case illustration, describe how it is implemented.

No. 9E
PHARMACOTHERAPIES FOR GAD: FROM ROUGH EMPIRICISM TO ELEGANT EVIDENCE

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

SUMMARY:

Anxiety is essential to protect any species from harm long enough to permit reproduction. Humans have evolved an elaborate anxiety apparatus and, for the most part, it has served homo sapiens well. But any normally distributed phenomenon will display dysfunction at its margins. Anxiety disorders cause distress and dysfunction for sufferers, lost productivity for society, and excessive health care expense. Medicinal remedies for anxiety have been sought and used through the millennia. Alcohol, herbs, bromides, and barbiturates have historical precedence, but have been largely supplanted by benzodiazepines, azapirones, antidepressants, and other agents for which efficacy has been demonstrated in randomized, controlled trials. This presentation will review strengths and limitations of pharmacotherapies for generalized anxiety disorder, tying their mechanisms to our current understanding of pathophysiology where possible.

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INDUSTRY-SUPPORTED SYMPOSIUM 10—SEX, SEXUALITY, AND 5HT
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium, participants will understand that brain circuitry/psychodynamics for love and sex are separate, understand the impact of psychotropics on love, sex, & sexuality understand strategies to enhance adherence.

No. 10A
DO SEXUAL SIDE EFFECTS OF MOST ANTIDEPRESSANTS JEOPARDIZE ROMANTIC LOVE AND MARRIAGE?

Helen E. Fisher, Ph.D., *4 East 70th Street Apartment 5E, New York, NY 10021*

SUMMARY:

Millions of Americans of reproductive age take selective serotonin-reuptake inhibitors (SSRIs). It is well established that these antidepressants cause dysfunction in sexual desire, arousal, and performance. We propose that these sexual side effects may have more serious consequences than currently appreciated, due to their impact on related neural mechanisms. The sex drive is one of three primary brain systems that evolved for courtship, mating, and reproduction; the others are romantic love and partner attachment. The sex drive evolved to motivate men and women to initiate sexual contact with a wide range of partners; romantic love evolved to enable men and women to focus their courtship attention on specific individuals, thereby conserving mating time and energy; the neural system for partner attachment evolved to motivate men and women to maintain a mateship at least long enough to rear a single child through infancy. These three brain systems are biologically inter-related; thus, the sexual side effects of SSRI antidepressants can potentially disrupt mate assessment, mate choice, attraction to a potential mate, pair-bonding behaviors, and partnership attachment. This paper discusses the biological inter-relationships between these three brain systems, lust, attraction, and attachment, to illustrate how the sexual side effects of SSRIs can potentially jeopardize romantic love and marriage. It concludes that the biological relationship between these three neural systems should be considered when prescribing SSRI antidepressants for long-term use among sexually healthy, sexual active patients.

No. 10B
LOVE AND SEX

Ethel S. Person, M.D., *135 Central Park W, New York, NY 10023-2413*

SUMMARY:

Love and sex, which may or may not go together, are key personal concerns for most of us, as well as topics for scrutiny in a variety of disciplines. The essentialist theory of sex is self-evident: sex is viewed as the expression of a biological force. Sexual liberation and gay liberation demonstrated that sex and gender are not hard wired, but have a cultural component. Culturalists argue that the form sex takes is socially constructed. This critique of essentialism raises questions about how history, meanings, diversity, choice, and particularly, issues of power impact on our sexual practices, and on the way we experience sex. Mediating between the biological and the culturalist points of view is the psychological/psychoanalytic perspective. This perspective addresses the way in which attachment, bonding, and early object relations impact overall development. This

presentation will also focus on how they impact on our sexual lives. The psychological/psychoanalytic perspective is also the discipline most pertinent to treating individuals with sexual dysfunctions and sexual conflicts. Love, like sex, can be studied from the perspectives of biology, culture, and psychology. Love is related to the human proclivity for parent and child to bond. But we cannot understand love so reductively. The human capacity for imagination and creativity has contributed to our honoring different kinds of love in different eras. Romantic love, so central to our current culture, first found its way into history with the famous courts of love in 11th century Provence. This presentation attempts to link the essentialist point of view and the culturalist position through the mediating bridge of our subjective psychological lives. It will focus on love dialogues over the life cycle and their relationships to sexuality in contemporary lives.

No. 10C
TALKING TO GAY PATIENTS ABOUT SEX: WHAT DO YOU NEED TO KNOW?

Serena Y. Volpp, M.D., *333 West 22nd Street Apt 2A, New York, NY 10011*

SUMMARY:

Lore about sex in the gay community abounds: gay men with thousands of sexual partners, lesbian couples moving in together and immediately suffering from "lesbian bed death" (lack of sexual activity). This presentation will start with a review of the research on sexual behavior in gay men and lesbians. The goal of the presentation is to help the audience separate myth from fact about sex/sexuality in gay and lesbian relationships. It will provide practitioners with the knowledge needed to take thorough and sensitive sexual histories from their gay patients.

The first part of the presentation will review the varieties of relationships encountered amongst people who engage in same-sex behaviors. For example, the practitioner should recognize that about 50% of gay men and 75% of lesbians have had intercourse with the opposite sex. The second part of the presentation will review the literature on the most common sexual practices in gay men and lesbians, and will present the available data on the trajectory of sexual activity in the life cycle of gay and lesbian couples, e.g., that 67% of gay male couples and 33% of lesbian couples have reported sexual activity three times or more a week in the first two years of a relationship, decreasing to 32% and 7%, respectively, in the third to tenth years of a relationship. Attitudes toward sexual fidelity and the use of substances around sexual activity will be addressed. The effect of HIV disease on sexual behavior and associated concepts such as safer sex and "bug chasing" will be discussed. Lastly, the impact of sociocultural factors such as homophobia on the sex life of gay men and lesbians will be explored.

No. 10D
EFFECTS OF PSYCHIATRIC ILLNESS AND MEDICATION ON SEXUAL FUNCTION

Anita L.H. Clayton, M.D., *2955 Ivy Road, Northridge Suite 210, Charlottesville, VA 22903*

SUMMARY:

Psychiatric illness may result in sexual dysfunction (SD) at greater rates than in the general population, likely due to changes in sex steroids such as estrogen, testosterone, and prolactin, and the neurotransmitters, dopamine, norepinephrine (NE), and serotonin. Comorbid occurrence of disorders and use of multiple medications may further contribute to SD in individuals with psychiatric illness. Major depression is associated with diminished libido and arousal problems in 50% to 80% of patients, while treatment with antidepressants may negatively impact on sexual function in one-fourth to one-half of patients, depending on the specific medication. Enhanced serotonergic function appears to be a primary contributor to SD with antidepressant medications through effects on central dopaminergic and noradrenergic pathways involving desire and arousal, and peripheral indirect effects on NE and nitric oxide, and direct effects on sensation and vasocongestion. Anxiety disorders also negatively affect sexual functioning, with differences among the anxiety disorders in sexual phases affected, severity of sexual dysfunction, and across gender. The sexual dysfunction is potentially related to behavioral and pharmacologic hyperadrenergic stimulation, and is exacerbated by antidepressant treatment. Nearly 50% of men and 30% of women with psychotic illness report sexual difficulties, with lack of an intimate relationship twice as likely in men. Dose-related hyperprolactinemia due to dopaminergic antagonism in the tuberoinfundibular system may explain some SD associated with antipsychotic medications. In general, atypical antipsychotics appear to have fewer negative effects on sexual functioning than conventional antipsychotic medications. Thus, both psychiatric illness and its treatment may affect sexual function, contributing to medication noncompliance and/or reduced quality of life.

No. 10E
TALKING ABOUT SEXUAL DYSFUNCTION TO ENHANCE ADHERENCE WITH MEDICATION

Philip R. Muskin, M.D., *622 West 168th Street/MB 427, New York, NY 10032-3874*

SUMMARY:

Approximately 40% of patients taking antipsychotic or antidepressant medication will have stopped the drugs by the end of the first four months of treatment. At least 25% of these patients report that adverse effects of the medication lead to the discontinuation. Physicians routinely avoid discussing sex with patients, though they may discuss sexuality, i.e., emotions, fantasies, and issues in relationships. When patients discontinue medication secondary to sexual dysfunction they are often reluctant to volunteer this information to the prescribing physician, or to future physicians, secondary to embarrassment and/or shame regarding the decision. This presentation will focus on simple strategies for enhancing adherence to medication by addressing sexual issues, starting with the consultation and progressing throughout the treatment. The intial step requires obtaining a sexual history. Techniques that are more likely to encourage honest responses will be discussed. Asking a patient, "Do you have sexual problems?" is less likely to yield a useful answer than, "What types of difficulties have you encountered in terms of having the type of pleasure you would like?" How to inquire, without appearing voyeuristic, will be discussed. Inquiry about trauma, both physical and sexual, will be addressed. After the initiation of pharmacotherapy, inquiry about side effects, including sexual side effects will be presented as part of the foundation to enhance adherence. Physician and patient barriers to discussing sexual matters will be presented. Once patients feel comfortable discussing issues related to sexual dysfunction, how to address these issues psychologically will be presented. As the data on medication-induced sexual dysfunction do not suggest there is a reliable antidote, practical and psychotherapeutic strategies must be employed. The foundation of all of the interventions is to enable the patient to cope with the sexual dysfunction, including coping with pressures exerted by the sexual partner. Discussions of the reality of the dysfunction in contrast to the disruption caused by the psychiatric disorder will be presented. As partners may exert pressure on the patient to discontinue the medication in order to restore sexual function, how to address this problem will be discussed. Give that the sexual dysfunction may be worse in fantasy than in reality, and that many patients require education about themselves and how they now need to approach

having sex, a discussion of engaging partners to discuss their sexual function will be presented. The use of humor will be addressed, i.e., for patients with delayed orgasm, where the time frame is longer than what had been the pattern with a partner, education regarding increased time spent in arousal is beneficial. Humor such as, "What is foreplay for couples together for 15 years? It is, 'Do you want to have sex?'" reminds patients that they might have done things differently in the past and now have the ability to change things in their sexual behavior, to result in enhanced satisfaction.

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INDUSTRY-SUPPORTED SYMPOSIUM 11—INTERFACE BETWEEN DEPRESSION AND MEDICAL ILLNESS
Supported by Wyeth Pharmaceuticals

EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium, the participant should be able to discuss the relationship between depression and comorbid medical conditions.

No. 11A
HEARTACHE AND HEARTBREAK: DEPRESSION AND CARDIOVASCULAR DISEASE

Charles B. Nemeroff, M.D., *1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

Although major depression and depressive symptoms are commonly encountered in medical populations, overwhelming evidence suggests that these disorders are frequently underdiagnosed and undertreated in patients with cardiovascular disease (CVD). Several studies have shown that depression and its associated symptoms are a major risk factor for both the development of CVD and death after index myocardial infarction (MI). Recognition of depression in patients with CVD, therefore, is of utmost importance when establishing treatment priorities. The Sertraline Antidepressant Heart Attack Randomized Trial (SADHART) was the first double-blind, placebo-controlled trial to investigate the cardiovascular safety, tolerability, and antidepressant efficacy of sertraline treatment (flexible dosing, 50–200 mg) in 369 hospitalized patients with acute MI or unstable angina in the immediate postinfarction period. Results of SADHART showed that sertraline-treated patients had a lower incidence of serious treatment-emergent cardiovascular events, compared with patients who received placebo. The pathophysiological mechanisms underlying the increased risk of MI and stroke in depressed patients have been scrutinized, and two major theories have emerged: the platelet hyperactivity hypothesis and the heart rate variability hypothesis. These pathological alterations in depressed patients are discussed in this presentation.

No. 11B
THE RELATIONSHIP OF DEPRESSION TO CANCER AND HIV INFECTION

David Spiegel, M.D., *401 Quarry Road, Room 2325, Stanford, CA 94305-5718*

SUMMARY:

Depression has been cited as a risk factor for both cancer and HIV infection and has also been linked to poor outcome in both conditions. In fact, in terms of cancer, there is mixed evidence about whether prior history of depression increases the likelihood that an individual will develop any form of malignancy. There is evidence that depression has an adverse effect on the immune system, and this could be a mechanism whereby mood disorder increases the risk for cancer. Once an individual has cancer, there is evidence that depression worsens overall prognosis for some types of cancer. At least two studies have shown that psychosocial therapy lengthens the life span in patients with breast cancer and multiple myeloma, but another study did not find this effect for breast cancer patients. There is also mixed evidence linking a history of depression to acquisition of HIV infection, but it is known that depression increases certain high-risk behaviors that are clearly linked to infection. Evidence has accumulated that depression worsens the prognosis for individuals with HIV infection, both in terms of measurable effects on the immune system and course of the illness. Depression has been shown to decrease the number of natural killer cells in patients with HIV infection. Some studies have shown that psychosocial treatment can improve immune status in patients with HIV infection, but this is a small effect compared to that of modern highly active anti-retroviral therapy (HAART) regimens.

No. 11C
COMORBIDITY OF DEPRESSION IN NEUROLOGICAL DISORDERS

William M. McDonald, M.D., *1841 Clifton Road, 4th Floor, Atlanta, GA 30329*

SUMMARY:

The prevalence of depression in neurological disorders is best characterized by depression in patients following stroke. In contrast to degenerative diseases such as Parkinson's disease (PD) and Alzheimer's disease (AD), in which disease onset is often hard to pinpoint, the timing and the location of a stroke (as defined by neuroimaging and clinical symptoms) make the association of changes in mood and onset more exact. The mean point prevalence of major depression and minor depression in patients after a stroke is approximately 20% and 19%, respectively, in studies from several countries. The prevalence of depression in PD, AD, and multi-infarct or vascular depression is more variable, with wide ranges depending on the study population. Other evidence suggests that there are subtypes of depressive disorders within each neurological disorder. For example, subtypes of depressive syndromes that have depressive symptoms but do not meet the time course or criteria of a DSM-IV major depression include the apathetic and emotional syndromes in PD. Depression has been shown to significantly affect functional recovery from stroke. The association of depression and AD is complicated by the fact that late-onset depression in cognitively intact individuals may be a risk factor for the later development of AD. There are few controlled trials of antidepressant therapy in patients with neurological disorders and comorbid depression, and there are no trials in the treatment of minor depression.

No. 11D
MOOD DISORDERS AND MEDICAL ILLNESS: DIABETES, OSTEOPOROSIS, OBESITY, AND PAIN

Robert N. Golden, M.D., *CB#7160/Neurosciences Hospital, Chapel Hill, NC 27599-7160*; Dominique L. Musselman, M.D.; Philip W. Gold, M.D.; Albert J. Stunkard, M.D.; Frank Keefe

SUMMARY:

There are important bidirectional interactions between mood disorders and several medical illnesses. Depression is found in 11%–15% of patients with diabetes and can have deleterious effects on glycemic control, possibly via decreased adherence to treatment recommendation and/or neuroendocrine factors. The pharmacotherapy of mood disorders in this population should be guided by potential effects on weight and glucose metabolism. More than 20% of patients with osteoporosis/osteopenia are depressed, and depression is associated with a substantially increased risk for osteoporosis. Some mood stabilizers appear to decrease bone mineral density and thus may be problematic in this population. Obesity in children/adolescents is linked to higher depression rates, possibly mediated via psychosocial factors. In adults, effective treatment of obesity improves outcomes in comorbid depression. Treatment plannings in this population must consider medication effects on appetite as well as potential adjustments in dosing. Pain clinic patients have a 30%–54% prevalence of depression. Comorbid chronic pain is associated with lower response rates to antidepressant treatment. Suicide rates are elevated in patients with comorbid depression and pain syndromes. Further research is needed to elaborate the mechanisms of comorbid mood and medical disorders and develop optimal treatment approaches.

No. 11E
MOOD DISORDERS IN THE MEDICALLY ILL: THE PATIENT'S PERSPECTIVE

Lydia J. Lewis, B.A., *730 North Franklin Street, Suite 501, Chicago, IL 60610*

SUMMARY:

Patients with mood disorders and a comorbid medical illness are at significant risk because they know little or nothing about the interaction between medical illnesses and mood disorders and thus are not empowered to have an active role in their treatment. Mood disorders remain significantly undiagnosed and untreated, so the issue of comorbidity may never arise. Patients—and physicians—often do not view mood disorders as equally dangerous as "physical" illnesses. This can lead to concentrating on treating the "physical" illness rather than both illnesses. Because clinicians lack sufficient knowledge and time, it becomes the patient's responsibility to discuss their comorbidity with their physicians. The challenge is to empower patients and their families through education because it will fall to them to get this issue on their physician's radar screen. By acknowledging that mood disorders affect the course and outcome of "medical" illnesses, the wall between the brain and the rest of the body may begin to be penetrated.

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SUNDAY MAY 2, 2004

INDUSTRY-SUPPORTED SYMPOSIUM 12—ANTIDEPRESSANT TREATMENTS YOU MAY NOT KNOW ABOUT, BUT SHOULD...
Supported by Organon Inc.

EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium, the participant should be familiar with a broad array of technologies for the treatment of depression, with a concentrated focus on those in development, soon to be available, or less well-known to the practitioner.

No. 12A
THE NEXT GENERATION OF ANTIDEPRESSANTS: WHAT IS IN THE PIPELINE?

Rajinder A. Judge, M.D., *10E 81st Street, #5, New York, NY 10028*

SUMMARY:

There is no shortage of treatments for major depressive disorder (MDD); thus, there is not a current need for more treatments as such but rather for novel treatments. The recent history of drug development as reflected in currently marketed antidepressants is variation on a theme, and although the array of available options means alternatives for patients who initially fail to respond, there is hope that true innovation in mechanisms of action will move the field forward in terms of increasing patient potential for a high quality response or sustained remission. Looking at the "pipeline" of antidepressants under development, there are several areas of innovation in mechanism of action. The potential and promise of these new tools is presented, including both possible pitfalls on the way to the market as well as the possibility of enhanced or unique outcomes for patients. Some of tomorrow's antidepressants are likely to include such compounds as NK-1 (Substance P) antagonists, CRF antagonists, glutamatergic agents, and drugs that directly influence intracellular signaling, as well as drugs that influence specific neurotrophic factors. In the meantime, incremental advantages maybe achieved with agents that influence specific serotonin receptors, enhance central dopaminergic function, or deliver multiple mechanisms of action involving dopamine, serotonin, and norepinephrine systems. Some innovative uses of older drugs through innovation in drug delivery are possible. As research progresses, new antidepressant medications may actually derive from an understanding of the pathophysiology of the disorder of MDD.

No. 12B
ALTERNATIVE MEDICATIONS FOR DEPRESSION

Andrew A. Nierenberg, M.D., *15 Parkman Street, WACC 815, Boston, MA 02114-3117*

SUMMARY:

Alternative medications are used by millions of people for the treatment of depression. These alternative medications include St. John's wort (SJW), s-adenosylmethionine (SAM-e), and omega-3 fatty acids. The evidence for efficacy and safety of each of these is far from established and generally viewed with skepticism by traditional researchers. Within the past few years, however, rigorous clinical trial methods have been used to assess the usefulness (or lack thereof) of these widely available natural products. St. John's wort was studied by two groups in the United States, with one study showing no difference between SJW and placebo and another showing not only no difference from placebo but also no difference between the active antidepressant control and placebo—an uninformative study. Despite some other studies done in Europe that showed efficacy of SJW, sales plummeted by over 45%. SAM-e was the subject of a popular book and sales of this dietary supplement soared—all with limited clinical data. Studies are now being conducted to assess if SAM-e has efficacy. Omega-3 fatty acids, cicosapentanoic and docosohexanoic acids, have been touted as a miracle cure for a wide variety of ailments, including depression, with a remarkable lack of controlled data. This presentation critically reviews the available evidence for efficacy and safety of these three important natural treatments.

No. 12C
EVIDENCE-BASED PSYCHOTHERAPY FOR DEPRESSION: PRINCIPLES AND PRACTICE

Timothy J. Petersen, Ph.D., *15 Parkman Street, WACC 812, Boston, MA 02114*

SUMMARY:

Some forms of psychotherapy have been shown to be effective in treating an acute major depressive episode. The depression-specific psychotherapies with the strongest evidence for acute-phase treatment efficacy are interpersonal psychotherapy (IPT) and cognitive therapy (CT). In addition, behavioral therapy and problem-solving therapy have also demonstrated efficacy in reducing acute-phase depressive symptoms. All of these psychotherapies are time limited and emphasize a collaborative therapist-patient relationship but differ in purported mechanisms of change. Research conducted to date on these therapies has typically taken place in outpatient mental health settings and has included depressed patients fitting common clinical trial criteria. While the acute-phase efficacy of these psychotherapies has been established, several developments in the understanding of major depressive disorder have and will influence recent and future research on depression-specific psychotherapies. Among these developments is greater recognition that depression is most often treated within a primary care setting and that major depressive disorder is often a recurrent and/or chronic illness. As a result, some researchers have utilized certain changes in the timing of treatment delivery and specific intervention strategies. Among these changes are delivering psychotherapy after acute-phase antidepressant response, targeting residual symptoms, enhancing well-being, teaching relapse prevention skills, and delivering psychotherapy within the primary care setting. With such changes, it is hoped that better long-term outcome can be achieved for patients with major depressive disorder.

No. 12D
DEVICE-BASED TREATMENTS FOR DEPRESSION

A. John Rush, M.D., *5323 Harry Hines Boulevard, MC9086, Dallas, TX 75390-9086*

SUMMARY:

Devices have been developed to deliver different kinds of stimulants to the brain. These include devices for the induction of generalized seizures (ECT) or more localized seizures (magnetic seizure therapy or MST), as well as devices to stimulate or inhibit selected anatomical cortical sites (transcranial magnetic stimulation or TMS) or to stimulate the vagus nerve (VNS). The rationale for developing these approaches are reviewed. Second, the published literature regarding the safety and efficacy of each of these potential treatments is reviewed. The place for each of these "treatments" in the context of other-treatments, such as medication or psychotherapy, is discussed.

No. 12E
THE FUTURE OF TREATMENT-MATCHING IN DEPRESSION

Steven P. Roose, M.D., *1051 Riverside Drive, New York, NY 10032*

SUMMARY:

The process of matching treatments for depression with specific patient types depends on identifying moderators of treatment response. It is not surprising that our current knowledge on this topic comes primarily from randomized controlled trials of antidepressant medications, because they are most plentiful and have sufficient size to identify at least probable moderators. Moderators of response may be a characteristic of the patient, e.g. age, or a characteristic of the illness, e.g., depressive subtype or the presence of a comorbid condition. This presentation reviews the current evidence about moderators of treatment response and discuss the results of a recently completed study of whether the melancholic subtype is predictor of a differential response to tricyclics versus SSRIs. Especially with new innovative treatments or treatments of last resort, previous-treatment history may also be a strong predictor of treatment response. Data from studies of electroconvulsive therapy are reviewed to illustrate this effect.

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3. Rush AJ, Thase ME: Psychotherapies for depressive disorders: a review, in Evidence and Experience in Psychiatry. Volume 1–Depressive Disorders. Edited by Maj M, Sartorius N. Chichester, UK, Wiley 1999; pp 161–206.
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INDUSTRY-SUPPORTED SYMPOSIUM 13—BROADENING THE HORIZON OF ATYPICAL ANTIPSYCHOTIC APPLICATIONS
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to review the evidence regarding the use of atypical antipsychotics in

new disorders and be able to use this evidence in his/her practice; demonstrate the role of atypical antipsychotic agents in the treatment of pediatric psychotic disorders and the common associated comorbidities.

No. 13A
ATYPICAL ANTIPSYCHOTICS IN ANXIETY AND PTSD

Mark B. Hammer, M.D., *109 Bee Street, Room B249, Charleston, SC 29401*

SUMMARY:

There may be an emerging role for atypical antipsychotic medications in the treatment of anxiety disorders, including obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), generalized anxiety disorder (GAD), and other anxiety disorders. Although not FDA approved for the treatment of anxiety, possible indications for atypicals include use as adjunctive agents in anxiety disorders refractory to standard treatments such as antidepressants and psychotherapy; or in anxiety disorders with comorbid psychosis. Compared with conventional antipsychotics, atypicals have less risk for certain adverse events, for example, extrapyramidal side effects, which may enhance their tolerability. However, this should be weighed against the potential for other side effects and cost. Besides tolerability, the rationale for investigating atypicals further includes their efficacy in reducing anxiety symptoms associated with schizophrenia, the frequent comorbidity of psychosis or mood disorders with anxiety disorders, and their biochemical effects on neurotransmitter systems implicated in stress and anxiety. Case reports, preliminary open trials, and initial controlled studies have suggested that atypical antipsychotics may be efficacious in treating refractory OCD, GAD, and core PTSD symptoms or psychosis comorbid with PTSD. This presentation will review the literature on the use of atypical antipsychotics in anxiety disorders and discuss the rationale for further researching the efficacy and safety of these agents in anxiety disorders.

No. 13B
ATYPICAL ANTIPSYCHOTICS TREATMENT OF SUBSTANCE ABUSE

E. Sherwood Brown, M.D., *5323 Harry Hines Boulevard, Dallas, TX 75390-8849*

SUMMARY:

Atypical antipsychotics are currently widely used in clinical practice. A growing body of evidence suggests these medications may hold promise in the treatment of substance-related disorders, especially in persons with comorbid psychiatric illness. The first atypical antipsychotic on the market was clozapine. Numerous case reports, open-label, and retrospective studies suggest clozapine may decrease drug and alcohol use in patients with schizophrenia. Reports have also emerged suggesting that other atypical antipsychotics, including risperidone, olanzapine, and quetiapine may also be effective in some patients with substance misuse. Data from recently completed and ongoing investigations by our group on the use of quetiapine and aripiprazole in patients with bipolar or schizoaffective disorders and substance dependence will be discussed. Possible mechanisms that might explain the efficacy of atypical antipsychotics in decreasing substance use and craving, including combined dopamine and serotonin receptor binding, and improvement in psychiatric symptomatology will be assessed. The potential role for atypical antipsychotics in the treatment of persons with substance abuse with or without other comorbid Axis I disorders will be discussed. Finally, the limitations of the currently available data are discussed, as are directions for future research.

No. 13C
ROLE OF ATYPICALS IN THE TREATMENT OF PEDIATRIC PSYCHOTIC DISORDERS AND COMMON COMORBIDITIES

Melissa P. DelBello, M.D., *231 Albert Sabin Way, PO Box 670559, Cincinnati, OH 45267-0559*

SUMMARY:

Pediatric psychotic disorders and the accompanying comorbidities can be devastating to patients and their families. Atypical antipsychotics have become an important part of treating psychotic disorders. The prescribing of atypical antipsychotics for children and adolescents is increasing. Factors that may be responsible for this increase in usage are the evidence that the newer agents are safer and more effective than conventional antipsychotics, that many pediatric and adolescent disorders do not adequately respond to traditional primary treatments, and that there is some evidence that atypicals have potential antiaggressive and anxiolytic properties. Atypical agents may be particularly helpful for child or adolescent patients who are especially susceptible to the side effects of medications and whose risk of tardive dyskinesia is high. This presentation will investigate the role of atypical antipsychotics in the treatment of pediatric psychotic disorders and its common comorbidities.

No. 13D
ATYPICALS IN THE TREATMENT OF ANOREXIA NERVOSA

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

SUMMARY:

Anorexia nervosa (AN) is a disorder of unknown etiology that predominantly occurs in adolescent women. This illness is characterized by restricted eating, the relentless pursuit of thinness, and obsessive fears of being fat. These symptoms result in profound weight loss and considerable morbidity. Because of limited efficacy of existing treatments, many people with AN have a chronic, relapsing illness, and AN has the highest death rate of any psychiatric disorder. There are few controlled trials of pharmacologic agents in individuals ill with AN, and none show clear efficacy. Recently, at least eight uncontrolled studies have raised the possibility that olanzapine may be useful in the treatment of AN because it reduces anxiety and depression, and perhaps reduces core eating disorder symptoms. To our knowledge, there have been no controlled studies of any atypical antipsychotics in AN.

Although the cause of eating disorders is presumed to be complex and influenced by development, social, and biological processes, twin, family, and genetic studies support the possibility that an underlying trait-related vulnerability places an individual "at risk" for developing AN. Recent studies implicate dopamine D2 and serotonin 2A receptor disturbances in the pathophysiology of AN and thus provide a rationale for the efficacy of atypical antipsychotics in this illness.

No. 13E
ATYPICALS IN BPD

S. Charles Schulz, M.D., *2450 Riverside Avenue, Minneapolis, MN 55454;* A. Adityanjee, M.D.

SUMMARY:

Low doses of traditional antipsychotic medications have been tested in borderline personality disorder (BPD) and found to lower symptoms of the illness, but were also seen to be poorly tolerated. With the advent of front-line atypical agents came the opportunity

to assess their use in BPD. In addition to lower rates of movement disorder side effects, the atypical antipsychotic medications have been shown to be useful in reducing mood symptoms—a common problem in BPD patients. In this presentation, trials of risperidone and olanzapine will be reviewed. The characteristics of the response to the atypical medications will be discussed along with the safety profile. Both medications have shown promise in BPD with good tolerability. A trial of quetiapine also will be presented. Eight of the planned 15 subjects have been enrolled and completed the eight-week trial. Even with this small number of patients, statistically significant reductions in BPRS and increases in GAF have been noted. Furthermore, cognitive assessments have been performed on patients and the results will be prescnted at the symposium. Risperidone, olanzapine, and quetiapine have all been tried in case series or double-blind trials for BPD. In addition to comparing the results of these initial experiences, a careful review of the methodological issues and future steps will be presented.

REFERENCES:

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2. Brown ES, Suppes T, Adinoff B, Thomas NR: Drug abuse and bipolar disorder: comorbidity or misdiagnosis? J Affect Disord 2001; 65:105–115.
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4. Malina A, Gaskill J, McConaha C, Frank GK, LaVia M, Scholar L, Kaye WH: Olanzapine treatmcnt of anorexia nervosa: a restrospective study. International Journal of Eating Disorders 2003; 33(2):234–237.
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INDUSTRY-SUPPORTED SYMPOSIUM 14—THE MANY FACES OF ANXIETY: ORIGINS, PATHOGENESIS, AND MANAGEMENT
Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium, the participant should be discuss the various manifestations of anxiety disorders and the pharmacologic and nonpharmacologic treatment options for each.

No. 14A
GENERALIZED ANXIETY, SOCIAL ANXIETY, AND PANIC DISORDER: NEW VIEWS ON VALIDITY AND NOSOLOGY

Risa B. Weisberg, Ph.D., *Box G - BH, Duncan Building, Providence, RI 02912*

SUMMARY:

While anxiety disorders may differ in their presentations and symptoms, they all have the potential to disrupt the lives of patients and their families. With social anxiety disorder, for example, the symptoms can be insidious, becoming well established and wreaking havoc long before a diagnosis can be made. Generalized anxiety disorder and panic disorder, each with its own set of diagnostic criteria, can be equally devastating. This presentation examines the validity of the current nosology of generalized anxiety disorder, social anxiety disorder, and panic disorder and reviews current opinion of the American Psychiatric Association's DSM diagnostic system and evidence supporting it. The results of the Primary Care Anxiety Project (PCAP), a longitudinal, naturalistic study that examined the clinical course, psychosocial functioning, treatment, and economic burden of anxiety disorders in 539 primary care patients, are discussed. Results from the PCAP study indicate that a significant proportion of primary care patients with anxiety disorders are not being treated, once again underscoring the need for increased education of primary care providers and the general public about the importance of early identification of anxiety disorders and their efficacious treatment.

No. 14B
ORIGINS AND PATHOGENESIS OF ANXIETY SYMPTOMS AND SYNDROMES

Dennis S. Charney, M.D., *15k North Drive, Bethesda, MD 20892-2670*

SUMMARY:

Discussion of the neurobiologic origins and pathogenesis of anxiety symptoms and syndromes will help address the many challenges of understanding and treating these conditions. An overview of the neurochemical and functional new anatomic abnormalities that have been associated with anxiety disorders is presented. Areas of discussion include the central and peripheral norepinephrine system, the serotonin (5-HT) system, the GABA neuronal system, abnormalities in the hypothalamic-pituitary-adrenal axis and central corticotropin-releasing factor neuronal functioning, and neuroimaging studies (structural and functional magnetic resonance (MR) imaging, MR spectroscopy, positron emission tomography, and single photon emission computed tomography). Environmental changes and triggers also have an effect on anxiety disorders and are reviewed. Behavioral inhibition has emerged as an important precursor to social anxiety disorder and possibly to other anxiety disorders. Epidemiologic and clinical studies suggest that factors within the family environment, such as overprotection, overcontrol, modeling of anxiety, criticism, and in some cases abuse, can play a role in the development of social anxiety disorder. Environmental stress, such as loss of a job and trouble finding another and chronic health concerns, can trigger generalized anxiety disorder.

No. 14C
PHARMACOLOGIC APPROACHES FOR PANIC DISORDER

David V. Sheehan, M.D., *3515 East Fletcher Avenue, Tampa, FL 33613-4706*

SUMMARY:

Panic disorder has a lifetime prevalence of 3.5% in the community and a much higher prevalence among medical outpatients (1-month prevalence, 8.3%). In the outpatient population, panic disorder may be mistaken for other disorders. Fortunately, when treating panic disorder, the clinician has multiple pharmacologic treatment options from which to choose, including the most commonly prescribed selective serotonin reuptake inhibitors (SSRIs) and benzodiazepines (BZs) as well as other agents that are used less frequently. This presentation provides the practicing clinician with a practical guide to choosing and appropriately prescribing medicines for treating panic disorder. Focusing on the use of SSRIs and BZs, the discussion emphasizes the initial choice of agent, dosing, sequencing of treatments, and when to use combination therapy or augmentation. Information on a new delivery system for benzodiazepines is presented. Other treatment alternatives, such as tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOIs), and newer options are covered as well. Treatments are discussed in the context of

interactive video case presentations that highlight patient features associated with each therapeutic choice.

No. 14D
GAD: CURRENT OPINIONS AND FUTURE OPTIONS

Linda L. Carpenter, M.D., *345 Blackstone Boulevard, Providence, RI 02906*

SUMMARY:

Less than 33% of people with generalized anxiety disorder (GAD) experience spontaneous remission, and the symptoms of GAD change throughout a person's life. This presentation focuses on current and future options for reducing the burden of GAD through pharmacologic therapy. Psychotherapeutic approaches, such as applied relaxation, cognitive therapy, and cognitive-behavioral therapy (CBT), have been shown to be effective when used as monotherapies and may be beneficial when used as adjunct therapy. A recent longitudinal study found CBT was associated with lower overall symptom severity, but there was no evidence that it influenced probability of recovery or patient perceptions of overall improvement. Medications with the most evidence of efficacy in GAD are benzodiazepines and antidepressants. Benzodiazepines have a low incidence of side effects but may cause physical dependence, withdrawal, and sedation. Newer antidepressants and buspirone are also efficacious but act less quickly than benzodiazepines. Tricyclic antidepressants have been shown to substantially reduce symptoms of anxiety but are not considered a first-line therapy due to side effects. Evidence is also building for the use of some anticonvulsant agents, such as gabapentin and pregabalin. Optimizing treatment through the combination of pharmacologic and nonpharmacologic therapies may enhance chances for response and recovery in patients who do not benefit from one treatment modality.

REFERENCES:

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2. Coupland NJ: Social phobia: etiology, neurobiology, and treatment. J Clin Psychiatry 2001; 62(suppl 1):25–35.
3. Kessler RC, McGonagle KA, Zhao S, et al: Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Archives of General Psychiatry 1994; 51:8–19.
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INDUSTRY-SUPPORTED SYMPOSIUM 15—FROM PATHOLOGY TO PRACTICE: EVOLVING THERAPEUTIC STRATEGIES FOR ALZHEIMER'S DISEASE
Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) comprehend the pathological basis supporting the development of novel anti-dementia agents, (2) review placebo-controlled trials examining the safety and efficacy of noncholinergic agents in the treatment of AD and vascular dementia, (3) understand how cultural barriers prevent early diagnosis and treatment of AD and how specific strategies can be employed to better manage these special patient populations, and (4) describe the rationale for a combination therapeutic approach to AD management.

No. 15A
SYNAPTIC DYSFUNCTION AND NEURODEGENERATION IN ALZHEIMER'S DISEASE

Gary L. Wenk, Ph.D., *350 Life Sciences North, Tuscon, AZ 85724*

SUMMARY:

Complex structural, humoral, and intracellular mechanisms underlie the formation and recall of mammalian learning and memory. Glutamate, the predominant excitatory transmitter in the central nervous system (CNS), is implicated in the etiology of numerous acute and chronic neurodegenerative disorders, such as Alzheimer's disease (AD), Parkinson's disease, and schizophrenia. This lecture will explore the significance of ionotropic glutamate receptors, specifically the NMDA receptor, which has been characterized as pivotal in learning, memory, and hippocampal AD pathology. The complexities of cholinergic and glutamatergic signaling within the CNS syncytium will be discussed, as well as their aberrations in AD. The cholinergic and glutamatergic hypotheses of AD will be reviewed with a focus upon the interrelationship of genetic predispositions, pathological hallmarks, such as tangles and plaques, and pathological cascades, such as inflammation and neurotoxicity. If this pathological cascade of events could be arrested in the future, that might prevent neurotoxicity and preserve normal neuronal function in AD patients. As a rationale for AD pharmacologic interventions, antagonism of the NMDA receptor has been the focus of much research. Because NMDA receptors are implicated in all stages of AD pathology, from prodrome to symptoms, NMDA receptor antagonists could provide neuroprotection at each stage of the disease course.

No. 15B
ALZHEIMER'S DISEASE UPDATE: NEW TARGETS, NEW OPTIONS

Jacobo E. Mintzer, M.D., *5900 Core Road, Suite 203, N. Charleston, SC 29404*

SUMMARY:

Although historically the acetylcholinesterase inhibitors (AChE-Is) have been the mainstay of Alzheimer's disease (AD) treatment, to date evidence of their efficacy is limited to providing symptomatic relief. Currently, a plethora of new agents targeting noncholonergic mechanisms are under development for the treatment of AD.

This lecture will briefly review the strengths and weaknesses of the existing cholinestherase inhibitors therapy. Following this review, the lecture will comprehensively examine evidence from clinical trials on compounds aiming at non-cholinergic targets for AD therapeutic development. The mechanisms to be examined include glutaminergic activity, excitotoxicity, inflammation, and toxic free-radical production mechanisms.

No. 15C
ALZHEIMER'S DISEASE AND VASCULAR DEMENTIA: WHERE IS THE OVERLAP?

John C. Morris, M.D., *4488 Forest Park Avenue, St. Louis, MO 63108*

SUMMARY:

Dementia is a common neurological syndrome with a major impact on the health and quality of life of the elderly. Two leading causes of dementia, Alzheimer's disease (AD) and Vascular dementia (VaD) share many features in common, and indeed the two disorders often co-exist in the same patient (mixed dementia). This lecture will focus on the overlap of factors between vascular and neurodegenerative diseases and address changes in the cerebrovasculature that may be implicated in the pathology of AD. Clinical studies suggest that AD

and VaD may share risk factors such as hypertension, hypercholesterolemia, and diabetes. Vascular insufficiency, ischemic injury, and excitotoxic cell death may contribute to brain injury responsible for dementia in both AD and VaD. Treatment and preventive strategies that may be relevant for both AD and VaD will be discussed.

No. 15D
MULTICULTURAL ISSUES IN ADDRESSING BARRIERS TO DIAGNOSIS AND TREATMENT

Warachal E. Faison, M.D., *523 Legends Club Drive, Mt. Pleasant, SC 29466*

SUMMARY:

One of the major barriers to diagnosis of Alzheimer's disease (AD) is late presentation. Late presentation is due to many factors, including mistrust of the medical establishment and perceived stigma associated with a diagnosis of AD or dementia, by the patient, family, and caregivers. This lecture will address concerns specific to ethnically diverse populations and challenges in patient education and management that impede optimal management of these important groups. The incidence and prevalence of AD in special populations will be compared with prevailing rates in the U.S. Strategies to help overcome these barriers, improve diagnosis, initiate optimal management, and provide caregiver support will be detailed.

No. 15E
A RATIONAL APPROACH TO COMBINATION TREATMENT

Mary Sano, Ph.D., *130 W. Kingsbridge Road, #1FO1, Bronx, NY 10468*

SUMMARY:

As our scientific understanding of the pathological basis of AD improves, so does our therapeutic approach to pharmacological management. More than one neurotransmitter system may be involved in AD, and a cholinergic treatment strategy may be enhanced by treatments acting through other mechanisms. Glutamate, an excitatory neurotransmitter in the CNS has been implicated in the pathology of AD. Novel agents that antagonize its excitotoxic effects at NMDA receptors have shown promising results as safe and efficacious in the treatment of AD. The lecture will detail how agents with potentially different mechanisms of action might be used in a combination approach to the treatment of AD to maximize benefits over a range of disease severity. Results of a randomized, controlled study examining the efficacy of an NMDA receptor antagonist in combination with acetyl cholinesterase inhibition will be presented.

REFERENCES:

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2. Doraiswamy MP: Non-Cholinergic strategies for treating and preventing Alzheimer's disease. CNS Drugs 2002; 16(12):811–824.
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INDUSTRY-SUPPORTED SYMPOSIUM 16—BROADENING HORIZONS: ADVANCES IN UNDERSTANDING THE ETIOLOGY, EFFECTS, AND TREATMENT OF ANXIETY DISORDERS
Supported by UCB Pharma, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the impact of anxiety disorders in the community, emerging data regarding the role of glutamate in pathologic anxiety, the influence of gender and cutting edge treatment approaches, as well as the application of cognitive-behavioral principles to improving compliance with pharmacologic and psychosocial therapies.

No. 16A
ANXIETY ON THE UPSWING? A PUBLIC HEALTH PERSPECTIVE

Murray B. Stein, M.D., *8950 Villa La Jolla Drive, Suite 2243, La Jolla, CA 92037*

SUMMARY:

Anxiety disorders are among the most prevalent of mental disorders. Though their importance from a public health perspective was relatively ignored until the end of the past century, it has become increasingly clear that these disorders are not only common, but frequently impairing. Moreover, their often early onset positions anxiety disorders in youth as a potential target for efforts directed at preventing disability and secondary comorbidity. This presentation will review the epidemiology of anxiety disorders in adults and youth, highlighting evidence that the prevalence of certain anxiety disorders may be increasing. The association of anxiety disorders with impaired functioning will be stressed. Individuals with anxiety disorders frequently present to primary care settings, where their impact on functioning and health-related quality of life may be best appreciated. New data focusing on the impact of anxiety disorders combined with psychiatric (e.g., major depression) and/or medical comorbidity will be presented.

No. 16B
NEURAL SUBSTRATES OF STRESS, ANXIETY, AND EARLY ADVERSITY: NEUROTROPHIC PERSPECTIVES

Jeremy D. Coplan, M.D., *1051 Riverside Drive, Unit 69, New York, NY 10032*

SUMMARY:

Existing pharmacological approaches for treating anxiety consist of benzodiazepines acting via facilitation of GABAergic neurotransmission; buspirone, a 5-HT_{1A} partial agonist; and venlafaxine and paroxetine, a mixed noradrenergic-serotonergic uptake inhibitor and a serotonergic uptake inhibitor, respectively. These treatments have significant limitations, such as sedation, cognitive impairment, dependence/withdrawal syndromes (benzodiazepines), or sexual dysfunction, sleep dysfunction, or activating events (paroxetine, venlafaxine). An agent with a more specific role in ameliorating the symptoms of anxiety without these features might have greater utility. *L*-glutamate (glutamate) is present throughout the central nervous system (CNS) and plays a major role as an excitatory neurotransmitter in most CNS processes. Glutamate-stimulated, fast synaptic transmission is modulated via G-protein-coupled (metabotropic) receptors (mGlu). The mGlu2 receptors are expressed (mGlu2 mRNA) primar-

ily in the brain's limbic structures. These areas (in particular, the amygdaloid nuclei) are thought to play an important role in the somatic expression of fear via the brain stem/spinal cord and to be an important site of action of anxiolytic drugs.

No. 16C
GENDER AND ANXIETY DISORDERS: IMPACT AND TREATMENT IMPLICATIONS

Naomi M. Simon, M.D., *15 Parkman Street, WANG ACC 815, Boston, MA 02114*

SUMMARY:

Anxiety disorders, such as panic disorder, have a much higher prevalence in women than in men. This increased prevalence may occur in part due to heritable anxiety sensitivity in women. Life events also have been shown to play a significant role in precipitating the onset of anxiety disorders in women. Further, women with anxiety disorders may have a more severe course with higher rates of relapse. According to the National Comorbidity Survey, female respondents with panic disorder were more likely than male respondents to experience respiration-related difficulties during panic attacks. Gender-related differences in the types of personality disorders in patients with anxiety disorders also may exist. Further, pregnancy and the postpartum period may be times of risk for worsening of pre-existing anxiety disorders such as panic disorder in women, and require careful management. Recent studies suggesting etiologies for gender differences in anxiety disorders, as well as treatment issues for women, will be discussed.

No. 16D
TREATING ANXIETY: CURRENT THERAPIES AND BEYOND

Mark H. Pollack, M.D., *15 Parkman Street, WACC-812, Boston, MA 02114*

SUMMARY:

Recognition of the high rates of anxiety disorders in the population and the associated distress and dysfunction in affected individuals has spurred clinicians and investigators to develop psychosocial and pharmacologic interventions for their treatment. While currently available pharmacologic and psychosocial interventions are clearly effective, data from both systematic studies and experience in practice demonstrate that many patients remain symptomatic despite treatment.

This presentation will examine the growing interest in the use of novel interventions for patients with anxiety disorders, including pharmacotherapies beyond antidepressants and benzodiazepines such as the atypical antipsychotics and mood stabilizers, as well as targeted, efficiently administered cognitive-behavioral and other psychosocial interventions, and combined modality approaches. In addition, novel treatments on the horizon will be discussed, including pharmacotherapies targeting a range of relevant CNS systems such as CRF, ion channels, glutamate, and substance P, which offer the potential for a greater range of effective interventions in improving outcome in patients with anxiety disorders.

No. 16E
TREATMENT WORKS: NOW WHAT DO WE DO? STRATEGIES TO ENHANCE TREATMENT ADHERENCE

Michael W. Otto, Ph.D., *15 Parkman Street, WACC-812, Boston, MA 02114*

SUMMARY:

Adherence to medication treatment is a central issue for the longer-term management of a wide variety of psychiatric disorders. For example, despite a plan for long-term medication use across the mood disorders, there is reliable evidence that adherence to pharmacotherapy often fails within the first several months of treatment. This presentation provides a practical clinical model for strategies to enhance medication adherence. Adherence difficulties associated with both acute and maintenance phases of treatment will be discussed, along with review of empirically supported strategies to enhance adherence, including the role of "motivational interviewing" to help patients better act in accordance with their own self-interests. These strategies will be placed in the context of social/psychological research indicating factors that are likely to influence the patient's opinions about their care and the importance of compliance with treatment. This information will be summarized in the context of practical clinical strategies for improving adherence and outcome in pharmacotherapy.

REFERENCES:

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INDUSTRY-SUPPORTED SYMPOSIUM 17—THE HIDDEN FACES OF ANXIETY
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should: become familiar with the bidirectional relationship between physical comorbidities and anxiety disorders; gain familiarity with differences in presentation, progression of disease, and response to treatment for anxiety between men and women and between cultures and ethnic groups; and become familiar with the difficulties in recognizing and treating anxiety in the elderly.

No. 17A
THE SOMATIC FACE OF ANXIETY

Prakash S. Masand, M.D., *Box 3391 Duke South, Room 3050B, Yellow Zone, Durham, NC 27710*

SUMMARY:

Patients with anxiety and other mood disorders commonly suffer from somatic symptoms, such as disturbances in appetite and sleep. This relationship between somatic symptoms and anxiety disorders displays a bidirectional comorbidity. In addition to somatic symptoms, a number of chronic physical illnesses also are associated with subsyndromal anxiety and anxiety disorders. Several such illnesses include chronic fatigue syndrome, fibromyalgia, irritable bowel syndrome, and neuropathic pain. Results from some studies have shown

that improvement of physical illnesses may depend on the severity of the anxiety disorder. Currently, benzodiazepines, selective serotonin reuptake inhibitors (SSRIs), and serotonin-norepinephrine reuptake inhibitors (SNRIs) are available treatments for anxiety disorders. These medications appear to demonstrate efficacy not only for anxiety, but also for the somatic manifestations of anxiety and physical illnesses. Serotonin appears to mediate both physical illness and anxiety, providing a possible explanation for the improvement of both disorders. To enhance overall therapeutic management of the patient, this program will review available data on the treatments of anxiety and their effects on somatic symptoms.

No. 17B
ANXIETY IN MEN AND WOMEN: TWO FACES OF THE SAME COIN

Kimberly A. Yonkers, M.D., *142 Temple Street, Suite 301, New Haven, CT 06510*

SUMMARY:

There is a high prevalence of anxiety disorders in both men and women. The National Comorbidity Survey (NCS) (N = 8098) found a lifetime occurrence of an anxiety disorder in approximately 20% of men and 30% of women. Clearly, this causes significant impairment in a large population and timely diagnosis and treatment of this disorder is of great importance. Therefore, it is essential for psychiatrists to recognize the potential differences in the clinical presentation of anxiety in men and women. For women, anxiety disorders may be more common than any other group of psychiatric illness. In addition to the differences in prevalence rates between men and women, there appear to be meaningful sex differences in the phenomenology and course of various anxiety disorders. This presentation will provide an overview of sex differences in the prevalence, expression, and course of selected anxiety disorders. Increased knowledge about these differences can assist in improved clinical detection and treatment management, which would be highly beneficial to the patients.

No. 17C
THE MANY FACES OF ANXIETY: UNDERSTANDING CULTURAL AND ETHNIC VARIATION IN PSYCHIATRIC ILLNESS

Geetha Jayaram, M.D., *600 North Wolf Street, M-101, Baltimore, MD 21205-2101*

SUMMARY:

While it is recognized that anxiety disorders are prevalent across all cultures, the somatic and psychological expressions of anxiety can be culturally bound and may differ remarkably across different ethnic groups. Inattention to transcultural variations in the rates and presentation of anxiety disorders can have a profoundly negative effect on epidemiological studies, diagnosis, treatment response, and clinical outcome. This presentation will review the prevalence of anxiety disorders and the impact of ethnic and cultural differences in African Americans, Hispanics, Asian Americans, and other Asian populations. Factors to be considered include stigma, somatization, comorbidity, and suicidality. New data from ongoing studies will be reviewed, including the Maanasi project, a case identification study on the epidemiology of psychiatric illness in 21 villages in Southern India. Ethnic and cultural differences in medication response and metabolism, as well as response to psychotherapy will be discussed. Future directions for research in different cultural groups will be presented.

No. 17D
FACETS OF PSYCHIATRIC ILLNESS IN THE ELDERLY

Warren D. Taylor, M.D., *DUMC 3903, Durham, NC 27710*

SUMMARY:

The elderly population is increasing rapidly and with it are the number of patients who require appropriate diagnosis and treatment of mental disorders. The recognition and diagnosis of mental disorders in the elderly is a large unmet need in this population. Frequently, elderly patients suffer from multiple medical illnesses, which mask the anxiety disorder. In addition, anxiety disorders may have a different presentation in the elderly, such as accompanying severe depression or refractory somatic symptoms, which are not commonly recognized as characteristics of anxiety. Besides underrecognition, many elderly patients also receive inadequate treatment of their anxiety. Physicians tend to prescribe benzodiazepines for these patients more often than selective serotonin reuptake inhibitors, which are preferred because they are less likely to cause motor or cognitive impairment. Furthermore, the elderly rarely receive psychotherapy, which has been shown to be very beneficial. These inadequacies are a great problem in providing optimal health care to the aging population and will be reviewed to promote awareness and understanding of the situation.

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2. Yonkers KA, Keller MB: An eight-year longitudinal comparison of clinical course and characteristics of social phobia among men and women. Psychiat Services 2001; 52:637–643.
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5. Katona C. Managing depression and anxiety in the elderly patient. Eur Neuropsychopharmacol. 2000; 10(suppl 4):S427–S432.

INDUSTRY-SUPPORTED SYMPOSIUM 18—TARGETING EXECUTIVE DYSFUNCTIONS FOR TREATMENT
Supported by Cephalon, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to review the circuits and symptoms associated with executive dysfunction and the role of executive dysfunction in deficit syndrome, geriatric depression, major depression, and attention-deficit hyperactivity disorder and to discuss therapeutic strategies targeted at resolving specific symptoms presented in each of these disorders.

No. 18A
EXECUTIVE FUNCTION: CIRCUITS AND SYMPTOMS

Stephen M. Stahl, M.D., *5857 Owens Avenue, Suite 102, Carlsbad, CA 92009*

SUMMARY:

Symptoms of executive dysfunction are strongly associated with brain circuits to and from frontal lobes and the prefrontal cortex,

specifically, the dorsolateral prefrontal cortex (DLPFC). Ascending monoaminergic pathways for dopamine (DA) and norepinephrine (NE) from the brainstem to the DLPFC, as well as ascending cholinergic pathways for acetylcholine (Ach) from the basal forebrain to the DLPFC, may regulate executive functioning. Ascending histaminergic (HA) hypothalamic pathways may regulate executive function and may be regulated by the hypothalamic sleep-wake switch, a set of reciprocally innervated hypothalamic nuclei. Blocking HAI receptors can cause both executive dysfunction and sleepiness; enhancing histamine actions with modafinil can improve both executive functioning and wakefulness. It is hypothetically possible to enhance executive functioning by boosting actions of one or more "smart" neurotransmitters (DA, NE, Ach, and HA) in the DLPFC. Specifically, NE reuptake inhibitors (atomoxetine, bupropion) can enhance actions of both NÈ and DA, and atypical antipyschotics can enhance the release not only of NE and DA but also Ach. Thus, the strategy of targeting symptoms in circuits by enhancing neurotransmitters in the DLPFC may lead to alleviation of symptoms of executive dysfunction such as difficulty in problem solving, while simultaneously enhancing alertness, increasing energy, alleviating sleepiness and fatigue, and brightening mood.

No. 18B
ADDRESSING THE NEUROBIOLOGICAL DYSFUNCTIONS OF DEFICIT SYNDROME

Rona Hu, M.D., *401 Quarry Road, Stanford, CA 94305-5723*

SUMMARY:

Deficit syndrome describes the cognitive impairments that can be present in schizophrenia, ADHD, Tourette's syndrome, and sleep apnea. A variety of neuropsychological deficits can be correlated with global diffuse brain impairment, while frontal lobe impairment is particularly implicated in executive dysfunction. While certain cognitive deficits and executive dysfunctions can be specific to the underlying disorder, evaluation of neuropsychological functioning, such as with functional magnetic resonance imaging (fMRI), provides insight into what brain areas mediate the cognitive deficits and executive dysfunctions. Once the structures, neurotransmitters, and pathways involved in regulating cognitive and executive functioning are identified, treatments can be proposed (e.g., targeting histamine, dopamine, or norepinephrine systems). In each of these disorders, enhancing cortical activity could significantly relieve symptoms of executive dysfunction.

No. 18C
LATE-LIFE DEPRESSION OF EXECUTIVE DYSFUNCTION: NOVEL TREATMENT DEVELOPMENT

George S. Alexopoulos, M.D., *21 Bloomingdale Road, White Plains, NY 10605*

SUMMARY:

Several studies suggest that geriatric depression and executive dysfunction often coexist. Patients with depression and executive dysfunction present with psychomotor retardation, anhedonia, pronounced behavioral disability, and limited depressive ideation. While clinical presentation of geriatric depression with executive dysfunction resembles medial frontal lobe syndrome, it is distinguished by the presence of depressed mood, depressive ideation, and initial and middle insomnia, all of which are symptoms of depression. Studies suggest that geriatric depression accompanied by executive dysfunction has slow, poor, or unstable response to classic antidepressants. Clinical, neuropsychological, and neuroimaging findings suggest that geriatric depression accompanied by executive dysfunction is contributed by structural and functional abnormalities of the frontostriatal-limbic system. These observations provide a rationale for testing efficacy of pharmacological agents with potential to optimize neurotransmitter system functions central to the frontostriatal-limbic system. Drugs enhancing dopamine, acetylcholine, and opiate neurotransmission are candidates for such studies. Alternately, the recently elucidated anatomy and function of alertness systems provides a rationale for interventions at different points along their circuitry. There is some evidence that modafinil, an alertness-inducing agent, may improve executive function and act as an augmenting agent to antidepressants. It remains to be investigated whether modafinil can be effective in genatric depression with executive dysfunction.

No. 18D
COGNITIVE AND EXECUTIVE DYSFUNCTION IN MAJOR DEPRESSION

Charles DeBattista, M.D., *401 Quarry Road, #2137, Stanford, CA 94305-5723*

SUMMARY:

Cognitive and executive dysfunctions are common symptoms in depression, with patients showing difficulty in short-term memory, learning, and motor skills independent of pharmacotherapy. These impairments are consistent with dysfunction of frontal and mediotemporal lobes. While cognitive symptoms usually improve with antidepressant therapy both during and after recovery, antidepressants have varying effects on cognitive functions and performance. Important to consider is that both cognitive and executive dysfunctions may be residual symptoms of depression or symptoms of antidepressant therapy. Augmentation strategies can enhance or boost antidepressant effects or manage residual symptoms. A clear cause-and-effect relationship between cognitive and executive dysfunction in depressed patients and fatigue and disruption of steep cycle is not yet established. However, DMS-IV recognizes symptoms of fatigue, reduced energy, and slowed speech and thinking as symptoms of major depressive disorder. Even when depressed patients achieve remission, residual symptoms of fatigue may remain and are predictive of relapse. Since the frontal cortex controls sleep cycle as well as executive functions, evaluation of neuropathways and neurotransmitters impaired in major depressive disorder may provide clues to assist with the development of targeted pharmacologic agents that relieve symptoms of fatigue and thus reduce the likelihood of relapsing or recurring major depressive disorder.

No. 18E
ADDRESSING EXECUTIVE DYSFUNCTIONS IN ADHD

James M. Swanson, M.D., *19722 MacArthur Boulevard, Irvine, CA 92697-4480*

SUMMARY:

Attention-deficit hyperactivity disorder (ADHD) refers to a group of cerebellar dysfunctions involving multiple neurological substrates and pathways of activation, vigilance, and motivation. Inattentiveness, overactivity, and impulsivity are classic symptoms of ADHD. Neurobiological dysfunctions associated with ADHD can adversely influence executive function. Currently, there are various models of executive function impairment in ADHD, and consensus has not yet been reached in the research community in this regard. However, the coexistence of underlying learning disabilities and other psychiatric comorbidities increases the severity of executive dysfunction in ADHD patients. Since executive dysfunction associated with ADHD is largely cognitive, the dysfunctions are not easily observed or captured in standard evaluations. Stimulants such as

methylphenidate, the mainstay of treatment for ADHD, have pronounced effects on cognitive functioning, improving attention and performance presumably due to their effects on increasing dopamine synaptically. However, on higher-order tasks, stimulants at high doses impair rather than improve performance. Moreover, the potential for abuse and side effects limit the usefulness of stimulants. Nondopaminergic agents such as modafinil have been shown to improve executive functioning in ADHD and may represent a viable alternative to the widespread use of stimulants for the disorder.

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INDUSTRY-SUPPORTED SYMPOSIUM 19—THE TREACHEROUS TRIAD FOR DEPRESSION
Supported by Wyeth Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss the role of physically unexplained symptoms in depression, describe recent neuroimaging studies linking the underlying mechanisms of affective disorders and pain, discuss changes observed in the hippocampus in response to stress, and describe why major depression is often overlooked in perimenopausal women.

No. 19A
UNDERDETECTION AND INADEQUATE TREATMENT OF PHYSICAL SYMPTOMS OF DEPRESSION: THE REAL BARRIERS TO REMISSION

Kurt Kroenke, M.D., *1050 Wishard RG6, Indianapolis, IN 46202*

SUMMARY:

The majority of patients with depression are initially seen in the general medical setting, and 80%–90% present with physical rather than psychological symptoms. Physical symptoms account for 57% of all general medical visits, and patients with physically unexplained symptoms are two to three times more likely to suffer from a depressive disorder. Other predictors of an underlying depressive disorder include the number of physical symptoms, symptom severity, recent stress, poor self-rated health, and physician-perceived difficulty of the encounter. Meta-analyses have established the efficacy of both antidepressants and cognitive behavior therapy for patients with physical symptoms and symptom syndromes (e.g., chronic pain disorders, fibromyalgia, functional gastrointestinal disorders, migraine and tension headache). Half of all physical symptoms are pain, and the presence and severity of pain has been shown to adversely affect the likelihood depressed patients will respond to treatment. Also, physical symptoms (both pain and nonpain) in depressed patients respond better to standard treatments than depressive or other psychological symptoms. Finally, underdetection and inadequate treatment are the rule rather than the exception. New collaborative detection and treatment strategies are required for effective management.

No. 19B
NEUROCHEMICAL SYSTEMS INTERFACING PHYSICAL AND EMOTIONAL STRESSORS

Jon-Kar Zubieta, M.D., *205 Zina Pitcher Place, Ann Arbor, MI 48109-0720*

SUMMARY:

Data from animal research and human neuroimaging studies reveal overlapping neuronal networks and neurochemical mechanisms mediating the regulation of physical stress, physical symptoms, and depressive symptoms. Brain regions such as the anterior cingulate, prefrontal and insular cortex, amygdala, ventral basal ganglia, and anterior thalamus have been implicated in the response to stress, affective challenges, and painful and noxious stimuli. These overlapping regions help explain clinical linkages among affective components, physical challenges, and the vulnerability to mood and anxiety disorders. Brain images showing neurochemical systems that appear to underlie these interfaces are presented. Gender differences in these circuits and other modulatory influences by gonadal steroids and genetic polymorphsims are part of the overlapping profile. Clinicians need to attend to these linkages when explaining the comorbidity of physical symptoms and comorbid mood and anxiety disorders.

No. 19C
STRESS EFFECTS ON THE HIPPOCAMPUS: RELEVANCE TO DEPRESSION

Bruce S. McEwen, Ph.D., *1230 York Avenue, New York, NY 10021*

SUMMARY:

The hippocampal formation, which expresses high levels of adrenal steroid receptors, is a plastic brain structure important for certain types of learning and memory. It is also vulnerable to stroke, seizures, and head trauma. The hippocampus is also vulnerable to the effects of stress and stress hormones and is reported to become smaller, at least in multiple-episode depression, whereas the amygdala may enlarge, at least in first-episode depression. The hippocampus displays neurogenesis throughout adult life as well as structural plasticity of dendrites. Suppression of dentate gyrus neurogenesis and atrophy of dendrites of hippocampal pyramidal neurons are produced by chronic psychosocial stress, involving the actions of adrenal steroids acting in concert with excitatory amino acid neurotransmitters. These changes are reversible as long as stress is terminated after a number of weeks. New evidence indicates that the amygdala is also a target of repeated stress, and this hypertrophy may explain increased anxiety and aggression that results from stress.

No. 19D
GENDER CONSIDERATIONS IN THE TREATMENT OF PHYSICAL SYMPTOMS OF DEPRESSION

Vivien K. Burt, M.D., *10921 Wilshire Boulevard # 403, Los Angeles, CA 90021;* Vivien K. Burt, M.D.

SUMMARY:

Depression is more prevalent in women than men in every adult age group. Women are more likely than men to experience recurrent major depression. Chronically depressed women exhibit more somatic symptoms than men; often these physical symptoms mask depression and result in extensive medical work-ups to rule out physical illness before major depression is diagnosed as the primary

disorder. Furthermore, chronically depressed women are more severely impaired than men with regard to physical functioning, bodily pain, and vitality. Times of reproductive transition (premenstruum, postpartum, perimenopause) represent times of increased risk for depressive disorders. It may be that the failure to address and adequately treat somatic symptoms associated with depression in women contributes to gender-specific treatment-refractoriness and chronicity. Evidence suggests that dual reuptake inhibitors of serotonin and norepinephrine alleviate physical discomfort associated with depression and achieve faster antidepressant response and higher remission rates. These dual-acting antidepressants may therefore be particularly useful to treat depression in women. The use of different treatment options based on careful analysis of presenting symptoms for women with depression and associated physical discomfort is discussed.

No. 19E
BEST PRACTICES FOR ACHIEVING REMISSION IN DEPRESSION WITH PHYSICAL SYMPTOMS: CURRENT AND FUTURE TRENDS

John F. Greden, M.D., *1500 East Medical Center Drive, Ann Arbor, MI 48109-0999*

SUMMARY:

Comorbid depression and physical symptoms, especially pain syndromes and fibromylagia, may be the most common profile for those presenting with depressive illnesses in primary care settings. The likelihood of mood disorder increases proportionately with the number of complaints. Recent findings reveal that such patients also are less responsive to first-line antidepressant treatments, such as SSRIs. When treated with these approaches, they often fail to achieve remission, and that in turn, leads to recurrences, chronicity, and treatment resistance. Newer antidepressants have displaced tricyclic antidepressants for many clinical indications but have not been shown to be effective for those with coexisting physical symptoms. New strategies are required. Dual reuptake inhibitors (SNRIs) are demonstrated to counteract mood and physical symptoms, produce greater clinical improvement in those with such comorbidities, and do it safely. This is perhaps understandable because serotonin and norepinephrine both modulate descending pain pathways. It remains to be shown whether they will prevent or reverse hippocampal atrophy or neuroimaging changes. Newer agents under development e.g., NK-1 antagonists, also may modulate such syndromes, but they remain in development stages. Cognitive behavior therapy approaches also should be incorporated. Regardless of the treatments used, current best practices require earlier detection, earlier intervention, achievement of remission, and prevention of progression. Psychiatrists and primary care physicians need to collaborate closely in implementing such best practices.

REFERENCES:

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INDUSTRY-SUPPORTED SYMPOSIUM 20—BEYOND 5HT: NEW TREATMENTS FOR DEPRESSION
Supported by Merck & Co., Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this seminar, the audience will have a working knowledge of existing strategies, both based on research and on anecdotal evidence, for enhancing the response of depressed patients to the standard pharmacotherapy, the SSRIs. In addition, they will be informed about new medications that are likely to be available soon for the treatment of depression.

No. 20A
COMBINING TREATMENT TO ENHANCE SSRI RESPONSE

Jack M. Gorman, M.D., *One Gustave L. Levy Place, Box 1230, New York, NY 10029*

SUMMARY:

Although selective serotonin reuptake inhibitors (SSRIs) are usually successful in treating depression, at least 30% of patients do not respond to a first course of treatment. A frequent strategy to handle this problem is to add additional medication to enhance or potentiate response. Although this was once criticized as "polypharmacy," it is now recognized that the judicious combination of medications may improve SSRI response. There is already evidence that adding benzodiazepines or 5HT1A antagonists (e.g., pindolol) can speed the onset of response to SSRIs. Currently under investigation is whether this is also the case with the addition of psychostimulants or atypical antipsychotics. For instances in which SSRI therapy alone has not produced adequate response, there is evidence that coadministration of lithium, triiodothyronine, and atypical antipsychotics may potentiate response. This may also be the case for the addition of other hormones (e.g., estrogen, testosterone), psychostimulants and dopamine agonists, and other mood stabilizers. Often neglected in these considerations is the importance of adding psychotherapy. At least one large study has shown that the combination of a brief, focused psychotherapy with antidepressant medication is superior to either treatment alone. Hence, combination treatments are clearly one way of enhancing the response to SSRIs.

No. 20B
WHAT TO DO FOR SSRI NONRESPONDERS?

Michael E. Thase, M.D., *3811 O'Hara Street, Pittsburgh, PA 152132593*

SUMMARY:

Psychiatrists have two main choices when an initial antidepressant trial does not lead to sufficient symptom relief: (1) switch medications, or (2) add something to try to augment the ineffective antidepressant. Switching may be similarly dichotomized to (1) within-class or (2) across-class strategies. This talk will focus on strategies that are intended to simultaneously modulate serotoninergic and noradrenergic neurotransmission. The relative merits of the following strategies will be considered: combining selective serotonin and norepinephrine reuptake inhibitors (e.g., SSRI—desipramine, bupropion, or atomoxetine) and switching from SSRI to imipramine, venlafaxine, mirtazapine, or duloxetine. It will be argued that the current passion for combining antidepressants is unjustified and far exceeds the level of empirical support.

No. 20C
THE RELATIONSHIP BETWEEN SUBSTANCE P, 5HT, AND OTHER NEUROTRANSMITTER SYSTEMS

Linda L. Carpenter, M.D., *345 Blackstone Boulevard, Providence, RI 02906*

SUMMARY:

At present, all FDA-approved medications for the treatment of major depression are believed to act principally through monoaminergic neurotransmiiter systems. While action through various mechanisms on central serotonin, norepinephine, or dopamine function has become a defining feature for this class of drugs, recently emerging evidence regarding the antidepressant potential of compounds which selectively block a neurokinin (NK1) receptor has inspired researchers to broaden their understanding of the relationships between the neuropeptide substance P and monoamines such as serotonin, norepinephrine, and dopamine. A growing body of results from preclinical and clinical investigations suggest that substance P and the NK1 receptor are intimately linked with a diverse array of biological markers and neurotransmitter system abnormalities which have traditionally been associated with mood and anxiety disorders. For example, behavioral and phsyciologic effects produced by genetic or pharmacologic inactivation of the substance p (NK1) receptor in laboratory animals suggest the antianxiety- and antidepressant-like effects of substance P antagonists may be mediated by effects on noradrenergic and serotonergic neurotransmission. Studies in humans show that approximately half of the serotonergic neurons in the dorsal raphe also express substance P. Serum and cerebrospinal fluid substance P levels are increased in depressed humans as compared with controls, and pharmacologic challenge with intravenous substance P in humans produces acute sleep, mood, and neuroendocrine changes. These and other biological data will be reviewed.

No. 20D
SUBSTANCE P ANTAGONISTS: MECHANISM OF ACTION AND CLINICAL IMPLICATIONS

K. Ranga R. Krishnan, M.D., Box 3018, Durham, NC 27710

SUMMARY:

Substance P (SP) belongs to the neurokinin (NK) family of neuropeptides and exerts its biological effects via interaction with the NK1 receptor. The SP-NK1 receptor system is one of the best-characterized neurotransmitter pathways in both the central and peripheral nervous systems. It has been postulated that this pathway may have important roles in a variety of centrally regulated pathophysiologic conditions, including depression. In animal models, injection of SP was associated with a series of anxiety-like behaviors, and this response could be abolished by pretreatment with SP (NK1) receptor antagonists (SPAs). On the basis of these and other encouraging preclinical results, several clinical trials have examined the potential of SPAs in the treatment of depression. In Phase 2 trials, therapy with the SPAs aprepitant (MK-0869) and another Merck compound resulted in improvements in depression and anxiety symptoms that were quantitatively comparable with those seen with selective serotonin reuptake inhibitors (SSRIs) and significantly greater than those seen with placebo. These positive findings have established a proof of concept that the inhibition of the SP-NK1 receptor pathway may be a potentially useful novel treatment option for management of patients with depression. The apparent lack of benefit with SPAs versus placebo in subsequent dose-finding studies with aprepitant is not surprising, considering the fact that the outcomes with an active control (SSRI) in these trials were also similar to those observed with placebo. Future trials with SPAs will focus on the identification of appropriate patients and drug regimens and will also define the role of these agents in the treatment of depression.

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INDUSTRY-SUPPORTED SYMPOSIUM 21—ARE ALL ATYPICAL ANTIPSYCHOTICS EQUAL FOR TREATMENT OF COGNITIVE AND AFFECTIVE SYMPTOMS IN SCHIZOPHRENIA?
Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the differences between typical and atypical antipsychotic drugs, use atypical antipsychotics to improve specific domains of patients' cognition and negative symptoms, understand the implications of atypical antipsychotic therapy choices for patients' overall health outcomes, and preserve gains made during acute treatment.

No. 21A
SCHIZOPHRENIA: FROM CIRCUITS TO SYMPTOMS

Stephen M. Stahl, M.D., *5857 Owens Avenue, Suite 102, Carlsbad, CA 92009*

SUMMARY:

The biochemistry of the brain has long been the central target for researching normal and abnormal mental states, including schizophrenia. More recently, specific neuronal circuits have been shown to mediate specific symptoms in schizophrenia. Thus, positive symptoms may reside in subcortical limbic circuits, whereas cognitive symptoms may be associated with decreased activation of dorsolateral prefrontal cortex and affective symptoms with increased activation of medial and orbital prefrontal cortex.

Atypical antipsychotics have both the properties of 5-HT2A antagonism and D2 antagonism with either fast dissociation from D2 receptors or partial agonist actions. Other binding properties distinguish one atypical antipsychotic from another and may account for clinical differences observed in tolerability as well as efficacy, including efficacy for cognition and affect.

During this presentation, Dr. Stephen Stahl will review both the similarities and the distinctions among the atypical antipsychotics in terms of their mechanisms of action and will discuss a scientific rationale for a hypothesis-based theme for the potential "brightening" effects seen clinically with regard to mood and cognition.

No. 21B
EFFECT OF ATYPICAL ANTIPSYCHOTIC DRUGS ON COGNITION AND NEGATIVE SYMPTOMS

Herbert Y. Meltzer, M.D., *1601 23rd Avenue South, Suite 306, Nashville, TN 37212-8645*

SUMMARY:

Atypical antipsychotic drugs, as a class, are superior to typical antipsychotics with regard to improvement in cognition and affect. The performance of these agents in these two domains has been shown to be particularly relevant to functional outcomes and compliance. Systematic review of the efficacy of the atypical antipsychotic drugs to affect cognitive function in schizophrenia reveals that these agents improve performance in the following domains: learning, working and long-term memory, verbal fluency, speed of processing, and motor skills. The magnitude of improvement is relatively small, overall, but a proportion of patients respond with large improvements. The pattern of improvements with the different antipsychotic drugs varies, with most important differences in vigilance, verbal fluency, and working memory. In addition, several augmentation strategies increase the opportunity for additional improvement in cognition. Data showing the functional effects of these improvements are presented. Systematic review also reveals that the atypical antipsychotic drugs improve primary and secondary negative symptoms, including flat affect. This presentation highlights differences among the atypical agents and presents possible biological mechanisms to account for the ability of these agents, which represent an important advance in the treatment of schizophrenia.

No. 21C
OPTIMAL HEALTH OUTCOMES IN SCHIZOPHRENIA

Jonathan M. Meyer, M.D., *3350 La Jolla Village Dr. 116-A, San Diego, CA 92161*

SUMMARY:

Mortality among patients with schizophrenia is significantly higher than in the general population and can be attributed to an increase in disease-related factors such as suicide and an increased rate of medical disorders. Most patients with schizophrenia report at least one health problem, the most common being related to eyesight, teeth, and hypertension. In a Swedish study, the standardized mortality ratio for all deaths among patients with schizophrenia was increased by a factor of 2.8 among males and 2.4 among females. Somatic causes of the increased mortality accounted for more than 50% of the increased death rates among females and nearly 50% of the excess death rates among males. A variety of diseases contributes to this increase, including cardiovascular disorders, obesity-related disorders, diabetes mellitus, respiratory disorders, and infectious diseases. It has been well established that the new atypical antipsychotics have distinct clinical advantages, compared with the older typical agents. They have a broader spectrum of action on positive, negative, and mood symptoms, and, because they are better tolerated, their use may lead to improved compliance. The differing medical profiles of the atypical agents provide the clinician with a wider variety of choices for therapeutic intervention. Because psychotic disorders typically require long-term therapy, the clinician must remain cognizant of the merits and shortcomings associated with each agent. The intervention that will produce the greatest overall benefit should be used.

No. 21D
MAXIMIZING FUNCTION IN PATIENTS WITH SCHIZOPHRENIA

Lili Kopala, M.D., *2121 Brew Bay Road RR3 # 11, Powell River B.C., Canada V8A 5C1*

SUMMARY:

Early intervention with antipsychotic medication has been shown to reduce the risk of relapse and to decrease long-term morbidity and mortality in patients with schizophrenia and related psychotic disorders. It is vitally important to develop treatment strategies for these patients that improve positive and negative psychotic symptoms as quickly as possible, with a minimal risk of the development of extrapyramidal side effects. While medications are effective, consistent adherence to them by patients is crucial in order to facilitate longer-term outcomes. In addition, medications must not in and of themselves be toxic and cause worsening of abnormal motor function, obesity, dyslipidemia, or diabetes. Functional outcome is a complex process that is unique to each individual and involves multiple dimensions. Cognitive performance is a correlate of functional outcome among patients with schizophrenia and is a significant predictor of job tenure. It is now clear that psychosocial treatments, when combined with medication, can improve the adjustment of patients with schizophrenia and prevent relapse far better than drugs alone. This presentation reviews data from a sample of first-episode patients who were followed for 2 years and discusses factors that affect outcomes and how effective treatment can enhance long-term outcomes.

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1. Slaby AE, Tancredi LR. Micropharmacology: treating disturbances of mood, thought, and behavior as specific neurotransmitter dysregulations rather than as clinical syndromes. Primary Psychiatry 2001; 8:28–32.
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INDUSTRY-SUPPORTED SYMPOSIUM 22—COMBINATION THERAPY: NEW STRATEGIES IN THE MANAGEMENT OF SEVERE MENTAL DISORDERS
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to review clinical trials of combination therapy and implement treatment strategies to improve outcomes in patients with severe mental disorders.

No. 22A
RATIONAL COMBINATION THERAPY VERSUS IRRATIONAL POLYPHARMACY

Susan L. McElroy, M.D., *MSB559 - 231 Albert Sabin Way, Cincinnati, OH 45267-0559*

SUMMARY:

Most patients with a severe mental illness receive multiple medications for the treatment of that illness. The reasons for treatments with multiple medications need to be fully understood to optimize outcome and minimize toxicity. In other words, rational combination therapy must be differentiated from irrational polypharmacy. Goals of rational combination therapy include acceleration of response, optimization or augmentation of inadequate response, treatment of comorbidity, and management of side effects. One example of rational combination therapy, therefore, includes beginning two active agents together to hasten acute response, achieve a more complete short-term response, and/or maintain a more complete response. Another example is adding a second agent to a single agent (or a third to two agents) to optimize the response to the original agent, treat an associated condition not treated by the first agent, or manage a side effect associated with the first agent. Rational combination therapy is distinguished from irrational polypharmacy in that it is based on controlled clinical trial evidence, pharmacologic principles, and continued evaluation of the benefits and risks of all medications. Examples of pivotal randomized clinical trials of rational combination therapy in the treatment of schizophrenia, bipolar disorder, and major depressive disorder are reviewed to display these concepts.

No. 22B
COMBINATION TREATMENT FOR ACUTE MANIA

Gary S. Sachs, M.D., *15 Parkman Street WACC 815, Boston, MA 02114*

SUMMARY:

Over the past 10 years the number of treatment options with proven efficacy for acute mania has grown, but clinical trials clearly demonstrate that after 3 weeks of monotherapy, the average patient still meets criteria for acute mania. Published treatment guidelines regard acute mania as a medical emergency typically requiring hospitalization and warranting aggressive treatment. Recent APA guidelines recommend combined treatment using "mood stabilizers" and atypical antipsychotics. This presentation reviews the available data on combined therapies for acute mania and suggest ways to avoid problems associated with concurrent use of multiple medications. The pattern of results from studies comparing treatment with lithium or valproate plus placebo to lithium or valproate combined with antipsychotic medication consistently indicates greater clinical efficacy for combining lithium or valproate with olanzapine, risperidone, haloperidol, or quetiapine. In an interesting finding, Yatham found combined treatment with carbamazepine and risperidone was not superior to carbamazepine used alone. As the needs of clinical practice continue to propel the field toward polypharmacy for the treatment of bipolar disorder, the very proliferation of combination treatments raises questions about the appropriateness of some treatment combinations. Fortunately, clinical trial data provide evidence supporting combination therapy and define the boundary between rational polypharmacy and well-intentioned prescribing undisciplined by evidence.

No. 22C
MANAGEMENT OF BIPOLAR DEPRESSION: COMBINATION THERAPY VERSUS MONOTHERAPY

Robert M.A. Hirschfeld, M.D., *301 University Boulevard 1.302RSH, Galveston, TX 77555-0188*

SUMMARY:

Depression is the bane of bipolar disorder. It receives much less attention than does mania, yet it causes much more suffering. Those with bipolar disorder spend much more time depressed than manic, and the burden of the illness is substantially greater. Depression has been much more resistant to treatment than mania in the past. Recently new data have emerged confirming efficacy of monotherapy and of combination therapy for bipolar depression. This presentation reviews these findings, as well as other newly emerging data, on the acute and maintenance treatment of bipolar depression.

No. 22D
MANAGING BIPOLAR DISORDER IN CHILDREN AND ADOLESCENTS

Karen D. Wagner, M.D., *Room 3.258, 301 University Boulevard, Galveston, TX 77555-0188*

SUMMARY:

The management of bipolar disorder in children and adolescents poses significant challenges for clinicians. Since the features of bipolar disorder in children tend to differ from those in adults (e.g., less episodic), this disorder may be unrecognized or misdiagnosed as attention-deficit/hyperactivity disorder (ADHD). Furthermore, comorbid ADHD complicates the clinical course and treatment of bipolar disorder in children. Although it is well recognized that bipolar disorder has a substantial negative effect on a child's school performance, peer relationships, and family functioning, there is very little empirical information about treatment of this disorder. Clinical practice is largely derived from pharmacotherapy studies of adults with bipolar disorder. The comparative efficacy of mood stabilizers and optimal treatment duration for children with bipolar disorder remain to be established. This presentation reviews the use of traditional mood stabilizers, antipsychotics, and newer anticonvulsants for treatment of children with bipolar disorder. Treatment issues, such as monotherapy versus combination treatment, medication side effects, and treatment duration are discussed. The role of the family in the child's treatment is also discussed.

No. 22E
EVIDENCE FOR THE MECHANISMS AND EFFICACY OF ANTICONVULSANTS IN THE TREATMENT OF SCHIZOPHRENIA

Henry A. Nasrallah, M.D., *231 Albert Sabin Way/P.O. Box 670559, Cincinnati, OH 45267-0559*

SUMMARY:

Clinical case reports and small studies over the last several years have included many positive reports of the use anticonvulsants in the treatment of schizophrenia. These are tantalizing because of their number and consistency. Now, there are two larger placebo-controlled studies, which provided a greater weight of evidence that this is a potential new treatment approach to enhance outcomes for persons with schizophrenia. A European study showed that lamotrigine had a positive effect in augmenting clozapine efficacy in persons with clozapine-resistant psychotic symptoms. The other study, conducted in a multicenter design in the United States, showed that divalproex augmented the magnitude and the speed of onset of second-generation antipsychotic action in acute schizophrenia. The target of this action in each study was the positive symptom cluster, not only the measures of excitement or affect. This session discusses additional data supporting the efficacy of anticonvulsant cotreatment in schizophrenia and suggesting the neural mechanisms of this clinical action. This clinical action may indicate a new direction for the

development of neural targets for schizophrenia treatment. Results of these studies and potential clinical applications are discussed.

REFERENCES:

1. Casey DE, Daniel DG, Wassef AA, et al: Effect of divalproex combined with olanzapine or risperidone in patients with acute exacerbation of schizophrenia. Neuropsychopharmacol 2003; 28:182–192.
2. Tohen M, Chengappa KN, Suppes T, et al: Efficacy of olanzapine in combination with valproate or lithium in the treatment of mania in patients partially nonresponsive to valproate or lithium monotherapy. Arch Gen Psychiatry 2002; 59:62–9.
3. Sachs GS, Grossman F, Ghaemi SN, Okamoto A, Bowden C: Risperidone plus mood stabilizer versus placebo plus mood stabilizer for treatment of acute mania of bipolar disorder: a double-blind comparison of efficacy and safety. Am J Psychiatry 2002; 159:1146–1154.
4. Wagner KD: Management of bipolar disorder in children and adolescents. Psychopharmacol Bull 2002; 36:151–159.
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INDUSTRY-SUPPORTED SYMPOSIUM 23—UNMASKING BIPOLAR DISORDER: OVERCOMING THE BARRIERS TO TREATMENT SUCCESS

Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to realize the safety profiles of common polypharmacological regimens, discuss cross-national differences in the nosology and epidemiology of bipolar disorder, understand the elements of psychosocial treatment as well as the results of recent studies documenting the efficacy of specific psychosocial approaches to treating bipolar disorder, and identify goals for different phases of treatment of bipolar disorder.

No. 23A
BIPOLAR DISORDER: A NATIONAL HEALTH CONCERN

Roger S. McIntyre, M.D., *399 Bathurst Street, Toronto, ON Canada M5T 2S8*

SUMMARY:

Bipolar disorder is a prevalent, often progressive disorder with significant illness burden. Most persons with the disorder are not currently diagnosed or receiving guideline-concordant care. It is disquieting that frequently reported delays in making the diagnosis leave modifiable morbidity and mortality risks untreated. There is increasing recognition that bipolar disorder is often complicated by multiaxial comorbidity, which frequently proceeds or obscures the underlying diagnosis of bipolar disorder. Moreover comobidity in a bipolar disorder patient will often predispose and presage poor outcome for persons affected. This composite invites the need for clinicians to be familiar with the relevance of comorbidity to the diagnosis and treatment of bipolar disorder. Novel pharmacological and psychosocial strategies are being developed that reduce morbidity and favorably influence the burden of illness attributable to bipolar disorder. From a mental health system perspective, increasing clinical acumen at establishing the diagnosis of bipolar disorder, initiating appropriate evidence based therapy, and effectively managing comorbidities holds promise of greatly improving individual quality of life and offering larger reductions in the aggregate disability attendant to bipolar disorder.

No. 23B
REDEFINING MOOD STABILIZING AGENTS: IMPROVED TREATMENT OPTIONS FOR BIPOLAR DISORDER

S. Nassir Ghaemi, M.D., *1493 Cambridge Street, Cambridge, MA 02139*

SUMMARY:

Management of bipolar disorder presents clinical challenges due to its lifelong course and multifaceted nature. The ultimate treatment goals for bipolar disorder include clinical response, functional recovery, and remission of patients suffering from this illness throughout their lives and, therefore, should encompass management not only of acute stages of this illness but also continuation and maintenance therapy. Until recently, pharmacological options for the treatment of acute manifestations of bipolar disorder targeted predominantly only one of the phases, manic (mood stabilizers, anticonvulsants, atypical antipsychotics) or depressive (antidepressants), but combination therapy is often required to manage both. Emerging clinical research suggests that mood stabilizers (lithium, valproate) can be useful in managing both phases of bipolar disorder not only in acute phase but also in maintenance, which is reflected in the recently published *Practice Guideline for the Treatment of Patients with Bipolar Disorder*. Atypical antipsychotics (olanzapine, risperidone) were also demonstrated in well-designed clinical trials to have mood stabilizing properties and, therefore, start to find their place in treatment of both manic and depressive symptoms of bipolar disorder either as a monotherapy or adjunctive therapy. Long-term risks of antidepressants also need to be carefully considered. This presentation focuses on defining the goals for the treatment of bipolar disorder in acute, continuation, and maintenance phases of treatment and discusses current knowledge of available pharmacotherapies for the treatment of different phases of bipolar disorder.

No. 23C
SAFETY CONSIDERATIONS IN TREATING THE BIPOLAR DISORDER PATIENT

Prakash S. Masand, M.D., *Box 3391 Duke South, Room 3050B, Yellow Zone, Durham, NC 27710*

SUMMARY:

Up to one-third of bipolar disorder patients do not respond to mood stabilizer monotherapy, and increasingly more patients are prescribed combinations of mood stabilizers or mood stabilizers augmented by other classes of medication including antidepressants, benzodiazepines, anticonvulsants, and atypical antipsychotics. Each of these classes is associated with potential adverse events, but taken in concert these combinations can present unique safety profiles of which clinicians should be aware. This presentation provides an overview of the safety and tolerability of individual agents within each class of medication most commonly used to treat bipolar disorder. Potential adverse events include somnolence, metabolic dyscontrol and weight gain, cardiovascular side effects, and movement disorders. Given the prevalence of polypharmacy in the treatment of bipolar disorder, the safety profiles of the more common combinatorial regimens, including drug-drug interactions, are also addressed. By using evidence-based psychiatry and being aware of the potential safety issues in the treatment of bipolar disorder, clinicians can place

these side effects in proper perspective toward the goal of enhancing adherence and long-term outcomes.

No. 23D
THE ESSENTIAL ROLE OF PSYCHOTHERAPY IN MANAGING BIPOLAR DISORDER

Michael W. Otto, Ph.D., *15 Parkman Street, WACC-812, Boston, MA 02114*

SUMMARY:

Despite advances in the pharmacologic treatment of bipolar disorder, it is clear that additional strategies are needed to provide patients with longer-term mood stability. In the last several years, new psychosocial strategies for bipolar disorder have been developed, and results to date suggest that these treatments, applied in conjunction with medications, are helpful in changing the course of bipolar disorder. In this presentation, elements of treatment from family-focused therapy, interpersonal therapy with a social rhythm component, and cognitive behavior therapy are considered and placed within a model of the stages and targets of treatment that are important for the adjunctive management of bipolar disorder. The presentation emphasizes the elements of psychosocial treatment that can be incorporated within standard pharmacotherapy, with the goal of improving medication adherence and outcomes for bipolar disorder.

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2. Ghaemi SN: New treatments for bipolar disorder: the role of atypical neuroleptic agents. J Clin Psychiatry 2000; 61(suppl 14):33–42.
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INDUSTRY-SUPPORTED SYMPOSIUM 24—RECOVERING FROM SCHIZOPHRENIA: HOW TREATMENT CAN IMPROVE OUTCOMES AND PREVENT CHRONICITY
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the importance of early diagnosis and intervention and the fostering of patient adherence in improving the long-term outcomes of schizophrenia.

No. 24A
LABORATORY AND IMAGING AIDS TO DIAGNOSIS AND ASSESSMENT OF SCHIZOPHRENIA

Aysenil Belger, Ph.D., *CB #7160, Med. School 250 201 Manning, Chapel Hill, NC 27599*

SUMMARY:

Information processing deficits in schizophrenia extend from sensory processing to decision-making. Recent evidence has also revealed that information processing deficits and the underlying putative neuropathology show further deterioration with illness duration and chronicity. The advances in novel *in vivo* brain imaging techniques have opened new windows of opportunity for identifying the brain dysfunction associated with cognitive deficits in schizophrenia. These techniques include electrophysiological recording or brain electrical activity and magnetic resonance imaging. Combined, these methods enable us to examine the timing and anatomical localization and distribution of the neural events that lead to higher order cognitive processes and experiences. Across a series of studies, we characterized the spatiotemporal aspects of brain activity related to visual and auditory processing in patients with first-episode schizophrenia and chronic schizophrenia, and in high-risk prodromal patients to further elucidate the neurodevelopmental course of sensory and executive processing impairments in schizophrenia. ERP and fMRI results indicated widespread information processing deficits in schizophrenia, particularly involving prefrontal and temporal cortical regions. The data suggested that the functional link between perception and cognition may be disrupted in schizophrenia. We will discuss how these techniques can further be used to track brain changes associated with treatment effects and disease progression.

No. 24B
TREATING FIRST-EPISODE SCHIZOPHRENIA: DIFFERENTIAL EFFECTS OF ATYPICAL AND TYPICAL ANTIPSYCHOTICS ON BRAIN PATHOMORPHOLOGY

Jeffrey A. Lieberman, M.D., *7025 Neurosciences Hospital, CB#7160, Chapel Hill, NC 27599-7160*

SUMMARY:

Changes in brain morphology have been documented through longitudinal imaging studies of first-episode schizophrenia. Such morphological changes may be linked to the pathological processes of the development and progression of schizophrenia. It has also been suggested that antipsychotics may play a role either in aggravating or preventing changes in brain morphology. In a long-term, controlled clinical trial, we assessed the effects of treatment with a typical (haloperidol) and an atypical (olanzapine) antipsychotics on the progression of morphological changes in the brains of first-episode patients. As measured via high-resolution MRI, we documented changes in whole brain volume, total and regional gray matter, white matter, and lateral ventricular volume. Progressive changes in brain volume were noted and could be selectively attenuated by treatment with the atypical antipsychotic olanzapine. Olanzapine was associated with significantly greater volumes of the whole brain and total cerebral gray matter and significantly smaller lateral ventricular volume compared to haloperidol.

No. 24C
APPROACHES TO IMPROVED MAINTENANCE TREATMENT AND RELAPSE PREVENTION

T. Scott Stroup, M.D., *10626 Neuroscience Hospital, Campus Box 7160, Chapel Hill, NC 27599-7160*

SUMMARY:

In spite of solid evidence for the efficacy of pharmacological and psychosocial treatments for schizophrenia, many persons with schizophrenia receive suboptimal treatment, experience poor quality of life, and suffer repeated relapses. Maintenance treatment with antipsychotic drugs greatly reduces the risk of relapse; however,

poor acceptance of the need for treatment and poor adherence to prescribed treatment regimens by patients contribute to a discrepancy between potential and actual treatment effectiveness. Effective interventions to improve long-term outcomes are greatly needed.

A major problem in maintenance treatment of schizophrenia is nonadherence to antipsychotic medication regimens, which occurs in up to 74% of patients with schizophrenia within two years of hospital discharge. Treatment nonadherence is associated with poorer outcomes, including higher rates of rehospitalization, higher levels of symptoms, more violent behavior, and higher incidence of homelessness. Treatment nonadherence is a multifactorial barrier to good outcomes that is surmountable with specific interventions or combinations of interventions that address the underlying causes. To date, evidence-based interventions include a variety of psychosocial interventions, including compliance therapy, assertive community treatment, behavioral tailoring, outpatient commitment, as well as changes in drug formulation and route of administration.

No. 24D
PSYCHIATRIC REHABILITATION

Robert E. Drake, M.D., *2 Whipple Place, Suite 202, Lebanon, NH 03756*

SUMMARY:

Prevention of disability among persons with severe mental illnesses such as schizophrenia requires attention to psychosocial interventions as well as psychopharmacology. This presentation will review current research on psychiatric rehabilitation for persons with schizophrenia and other severe mental illnesses. Psychiatric rehabilitation refers to interventions to enhance role functioning by building skills and establishing supports.

The presentation will summarize the evidence that psychiatric rehabilitation can reverse and prevent disability. Specific areas to be covered include supported employment, social skills training, cognitive behavior interventions for residual symptoms, and treatments for problems related to substance abuse and trauma.

In each case, an accumulating body of research indicates that psychiatric rehabilitation enhances functioning in normative adult roles, such as employee, social participant, and independent adult who manages his or her own illnesses. Common themes in the literature, such as emphasis on developing cognitive and behavioral skills and having access to appropriate supports will be emphasized.

No. 24E
COGNITIVE IMPROVEMENT AND THERAPEUTIC ALLIANCE

Richard S. Keefe, Ph.D., *Box 3270, Durham, NC 27710*

SUMMARY:

The outcome of schizophrenia is greatly variable and the early stages of illness may dictate these long-term outcomes. Patients who have improved cognitive functions may be more motivated socially, and as a result, more likely to engage in a productive therapeutic alliance. Recent data suggest that patients in the first episode of psychosis have frontal cortex volume reductions over time, which are associated with worsening cognitive functions, but not with clinical changes. These data raise the question of whether treatment success in the early phases of illness may be associated with the reduction of the harmful effects of psychosis in the later stages. Recent results of an international study of first-episode psychosis suggest that patients treated with olanzapine have greater improvement in neurocognitive function, similar clinical response, and fewer extrapyramidal symptoms than patients treated with low doses (mean modal dose=4.4 mg/day) of haloperidol. Patients treated with olanzapine did not have MRI signal intensity changes consistent with frontal gray matter reduction found in the patients treated with haloperidol. Thus, this study illustrates that atypical medications such as olanzapine may help improve cognition and the therapeutic alliance and avoid putative long-term harmful effects of early psychosis or treatment with older, typical medications.

REFERENCES:

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2. Lieberman J, et al: Antipsychotic treatment effects on progression of brain pathomorphology in first episode schizophrenia. Presented at Society of Biological Psychiatry 58th Annual Scientific Convention and Program, San Francisco, May 15–17, 2003.
3. Zygmunt A, Olfson M, Boyer CA, Mechanic D: Interventions to improve medication adherence in schizophrenia. Am J Psychiatry 2002; 159:1653–1664.
4. Keefe RSE, Mohs RC, Bilder RM, Harvey PD, Green MF, Meltzer HY, Gold JM, Sano M: Neurocognitive assessment in the CATIE Project schizophrenia trial: development, methodology, and rationale. Schizophrenia Bulletin (in press).

INDUSTRY-SUPPORTED SYMPOSIUM 25—NOVEL INTERVENTION STRATEGIES ACROSS THE SPECTRUM OF DEMENTIA: REAL PATIENTS AND REAL OUTCOMES
Supported by Eisai, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the complexities of dementia and differentiate between mild cognitive impairment and early-stage Alzheimer's disease (AD), evaluate management options for mild cognitive impairment and early AD, describe cognitive and behavioral disturbances associated with vascular dementia (VaD), distinguish between VaD and AD and discuss existing options for their treatment, identify positive treatment options associated with cholinesterase inhibitors, and discuss novel technologies and strategies for improving and maintaining memory and brain fitness.

No. 25A
IDENTIFYING EARLY DEMENTIA: MILD COGNITIVE IMPAIRMENT AND EARLY-STAGE ALZHEIMER'S DISEASE

P. Murali Doraiswamy, M.D., *3350 Hospital South, Box 3018, Durham, NC 27710*

SUMMARY:

Mild cognitive impairment (MCI) is regarded as an important transitional stage of cognitive dysfunction between normal aging and early Alzheimer's disease (AD). Characterized by significant short-term memory impairment in the absence of frank dementia or impaired function, the clinical criteria for MIC include memory complaints by the patient and/or family member, objective evidence of memory impairment, normal general cognitive functioning, and preserved or only minimally impaired activities of daily living. Although some experts believe that not all individuals with MCI progress to dementia or AD, there is increasing consensus that evaluation and monitoring may be appropriate. Meanwhile, the rationale for treating very mild AD is clear: Analysis of pivotal trials data demonstrates that in patients with mild AD, there is a greater potential for improving cognition (above baseline) than in patients with moderate

AD. Finally, early treatment can help preserve and maintain function at a higher level for longer periods of time.

No. 25B
IDENTIFYING AND TREATING EARLY DEMENTIA: CASE STUDIES

Daniel Dee Christensen, M.D., *501 Chipeta Way, Salt Lake City, UT 84108-1222*

SUMMARY:

The importance of early recognition of mild cognitive impairment (MCI) and early-stage Alzheimer's disease (AD) cannot be understated, as those with MCI may be at risk for developing AD and, in those with early-stage AD, early intervention can help preserve and maintain function. This presentation provides practical direction for the "real-world" management of MCI and early AD in the psychiatric setting through use of a series of case study examples and patient video clips. The benefits of early treatment and how it can help patients achieve better outcomes are reviewed and data from a new trial underscoring the beneficial effects of treating early AD, based on Alzheimer's Disease Assessment Scale–cognitive subscale scores are presented. The effect of delaying treatment and its effect on cognition is also discussed.

No. 25C
EXPLORING VASCULAR DEMENTIA: DIAGNOSIS, TREATMENT, AND BEHAVIOR

Helen Lavretsky, M.D., *760 Westwood Plaza, Room 37-384, Los Angeles, CA 90095*

SUMMARY:

Vascular dementia (VaD) is the second most common type of progressive dementia after Alzheimer's disease (AD) and is commonly associated with cognitive and behavioral disturbances. Although there are no approved treatments for either cognitive or behavioral disturbances of VaD, there is growing evidence that the novel cholinesterase inhibitors, such as donepezil, may be useful in preventing cognitive and functional decline, as well as in the treatment of some behavioral symptoms, such as depression, anxiety, and apathy. This presentation reviews the latest data pertaining to the diagnosis and clinical features of cognitive impairment and associated behavioral symptoms as well as the course of cognitive and functional decline. Existing treatment options and novel therapeutic approaches are also discussed.

No. 25D
EXPLORING DIFFERENCES BETWEEN VASCULAR DEMENTIA AND ALZHEIMER'S DISEASE: CASE STUDIES

Stephen P. Salloway, M.D., *345 Blackstone Boulvard, Providence, RI 02906*

SUMMARY:

Making an accurate diagnosis of dementia is important for educating patients and families and developing an effective treatment plan. Recent evidence from large-scale clinical trials demonstrates important differences between patients with vascular dementia (VaD) and Alzheimer's disease (AD). Compared with AD patients, those with VaD are more likely to be male, have abrupt onset and stepwise progression, have more vascular risk factors and executive dysfunction, and show improvement after treatment with cholinesterase inhibitors. This presentation utilizes case examples to demonstrate differences in clinical and imaging characteristics and response to treatment in each disorder. The clinical overlap between VaD and AD is discussed. Both dementias may begin in a transitional form known as mild cognitive impairment (MCI). Videotaped examples showing the features of amnestic MCI and AD and vascular MCI and VaD are presented.

No. 25E
DEFINING AND ACHIEVING POSITIVE OUTCOMES IN DEMENTIA PHARMACOTHERAPY

David Geldmacher, M.D., *P.O. Box 800394, Charlottesville, VA 22908*

SUMMARY:

Maintaining cognitive ability and daily function are primary goals in the medical approach to Alzheimer's disease (AD) throughout the spectrum of dementia severity. Regulatory and practice issues tend to emphasize assessment of cognitive outcomes rather than functional ability. However, caregivers and prescribers define and measure goals for AD pharmacotherapy differently. Many caregivers place greater emphasis on daily function and quality of life than they do cognitive benefits. Early recognition of AD symptoms provides an opportunity to intervene and reduce progression of dementia-related functional disability. This is closely aligned with caregiver desires and may have greater public health implications than delaying cognitive decline. This presentation reviews data from several clinical trials demonstrating the efficacy of cholinesterase inhibitors in non-cognitive outcomes. These studies include a placebo-controlled trial that showed that donepezil treatment for 1 year was associated with a 38% reduction in the risk of functional decline in patients with mild-to-moderate AD and a second study in which donepezil-treated patients demonstrated significantly less decline than patients who had received placebo in instrumental and basic activities of daily living in patients with moderate-to-severe AD. Additional outcomes defined as important by caregivers, such as reduced risk for, or delayed nursing home placement, have also been associated with donepezil therapy.

No. 25F
ALZHEIMER'S DISEASE PREVENTION: STRATEGIES FOR IMPROVING BRAIN AND MEMORY FITNESS

Gary W. Small, M.D., *760 Westwood Plaza 88-201, Los Angeles, CA 90024-8300*

SUMMARY:

This presentation reviews the most recent evidence on drug treatments and nonpharmacological strategies for improving and maintaining memory and brain fitness and possibly delaying the onset of Alzheimer's disease (AD). Neuroimaging and neuropathological studies indicate that brain aging begins early in adult life, many decades before people reach the average age for dementia onset. Declines in neurotransmitter systems and accumulation of amyloid plaques and neurofibrillary tangles occur in key brain regions modulating memory. Presymptomatic cognitive changes have been categorized into severity states, such as age-associated memory impairment and mild cognitive impairment, and clinical trials designed to decelerate cognitive decline rates and delay dementia onset are in progress, using cholinesterase inhibitors, antiinflammatory drugs, statins, estrogen, and ginkgo biloba. Antiplaque and antitangle drugs are in development. For people with mild forms of age-related memory loss, recent studies have demonstrated several nonpharmacological factors that may protect against the development of AD, including mental activity, physical aerobic conditioning, a healthy diet, and stress reduction. Although definitive proof of their value is not yet

available, the risks are minimal and are not likely to outweigh the many benefits.

REFERENCES:

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INDUSTRY-SUPPORTED SYMPOSIUM 26—EFFECTIVE LONG-TERM MANAGEMENT OF SCHIZOPHRENIA: REAL-WORLD CONSIDERATIONS

Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss the evolution of antipsychotics' mechanisms of action and the implications for efficacy, safety, and tolerability profiles; understand the impact of adverse effects on overall patient health and antipsychotic treatment outcomes; optimize the management of patients who are refractory to treatment with various antipsychotic agents; and evaluate clinical trials that include real-world measures of antipsychotic effectiveness.

No. 26A
THE EVOLUTION OF ANTIPSYCHOTIC AGENTS: A MECHANISM-BASED REVIEW

Anissa Abi-Dargham, M.D., *1051 Riverside Drive #42, New York, NY 10032*

SUMMARY:

The mechanisms of action of antipsychotics have evolved dramatically since the fortuitous discovery of chlorpromazine and the consequent realization that its efficacy against psychotic symptoms was related to inhibition of dopaminergic signaling at the D_2 receptor. We have since come to understand that while positive symptoms are caused by dopaminergic hyperactivity and D_2 hyperstimulation in the mesolimbic pathway, negative symptoms are caused by dopaminergic hypoactivity and suboptimal stimulation of the D_1 receptor in the mesocortical pathway. Absolute D_2 antagonism offers little efficacy against negative symptoms and in the nigrostriatal and tuberoinfundibular pathways is associated with extrapyramidal symptoms (EPS) and elevations in prolactin, respectively. Furthermore, absolute D_2 antagonism in the mesolimbic system, while therapeutic for positive symptoms, can interfere with the role of dopamine in the reward system and aggravate dysphoria and anhedonia. The second-generation agents display concomitant dopamine and serotonin 5-HT_{2A} antagonism and generally are associated with improved efficacy against negative symptoms and decreased rates of EPS, presumably due to serotonergic modulation of dopamine pathways. However, broader receptor-binding profiles and pharmacodynamic interactions have been associated with cardiovascular, Neurologic, and metabolic adverse effects. The next generation of antipsychotics stabilizes dopaminergic and serotonergic pathways through a combination of partial agonism at both dopamine D_2 and serotonin 5-HT_{1A} receptors, and antagonism at 5-HT_{2A} receptors, offering benefits for both positive and negative symptoms without the EPS, hyperprolactinemia, and dysphoria associated with absolute dopamine antagonism.

No. 26B
OPTIMIZING THE LONG-TERM EFFECTIVENESS OF ANTIPSYCHOTIC THERAPY

Stephen R. Marder, M.D., *11301 Wilshire Boulevard, Building 210A, Los Angeles, CA 90073-1003*

SUMMARY:

Antipsychotic medications are effective for treating the acute symptoms of schizophrenia and for preventing relapse for individuals who are stable. This presentation will focus on the assessment of effectiveness of long-term therapy with antipsychotics. This assessment should concentrate on the control of the symptoms of schizophrenia as well as the tolerability of the antipsychotic. Tolerability is particularly relevant during long-term treatment since even mild discomfort from side effects can lead to drug refusal or partial compliance. In addition, patients who remain in sustained drug therapy are more likely to respond to the psychosocial treatments that may improve social functioning, vocational functioning, and quality of life. This presentation will also focus on the serious health problems including diabetes, obesity, and heart disease that affect individuals with schizophrenia and will present strategies for improving health outcomes.

No. 26C
MANAGING PATIENTS WITH TREATMENT-RESISTANT SCHIZOPHRENIA

John M. Kane, M.D., *75-59 263rd Street, Glen Oaks, NY 11004-1150*

SUMMARY:

Treatment-resistant schizophrenia presents unique challenges in both clinical practice and the design of clinical trials. Clinicians treating patients for whom numerous regimens have failed face the dual challenge of limited treatment options and limited data on the efficacy of antipsychotic agents in these patients. While clozapine has demonstrated efficacy in patients refractory to treatment with conventional antipsychotics, the risk of agranulocytosis has limited its role to a treatment of last resort. Further clinical trials to measure efficacy in treatment-resistant patients are challenging because of the relatively small pool of potential patients and the difficulty of choosing an appropriate control group. This presentation will discuss the design of clinical trials for treatment-resistant schizophrenia, review the clinical data, and discuss options for optimum patient management.

No. 26D
WHAT IS EFFECTIVENESS WITH ANTIPSYCHOTIC MEDICATIONS?

Peter J. Weiden, M.D., *450 Clarkson Ave./Box 1203, Brooklyn, NY 11203*

SUMMARY:

Outcomes research in schizophrenia has demonstrated that there can be clinically meaningful differences between efficacy (response as measured in clinical trials) and effectiveness (outcomes under conditions of usual practice). During the previous era of conventional antipsychotics, it took many years of clincial experience to learn how to best use these medications in long-term maintenance treatment. It has been about 10 years since the "atypical" antipsychotics have become widely used and we are now in the position to understand

potential differences between efficacy and effectiveness with the newer agents. We are also learning about other important factors in real-world effectiveness including cognition, motivation, and the ability to move away from disability and engage in everyday life. This presentation will cover recent examples of effectiveness research that address some of these important treatment goals.

REFERENCES:

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2. King DJ: Drug treatment of the negative symptoms of schizophrenia. Eur Neurpsychopharmacol 1998; 8(1):33–42.
3. Kane JM: Treatment-resistant schizophrenic patients: J Clin Psychiatry 1996; 57 Suppl 9:35–40.
4. Kujawa M, Saha AR, Ingenito G, et al: Aripiprazole for long-term maintenance treatment of schizophrenia [abstract P.4.E.032]. Int J Neuropsychopharmacol 2002; 5(suppl 1):S186.

INDUSTRY-SUPPORTED SYMPOSIUM 27—MODERATORS AND MEDIATORS OF ANTIDEPRESSANT RESPONSE

Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize that demographic and clinical characteristics can affect treatment outcome, as can variable aspects of treatment itself (such as duration of treatment and adherence to medication regimen), so that treatment decisions can be better informed.

No. 27A
MODERATORS AND MEDIATORS OF TREATMENT EFFECTS IN ANTIDEPRESSANT TRIALS

Philip Lavori, Ph.D., *Stanford, CA 94305*

SUMMARY:

Among currently available antidepressant agents, even the most potent are limited in their effects, helping many but not all patients. Thus, efforts to improve the effectiveness of pharmacologic treatment for depression will require a better understanding of which patients are most likely to benefit from a particular treatment and why this is so. Conceptually, moderators of treatment identify for whom and under what circumstances a treatment is effective, whereas mediators suggest possible mechanisms through which a treatment exerts benefit. Looked at another way, moderators of response are variables that are not correlated with treatment but that affect outcome, such as demographic or clinical characteristics that exist prior to treatment. Mediators, by comparison, are variables that occur during the course of treatment that may affect outcome. Examples include dose of medication and duration of treatment. Well-controlled and randomized trials are uniquely valuable in generating hypotheses about potential moderators and mediators of outcome that can then be used to inform the next generation of clinical investigations. Ultimately, knowledge of moderators and mediators can suggest to clinicians which of their patients may respond preferentially to one treatment versus another and suggest treatment strategies and tactics that increase the likelihood of a favorable outcome.

No. 27B
GENDER AS A MODERATOR OF ANTIDEPRESSANT RESPONSE

Susan G. Kornstein, M.D., *P.O. Box 980710, Richmond, VA 23298*

SUMMARY:

One of the most consistent findings in psychiatric epidemiology is that depressive disorders are about twice as common in women as in men, particularly during the childbearing years. There also appear to be gender-related differences in clinical presentation, course of illness, and treatment response. Results from randomized clinical studies have demonstrated that gender may be a moderator of both responsivity to and tolerability of antidepressant treatment. That differences in antidepressant response rates have been observed primarily in premenopausal women suggests that female sex hormones may interact with treatment modalities to affect outcome. This presentation reviews available evidence regarding differences in the phenomenology and treatment of depression in men and women, with a focus on gender differences in response to antidepressant treatment.

No. 27C
MOVING THE GOALPOSTS: TREATING BEYOND RESPONSE TO REMISSION

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

SUMMARY:

Major depression is an episodic, but often recurrent disorder, associated with considerable mortality, morbidity, and functional impairment. Despite the chronic nature of the illness, the great majority of antidepressant clinical trials focus on short-term efficacy, with response typically defined as a 50% reduction in symptoms after 6 to 8 weeks of treatment. Accumulating evidence over the past decade, however, suggests that full remission—the virtual elimination of depressive symptoms and restoration of psychosocial functioning—should be the primary goal of the initial phase of therapy. Treating a depressive episode to full remission is associated with significant improvement in the patient's clinical status, functional ability, and quality of life, as well as lower resource utilization costs related to the disease and its comorbidities. Moreover, patients who achieve remission are less likely to relapse than those who do not. Unfortunately, only about 35% to 40% of patients will achieve remission after 6 to 8 weeks of antidepressant treatment, and there is little empirical data to inform treatment decisions for patients who, despite substantial improvement from baseline, show residual symptoms after a short course of therapy. Implications for the future design of clinical trials, as well as strategies to achieve full remission in clinical practice, are discussed.

No. 27D
ANTIDEPRESSANT TREATMENT DURATION: THE DECISION TO CONTINUE OR SWITCH TREATMENT

Harold A. Sackeim, Ph.D., *1051 Riverside Drive, Unit 126, New York, NY 10032*

SUMMARY:

The optimal duration of acute-phase antidepressant treatment is uncertain. There are divergent goals when considering trial duration. One goal is to ensure that patients have sufficient opportunity to remit by providing sufficient treatment exposure, which may require a long trial duration. The second goal is to minimize exposure to inefficient treatment that prolongs suffering and may exacerbate

morbidity by contributing to hopelessness and subsequent treatment nonadherence or refusal. To minimize exposure to ineffective treatment, it is necessary to determine the shortest trial duration that will detect patients unlikely to remit. The adoption of remission as the treatment aim has deepened the divergence between these goals. More time is needed for patients to achieve remission, compared to response, leading to longer trial duration. However, while it is generally estimated that 50%–70% of patients respond during an acute-phase antidepressant trial, only 20%–45% achieve remission. Therefore, the majority of patients have prolonged exposure to treatment that does not result in remission. Analyses of large databases from randomized clinical trials of antidepressant treatment using signal detection theory provide critical data that allow the clinician to make evidence-based decisions about when to switch or continue a patient's antidepressant treatment. The goals of minimizing exposure to ineffective treatment and yet maximizing remission rates cannot be fulfilled by the use of fixed treatment duration in antidepressant trials and require the adoption of an innovative approach.

No. 27E
PLACEBO, COMPARATOR, OR OPEN TREATMENT? DESIGN COUNTS

Steven P. Roose, M.D., *1051 Riverside Drive, New York, NY 10032*

SUMMARY:

One mediator of treatment response that has been often overlooked is the study design itself. Compared to placebo-controlled trials, comparator trials consistently reported greater effect sizes and higher response and remission rates. This greater antidepressant effect in comparator trials is often attributed to physician and patient bias. All parties know that the patient is receiving an active treatment, and consequently there are increased expectations that improvement will occur. These expectations result in higher rates of response and remission, due to a combination of rater bias in outcome assessment and greater actual improvement due to the effects of patient expectancies. Another factor is that many patients find it disconcerting, or even humiliating, to respond to a placebo, believing that they will be labeled as hypochondriacal. Thus it is acceptable to be a medication nonresponder, but not a placebo responder. Therefore, patients may report minimal improvement to protect against an embarrassing outcome. Though placebo trials are necessary to establish treatment efficacy, in many ways they represent the most radical departures from standard practice, and the results may be the least generalizable. In contrast, it can be argued that comparator, or even open, trials of antidepressants may more truly reflect the response and remission rates that can be expected in clinical practice. This presentation reviews outcome data from placebo, comparator, and open trials of the same medication in the same patient population and discusses the research and clinical implications of the findings.

REFERENCES:

1. Kraemer HC, Wilson GT, Fairburn CG, Agras WS: Mediators and moderators of treatment effects in randomized clinical trials. Arch Gen Psychiatry 2002; 59:877–883.
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3. Schatzberg AF, Kraemer HC: Use of placebo control groups in evaluating efficacy of treatment of unipolar major depression. Biol Psychiatry 2000; 47:736–744.
4. Nierenberg AA, Farabaugh AH, Alpert JE, et al: Timing of onset of antidepressant response with fluoxetine treatment. Am J Psychiatry 2000; 157:1423–1428.
5. Frank E, Prien RF, Jarrett RB et al: Conceptualization and rationale for consensus definitions of terms in major depressive disorder: remission, recovery, relapse, and recurrence. Arch Gen Psychiatry 1991; 48:851–855.

INDUSTRY-SUPPORTED SYMPOSIUM 28—BEYOND SLEEP ONSET: NEW PERSPECTIVES ON THE TREATMENT OF INSOMNIA
Supported by Sepracor, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to describe the prevalence of insomnia and its impact on daytime function; list the key elements of the sleep history and describe how sleep history findings can be used in the differential diagnosis; define measures of hypnotic efficacy; and discuss management of insomnia.

No. 28A
PREVALENCE AND IMPACT OF INSOMNIA: TREATING THE ENTIRE INSOMNIA SYNDROME

Mugdha E. Thakur, M.D., *Box 3309, Durham, NC 27710*

SUMMARY:

Prevalence rates for chronic and transient insomnia in the general population have been estimated to be 10% to 15% and 25% to 35%, respectively. Prevalence estimates for patients with psychiatric and medical conditions have been found to be even higher, and recent evidence suggests that insomnia may be a growing problem. Socioeconomic and personal costs related to insomnia and its consequences are high. There is also growing evidence that insomnia may contribute to the development of depression, and is associated with risk of relapse and worsened outcomes in patients with depression, and that treating secondary insomnia may improve outcomes in some psychiatric conditions, like depression and bipolar disorder. This presentation will serve to present recent research evidence for the burden of primary and secondary insomnia and will focus on current thinking regarding the impact of insomnia, and the various symptoms of insomnia on quality-of-life and daytime function. We will highlight the importance of insomnia recognition in the busy psychiatric practice and present evidence for the importance of appropriate diagnosis and management of this condition.

No. 28B
DIFFERENTIAL DIAGNOSIS OF INSOMNIA AND COMORBID CONDITIONS: IMPORTANCE OF SLEEP HISTORY

Jed E. Black, M.D., *401 Quarry Road, 3301, Stanford, CA 94305*

SUMMARY:

Insomnia is frequently seen in the busy psychiatric setting, occurring in an estimated 40% of this population. While questions regarding insomnia form a large part of the specific history of many psychiatric illnesses, evidence suggests that insomnia tends to be underdiagnosed. In addition, many illnesses such as sleep apnea and restless leg syndrome can lead to symptoms of insomnia, such as difficulty staying asleep and diminished next-day functioning. This presentation will focus on the importance of appropriately diagnosing the patient presenting with a history of insomnia, and how this impacts appropriate management. We will also focus on the importance of the sleep history in establishing the presence of insomnia symptoms, identifying comorbid conditions, and developing the differential diagnosis.

No. 28C
MEASURES OF TREATMENT EFFICACY

Thomas Roth, Ph.D., *2799 West Grand Boulevard, CFP3, Detroit, MI 48202*

SUMMARY:

The measurement of hypnotic efficacy has evolved in the last few years. Historically, subjective measures were used to appraise subjects sleep the previous night. While measures like these are important, they were not objectively validated. Validation of efficacy measures has been made possible with the advent of polysomnography (PSG). Initially PSG was used to measure sleep efficiency and total sleep time, but with the development of newer, shorter acting agents, sleep onset measures, such as latency to sleep onset, were emphasized. However, sleep maintenance problems are more common in some populations, such as the elderly, and insomnia is defined as difficulty in initiating sleep, maintaining sleep, or obtaining restorative sleep. Therefore, evaluation of a drug's efficacy should include measures of sleep induction, sleep maintenance, and sleep quality. In the future, sleep efficacy measures may evolve to evaluate the impact of improved sleep on daytime functioning and medical and psychiatric illnesses.

No. 28D
OVERVIEW OF INSOMNIA TREATMENT

Andrew D. Krystal, M.D., *Box 3309/Room 54216/Trent Drive, Durham, NC 27710*

SUMMARY:

Evidence suggests that insomnia is underdiagnosed and undertreated. However, when a patient has been diagnosed, the practitioner faces a number of challenges in instituting treatment. Little data exist to guide management in the most frequent types of insomnia problems including (1) insomnia occurring in the setting of a psychiatric disorder (40% of psychiatric patients have insomnia), (2) difficulties staying asleep (82% of insomnia patients), and (3) chronic insomnia (duration exceeds one year in 20% to 36%). This presentation will review the literature on the management of insomnia in these settings and provide strategies for optimizing management based on the available research.

REFERENCES:

1. Roth T, Ancell-Israel B: Daytime consequences and correlates of insomnia in the United States: results of the 1991 National Sleep Foundation Survey. II. Sleep 1999; 22 Suppl 2:S356–S358.
2. Ohayon MM: Prevalence of DSM-IV diagnostic criteria of insomnia: distinguishing insomnia related to mental disorders from sleep disorders. J Psychiatr Res 1997; 31:333–346.
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4. Roth T: New developments for treating sleep disorders. J Clin Psychiatry 2001; 62 Suppl 10:3–4.

INDUSTRY-SUPPORTED SYMPOSIUM 29—PSYCHOPHARMACOLOGY AND REPRODUCTIVE TRANSITIONS: IMPACT OF PSYCHOTROPIC MEDICATIONS AND SEX HORMONES ON BRAIN FUNCTIONING, WEIGHT, AND REPRODUCTIVE SAFETY
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the existing data on the impact of psychotropic agents on reproductive safety issues and weight gain; to recognize the complex interactions between sex hormones changes and aging men and women.

No. 29A
LABELING PRODUCTS FOR USE IN PREGNANCY: MOVING FORWARD

Sandra L. Kweder, M.D., *1451 Rockville Pike, HFD 020, Rockville, MD 20852*

SUMMARY:

Drug labeling is one source of information; however, it is usually outdated regarding teratogenic risks. Multiple other sources are available to assist physicians in assessing reproductive toxicities from drug exposures. The online REPRORISK system (available from Micromedex) contains electronic versions of four teratogen information databases: REPROTEXT, REPROTOX, Shepard's Catalog, and TERIS. These resources are updated and scientifically reviewed and provide a critical evaluation of the literature regarding human and animal pregnancy drug exposures. More than 20 comprehensive multidisciplinary Teratogen Information Services (TIS) are located in the United States and Canada that provide patient counseling and risk assessments regarding potential teratogenic exposures (www.otispregnancy.org). The National Society of Genetic Counselors (www.nsgc.org) also can locate genetic counselors in most geographic regions. Erroneous information about drug-associated teratogenic risks is prevalent and can result in unwarranted anxiety along with unnecessary health care interventions, including elective termination of wanted pregnancies.

The FDA is working to improve the information contained in the pregnancy section of product labeling and has been proactive in encouraging the collection of more and better data about drug effects during pregnancy (both to mother and fetus) through the use of pregnancy exposure registries. This ongoing process will be discussed during this presentation, as well as an update on existing sources available to assist physicians in assessing reproductive toxicities from drug exposures.

No. 29B
WEIGHT GAIN, PSYCHOTROPIC MEDICATIONS, AND GENDER: POTENTIAL PHARMACOLOGIC STRATEGIES

Barbara L. Gracious, M.D., *300 Crittenden Boulevard, Rochester, NY 14642*

SUMMARY:

Weight gain due to psychotropic medication is increasingly recognized as a serious problem for our patients who have no other viable options for non-weight inducing effective pharmacologic treatment. Potential consequences of weight gain include not only insulin resistance, but also a constellation of findings that are collectively known as the metabolic syndrome, which increases risk for diabetes as well as cardiovascular disease, leading to multiple systemic organ impairment.

This presentation will review the data to date on the gender-related characteristics associated with weight gain induced by psychotropic medications, and their subsequent systemic effects. Potential novel pharmacologic options for management will be discussed.

No. 29C
TESTOSTERONE DECLINE IN THE AGING MALE: DOES ANDROPAUSE EXIST?

Stuart N. Seidman, M.D., *617 West End Avenue, Suite 1B, New York, NY 10024*

SUMMARY:

In contrast to women, men do not experience a sudden cessation of gonadal function comparable to menopause. However, there is a progressive decline in hypothalamic-pituitary-gonadal (HPG) function in aging men; testosterone (T) levels decline and there is a loss of circadian rhythm of T secretion. By age 75, mean plasma T levels have decreased 35% compared with young adults, and more than 25% of men this age are clinically hypogonadal. Age-related hypogonadism, which has been term "andropause," is thought to be responsible for a variety of symptoms experienced by elderly men, including reduced muscle and bone mass, sexual dysfunction, depression, fatigue, and irritability. However, it has been difficult to establish correlations between these symptoms and plasma T levels. Studies of T replacement have documented some symptom relief (e.g., improved muscle strength and bone mineral density), yet studies to date on the specific relation between depression and T level have been methodologically flawed. Data will be presented from systematic clinical and epidemiological studies with bearing on this relation: (1) placebo-controlled trials of T replacement in men with major depressive disorder (MDD), and (2) population-based assessments of the relation between T level, genetic factors, and depression in elderly men. Results suggest that age-related HPG hypofunction may have particular etiologic importance in late-onset male dysthymia.

No. 29D
PERIMENOPAUSE-RELATED MOOD DISTURBANCE: AN UPDATE ON RISK FACTORS AND NOVEL TREATMENT STRATEGIES AVAILABLE

Claudio N. Soares, M.D., *15 Parkman Street, WAC 812, Boston, MA 02114*

SUMMARY:

The menopausal transition has been associated with a higher risk for exacerbation of depressive symptoms. It has been speculated that sex steroids exert a significant modulation of brain functioning, possibly through interactions with various neurotransmitter systems. It is therefore intuitive that abrupt alterations of these hormones would interfere with mood and behavior. However, accumulating data suggest that hormonal interventions may also promote relief or even remission of depressive symptoms.

This presentation will critically review existing data on the complex interactions between sex hormones and mood during the perimenopause. Recent findings derived from a community-based, prospective study (The Harvard Study of Moods and Cycles) will be discussed, including data on prevalence and risk factors for new onset of depression during the perimenopause. Essentially, it has been suggested that even women without history of depression may be at higher risk for developing clinically significant depressive symptoms while approaching menopause, particularly if presenting with significant vasomotor symptoms. The recent controversy involving hormone therapy strengthens the need for novel hormonal and non-hormonal treatment alternatives for the range of symptoms experienced by the growing population of menopausal patients. Thus, data on the efficacy of antidepressants for menopause-related symptoms will be critically reviewed.

No. 29E
ESTROGEN PLUS PROGESTIN AND THE INCIDENCE OF DEMENTIA AND MILD COGNITIVE IMPAIRMENT IN POSTMENOPAUSAL WOMEN: THE WOMEN'S HEALTH INITIATIVE MEMORY STUDY UPDATES

Sally A. Shumaker, Ph.D., *2000 West First Street Piedmont Plaza II, Winston-Salem, NC 27104;* Claudine Legault, Ph.D.; Stephen R. Rapp, Ph.D.

SUMMARY:

Postmenopausal hormone therapy has been associated with beneficial effects on cognition in animal studies; observational epidemiologic cohort studies suggest that hormone therapy reduces women's risk for Alzheimer's disease. Clinical trial evidence to date, however, has been equivocal. The WHI Memory Study (WHIMS) is a randomized, double-blind, placebo-controlled clinical trial designed to evaluate the impact of estrogen plus progestin on the incidence of dementia and mild cognitive impairment relative to placebo. A total of 4,532 women, 65 years of age and older, were followed for an average of four years. They were randomized to receive either conjugated equine estrogen, 0.625 mg, plus 2.5 mg medroxyprogesterone acetate (N = 2,229), or a matching placebo (N = 2,303). The main outcomes were probable dementia and mild cognitive impairment (MCI) identified through a structured clinical assessment. Overall, 61 women were diagnosed with probable dementia, 40/2,229 in the E+P group compared with 21/2,303 in the placebo group. The hazard ratio for probable dementia was 2.05 (95% CI = 1.21–3.48, 45 vs 22 per 10,000 person-years, p = 0.01). Alzheimer's disease was the most common classification of dementia in both study groups. There were no differences in treatment effects on mild cognitive impairment. No interactions were found between treatment and risks for dementia (e.g., age, education, prior history of stroke, prior hormone, or statin use). In addition, controlling for adherence to study protocol did not alter the findings. E+P did not prevent mild cognitive impairment in these women. These data will be discussed within the context of prior studies suggesting a potential benefit of hormone therapy on cognition and dementia prevention.

REFERENCES:

1. Uhl K, Kennedy DL, Kweder SL: Accurate information on drug effects on pregnancy is crucial. Am Fam Physician 2003; 67(4):700–1.
2. Gracious BL, Krysiak TE, Youngstrom EA: Amantadine treatment of psychotropic-induced weight gain in children and adolescents: case series. J Child Adolesc Psychopharmacol 2002; 12(3):249–57.
3. Seidman SN. Testosterone deficiency and mood in aging men: pathogenic and therapeutic interactions. World J Biol Psychiatry 2003; 4(1):14–20.
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INDUSTRY-SUPPORTED SYMPOSIUM 30—CHOOSING THE RIGHT DOSE OF ATYPICAL ANTIPSYCHOTICS: ART OR SCIENCE?
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should appreciate dosing profiles of each atypical antipsychotic; appreciate dosing strategies for stabilization and maintenance pharmacotherapy in schizophrenia and bipolar disorders; understand the impact of antipsychotic polypharmacy.

No. 30A
DOSING WITH ATYPICALS: RECEPTOR OCCUPANCY AS A GUIDE TO TITRATION AND MAINTENANCE

Shitij Kapur, M.D., *250 College Street, Toronto, ON Canada M5T 1R8*

SUMMARY:

Dosing is an essential element of drug action, and while great attention is paid to design of the molecules, relatively lesser attention is paid to their dosing in practice. This talk will review the contributions of receptor occupancy studies toward understanding the optimal dose for antipsychotics. The presentation will first review some of the concepts that allow us to use occupancy as a means of dose determination, followed by a discussion of findings with haloperidol, olanzapine, risperidone, and ziprasidone, which generally conform to the 60% to 70% D_2 occupancy rule for dosing. Variations to the rule, as defined by the action of clozapine, quetiapine, and aripiprazole, will be addressed, as well as the concept of occupancy to unite findings at the "bench" to the "bedside." Finally, the presentation will show that there is no "delayed-onset" of antipsychotic effect and that there is a closer relationship between dopamine blockade and antipsychotic response than was originally anticipated. Implications of these ideas for once-a-day dosing, extended dosing, depot antipsychotics, and other newer medications will be discussed.

No. 30B
ACUTE STABILIZATION OF PSYCHOSIS: OPTIONS AND APPROACHES

K.N. Roy Chengappa, M.D., *3811 O'Hara Street, Pittsburgh, PA 15213-2593*

SUMMARY:

Acute psychotic episodes in the context of schizophrenia, schizoaffective or bipolar disorder, drug-induced conditions, or dementia often present as psychiatric emergencies. The medical management may involve hospitalization and the administration of short-acting injectable antipsychotic and anxiolytic agents or the use of liquid or quick-dissolving formulations of these agents. Not uncommonly, interventions, such as the use of physical restraint or seclusion, may occur in these situations.

Data to guide clinicians regarding the dosage and administration of the first- or second-generation antipsychotic agents for such acute use are typically sparse. Further, combinations of the antipsychotic agents plus either benzodiazepines or anticonvulsants, which are typically employed in clinical practice, are backed by minimal empirical data. Consequently, and not unexpectedly, clinicians tend to favor the "tested and true" combinations of the first-generation antipsychotic agents and benzodiazepines in emergency settings. While these combinations have been effective, they also cause dystonias, akathisia, rigidity, and orthostasis, which result in short- and long-term nonadherence and serious relapses.

This presentation will focus on dosage and administration strategies of the antipsychotic agents either as monotherapy or in combination with benzodiazepines or anticonvulsant agents for the treatment of acute psychotic episodes in schizophrenia or schizoaffective disorder, and differentiate these from dosage administration in bipolar disorder.

No. 30C
STRATEGIES FOR MAINTENANCE PHARMACOTHERAPY: HIGH, LOW, OR SWITCH?

Peter F. Buckley, M.D., *1515 Pope Avenue, Augusta, GA 30912-3800*

SUMMARY:

Finding and staying on the antipsychotic medication that works best and has the fewest side effects in a given patient still remains (in spite of our advances in pharmacotherapy) somewhat a process of trial and error. This is most relevant for the maintenance pharmacotherapy of schizophrenia, wherein clinicians and patients must jointly juxtapose efficacy and tolerability considerations of the atypical antipsychotic at its current dose, at a higher dose (if tolerability permits and if efficacy requires), with switching to another agent as the next choice in the individualized treatment algorithm. Evidence from research that bears upon this complex decision derives from maintenance and dosing clinical trials, direct head-to-head comparisons of atypical antipsychotics, and switching and naturalistic trials of each of these agents. Treatment algorithms offer broad guidance but can be readily outdated by emergent data on new agents and by new studies directly comparing atypical antipsychotics. A key consideration throughout this synthesis of information from these disparate is the appropriate dose of the atypical antipsychotic. This presentation will draw from several data sources (comparative trials, the latest data on prescription practices in several settings, emergent naturalistic and switching trials) to illuminate the current practice and direction for dosing with each of the atypical antipsychotics. Because this is a topic of keen interest and will likely evoke vigorous audience response, an interactive format will be used for this presentation.

No. 30D
ADMINISTRATION OF ATYPICALS IN BIPOLAR DISORDER

Claudia F. Baldassano, M.D., *3535 Market Street, 2nd Floor, Philadelphia, PA 19104-3309*

SUMMARY:

Atypical antipsychotic medications are widely used for the treatment of bipolar disorder. Most empirical data suggest that these medications are efficacious in the treatment of acute mania, and there is emerging evidence to support their mood-stabilizing and antidepressant properties. This literature will be reviewed.

Bipolar patients are more sensitive to side effects compared with schizophrenic patients and, therefore, dosing strategies may differ. Dosing strategies of the atypical antipsychotic medications during all phases of illness will be reviewed and a practical algorithm will be presented.

No. 30E
IS POLYPHARMACY THE RESULT OF CONFUSED DOSING STRATEGIES FOR ATYPICAL ANTIPSYCHOTICS?

Alexander L. Miller, M.D., *7703 Floyd Curl Drive, San Antonio, TX 78249*

SUMMARY:

Many patients treated with an antipsychotic are also on other psychotropic agents, including second and even third antipsychotics. This presentation will explore some of the issues of medication dosing that can lead to antipsychotic polypharmacy when monotherapy would be sufficient. These issues include inadequate dosing, inappropriately brief dosing, and partial patient adherence (covert underdosing). The need to complete cross-titrations of antipsychotics and the importance of measuring and documenting treatment outcomes will be emphasized. Strategies for recognizing unnecessary polypharmacy and for simplifying medication regimens will be discussed.

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MONDAY MAY 3, 2004

INDUSTRY-SUPPORTED SYMPOSIUM 31—NEW ADVANCES IN THE TREATMENT OF PSYCHOSIS, PART 1
Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the special characteristics of geriatric patients with dementia and how they impact treatment options, optimize the management of geriatric patients with dementia who present with common comorbidities, discuss the key criteria influencing the choice of the most appropriate antipsychotics for the pediatric patient with psychotic symptoms, and understand the need for and the clinical implications of early antipsychotic pharmacotherapy in first-episode patients.

No. 31A
PSYCHOSIS ASSOCIATED WITH DEMENTIA: EFFICACY OF THE NEWER ANTIPSYCHOTICS

Dilip V. Jeste, M.D., *VA La Jolla Village Drive, 116A-1, San Diego, CA 92161*

SUMMARY:

Psychotic disorders are prevalent in the long-term care setting, with Alzheimer's disease and other dementias being the underlying factor in a majority of these patients. Dementias have multiple overlapping causes, and the pathophysiology of these disorders is not yet fully understood. The essential features of dementia are multiple cognitive impairments, generally accompanied by different degrees of disruptive behavior. Psychotic symptoms develop in more than 50% of patients with dementia and tend to persist for months and even years. Accompanied by agitation and aggression, these symptoms often lead to high caregiver distress. Emerging clinical evidence indicates that atypical antipsychotics are at least as effective as conventional antipsychotics for the treatment of geriatric psychosis while having fewer adverse effects, including worsening cognitive deficits. Cognitive abilities play an important role in everyday functioning. Geriatric studies are ongoing to assess the efficacy and safety of the newer antipsychotics in geriatric patients with dementia. Data from recently completed trials are presented and are compared and contrasted with those from earlier reports.

No. 31B
ANTIPSYCHOTIC THERAPIES IN PEDIATRIC PATIENTS: THE IMPORTANCE OF SAFETY AND TOLERABILITY

Robert L. Findling, M.D., *11100 Euclid Avenue, Cleveland, OH 44106-5080*

SUMMARY:

Children with serious psychiatric disorders and externalizing behavior problems may present with psychotic symptoms. The pharmacologic management of aggression in children and adolescents is often necessary. Initial progress is being made in the development of psychopharmacotherapy for conduct disorders of the young, although a considerable gap persists in the knowledge of treatment efficacy and long-term safety in children and adolescents, compared to adults. Atypical antipsychotics can play an important role in these populations, where safety and tolerability concerns are paramount. This presentation reviews the most recent data on the use of antipsychotics in pediatric populations. Efficacy results and associated adverse effects from selected clinical trials are presented. The pharmacokinetic and pharmacodynamic profiles of the newer antipsychotic agents in pediatric patients are discussed.

REFERENCES:

1. Katz IR, Jeste DV, Mintzer JE, Clyde C, Napolitano J, Brecher M: Comparison of risperidone and placebo for psychosis and behavioral disturbances associated with dementia: a randomized, double-blind trial. Risperidone Study Group. J Clin Psychiatry 1999; 60:107–115.
2. Findling RL, Schulz SC, Reed MD, Blumer JL: The antipsychotics: a pediatric perspective. Pediatr Clin North Am 1998; 45:1205–1232.
3. Koro CE, Fedder DO, L'Italien GJ, et al: Assessment of independent effect of olanzapine and risperidone on risk of diabetes among patients with schizophrenia: population based nested case-control study. BMJ 2002; 325:243.
4. Strakowski SM, Williams JR, Sax KW, Fleck DE, DelBello MP, Bourne MI: Is impaired outcome following a first manic episode due to mood-incongruent psychosis? J Affect Disord 2000; 61(1–2):87–94.

INDUSTRY-SUPPORTED SYMPOSIUM 32—CURRENT ALZHEIMER'S DISEASE TREATMENTS AND BEYOND: ADVANCES IMPACTING CLINICAL PRACTICE, PART 1
Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize how current findings in AD genetics provide insights for new treatments; evaluate alternative therapeutic options for possible treatment and prevention of AD; discuss the assessment and treatment of AD-associated neuropsychiatric symptoms; understand the impact of emerging neuroimaging techniques.

No. 32A
THE MOLECULAR GENETICS OF ALZHEIMER'S DISEASE

Rudolph Tanzi, Ph.D., *114 16th Street, Charleston, MA 02129*

SUMMARY:

Over the past 15 years, groundbreaking research has provided important molecular and genetic insights into the pathogenesis of the

devastating neurodegenerative disorder, Alzheimer's disease (AD). These landmark findings include the identification of five different genes implicated in familial AD, all of which have been shown to affect the accumulation of beta-amyloid, the primary component of AD amyloid plaques. Of these, the genes encoding amyloid precursor protein (APP) and presenilins 1 and 2 (PSEN1, PSEN2) cause defects that directly contribute to the onset of AD before the age of 60 years and lead to an increased generation of beta-amyloid. Variants in two other AD-associated genes (APOE4 and A2M) indicate an increased risk of late-onset AD and predominantly hinder the clearance and degradation of beta-amyloid in the brain. In addition to the continued search for genetic risk factors, ongoing research will seek to connect particular genetic defects to altered molecular pathways, which may provide us with novel therapeutic strategies. Ultimately, it may be possible to identify and characterize individuals with predisposing genetic factors and deliver a tailored treatment regimen.

No. 32B
DIVERSITY OF NEUROPSYCHIATRIC IMPAIRMENT: COGNITIVE AND BEHAVIORAL IMPLICATIONS

Jeffrey L. Cummings, M.D., *710 Westwood Plaza, Los Angeles, CA 90095*

SUMMARY:

Alzheimer's disease (AD) patients experience not only a loss of cognitive function but also devastating behavioral symptoms, including depression, agitation, psychosis, and apathy. These neuropsychiatric symptoms contribute significantly to the personal cost and caregiver burden associated with AD. Studies addressing treatment of these behavioral symptoms in AD have included both pharmacologic (e.g., SSRIs, antipsychotics, anticonvulsants, and cognitive enhancers) and non-pharmacologic options, though successful management most often involves drug therapy. Recent clinical data for the pharmacologic treatment of behavioral disturbances, as well as new tools for the characterization of neuropsychiatric symptoms of AD will be reviewed. Finally, the heterogeneous incidence of behavioral disturbances must be recognized, and an understanding of the underlying neurochemistry and genetics of particular AD-associated behavioral disorders will be discussed, providing new insights for emerging treatments or treatment strategies.

INDUSTRY-SUPPORTED SYMPOSIUM 33—RECOGNIZING THE MANY FACES OF BIPOLAR DISORDER, PART 1
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should be able to recognize the presentation of bipolar disorder in childhood and late life, understand the functional outcomes of the illness and new directions in medication development.

No. 33A
DIFFERENTIAL DIAGNOSIS OF BIPOLAR DISORDER: CLINICAL FINDINGS

Stephan H. Heckers, M.D., *115 Mill Street, Belmont, MA 02478*

SUMMARY:

Patients with bipolar disorder may present with the signs and symptoms of mania, depression, or psychosis. This constellation of clinical features overlaps with unipolar depression and several psychotic illnesses, including schizophrenia, schizoaffective disorder, and drug-induced psychoses. When followed over time, many patients with bipolar disorder can be diagnosed accurately based on the characteristic time course of manic and depressive episodes. For some patients, however, the differential diagnosis can be challenging, especially when both affective and psychotic symptoms are prominent.

The presentation will address the clinical challenges in the differential diagnosis of bipolar disorder. We will review whether the timing, the degree, or the constellation of affective and psychotic symptoms are helpful in the differential diagnosis of bipolar disorder. In addition, neuroimaging and genetic studies have provided new insights into the etiology and neural mechanisms of bipolar disorder. We will outline how these novel findings can assist in the differential diagnosis of bipolar disorder.

No. 33B
RECOGNIZING BIPOLAR DISORDER IN CHILDREN AND ADOLESCENTS

Gabrielle Carlson, M.D., *Putnam Hall South Campus, Stony Brook, NY 11794-8790*

SUMMARY:

There is considerable interest and controversy regarding the diagnosis and pharmacologic treatment of bipolar disorder in youth. Some of the recent interest has been related to the findings from several research groups that bipolar disorder may be comorbid with ADHD in youth. However, children with bipolar disorder rarely present with long cycles of elated mood, expansive mania, or abject depression, and rapid cycles may be hard to distinguish from the disinhibited, labile behavior of the hyperactive/impulsive child. Moreover, the phenomenology of other conditions in childhood easily lend themselves to confusion with bipolar disorder, especially if one does not understand the effects of development on activity level, language, cognition, self-control, and reality testing. The point of making a clinical diagnosis is to inform the patient and family of prognosis and treatment. Although there is some divergence as to the best label for children with severe emotional lability, aggression, and disinhibition, there is little disagreement that the condition is serious, chronic, difficult-to-treat, and doesn't generally evolve into classic bipolar disorder.

No. 33C
BIPOLARITY IN OLD AGE: DIAGNOSTIC AND MANAGEMENT ISSUES

Kenneth I. Shulman, M.D., *2075 Bayview Avenue, Toronto, ON Canada M4N 3M5*

SUMMARY:

A high prevalence of comorbid neurologic disorders in old age poses special challenges for diagnosis, classification, and management. Affective vulnerability combined with right-sided heterogeneous cerebrovascular pathology involving the orbitofrontal cortex are all relevant in the manifestation of mania in late life. Are manic syndromes in old age a form of frontal disinhibition as seen in neurologic descriptions of secondary mania and frontotemporal dementia? Is vascular mania a separate subtype? The clinical presentation in old age often involves cognitive and executive brain dysfunction in addition to the traditional symptoms of bipolarity.

A discussion of special issues in the management of elderly patients with bipolar disorder includes attention to neurological assessment and treatment as late-onset mania is highly suggestive of a recent neurological insult. Special aspects of pharmacological management with lithium carbonate, other mood stabilizers, and atypical

neuroleptics will be reviewed, including pharmacokinetic and pharmacodynamic changes associated with old age. Guidelines for clinicians will be presented for managing elderly patients with bipolar disorder whose illness has been evident from early in life as well as late onset cases. Combination therapies may be the optimal approach in an elderly population especially vulnerable to side effects and toxicity and will be discussed.

REFERENCES:

1. Carlson GA: Current concepts of bipolar disorder in youth, in The Many Faces of Depression in Childhood and Adolescents. Edited by Shaffer D, Waslick B (editors), APA Annual Review of Psychiatry, APPI Press Washington, DC 2002, pp 105–128.
2. Heckers S: How many bipolar mixed states are there? Harvard Review of Psychiatry 2002; 10:276–279.
3. Shulman KI, Hermann N: The nature and management of mania in old age. The Psychiatric Clinics of North America 1999; 22(3):649–665.

INDUSTRY-SUPPORTED SYMPOSIUM 34—EVIDENCE-BASED MEDICINE: THE NEXT GENERATION, PART 1
Supported by Wyeth Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand how judgments are made under conditions of uncertainty and how to use evidence in the treatment of depression and anxiety.

No. 34A
HOW TO MAKE JUDGMENTS UNDER UNCERTAINTY

K. Ranga R. Krishnan, M.D., *Box 3018, Durham, NC 27710*

SUMMARY:

When clinicians make decisions during the evaluation of patients and in treatment selection, they have to make judgments using limited information. The cognitive process by which these intuitive judgments are made are of great theoretical and practical interest. In the 1960s, Tversky and Kahnemann introduced the notion that individuals acting under uncertain conditions use a limited number of cognitive processes that are quick and generally accurate. The automatic cognitive processes, the strategies that people use to make everyday judgments, are called heuristics. Classic examples of heuristics are representativeness and availability. Representativeness is based on assessing similarity, reflecting the believe that a member of a category should resemble the prototype. The availability heuristic refers to the common process by which individuals estimate the likelihood of an event by the ease with which instances come to mind. These approaches are practical, common, and often extremely accurate, but they sometimes lead to errors or biases. These intuitive processes are different from the deliberative process of reasoning. Reasoning is an effortful process, it is deductive, slow, and purposeful, and it requires information and statistical awareness. This discussion is designed to raise awareness of the cognitive processes clinicians traditionally use to make judgments in medicine and to distinguish these processes from the reasoning process associated with evidence-based medicine.

No. 34B
IMPROVING OUTCOMES IN ANXIETY DISORDERS

Nick Freemantle, Ph.D., *University Birmingham, Edgbastan, Birmingham B15 2TT, United Kingdom*

SUMMARY:

Anxiety disorders affect more than 25 million Americans. They are associated with disability rivaling that of many chronic medical conditions and major depression. Moreover, they are frequently comorbid with depressive and substance use disorders, both of which can complicate treatment and lead to poorer outcomes. In the past few years, many large, double-blind, placebo-controlled studies have confirmed the efficacy of selective serotonin reuptake inhibitors (SSRIs) and several other classes of drugs for the treatment of panic disorder, generalized anxiety disorder, social anxiety disorder, and posttraumatic stress disorder. Results from several of these major studies are highlighted. As good as these pharmacological treatments are, however, many patients benefit only partially and some not at all. In some patients, there is likely a role for combination therapy using additional medications and/or specific psychotherapies. New evidence-based recommendations in this regard are provided.

No. 34C
STUDY DESIGNS AND OUTCOME IN ANTIDEPRESSANT CLINICAL TRIALS

Arifulla Khan, M.D., *1900 116th Avenue, N.E., Suite 112, Bellevue, WA 98004*; Shirin R.F. Khan, B.S.; Russel Korts, Ph.D.; Michael E. Thase, M.D.; Walter A. Brown, M.D.

SUMMARY:

Compared to earlier clinical trials, recent antidepressant trials more frequently fail to show a difference between drug and placebo. This presentation reviews research that sought to identify some of the factors that account for the diminishing drug-placebo difference. The FDA database was used to assess 46 randomized, double-blind, placebo-controlled clinical trials, evaluating nine antidepressants. First earlier (1980–1987) and then later trials (1987–1994) were examined for both the frequency of positive results (drug superior to placebo) and for the presence of certain research design features, including patient characteristics. Following this analysis, multifactorial regression analysis was used to assess the effect of specific research design features on trial outcome. Fifty-two percent of earlier trials but only 28% of later trials were positive ($U=430.5$; $p<0.05$). Severity of depression at trial entry, use of flexible versus fixed dosing schedule, duration of the trial, the number of treatment arms, and the proportion of males accounted for a statistically significant degree of variance ($R2=0.46$) in antidepressant-placebo differences. Research design factors, including patient characteristics, significantly influence outcome of antidepressant trials. These findings may help inform the design of future antidepressant clinical trials.

REFERENCES:

1. Gilovich T, Griffin D, Kahneman D, eds: Heuristics and Biases: The Psychology of Intuitive Judgment. New York, Cambridge University Press, 2002.
2. Stein HE: A 46-year-old man with anxiety and nightmares after a motor vehicle collision. JAMA 2002; 288:1513–1522.
3. Khan A, Khan SR, Walens G, et al: Frequency of positive studies among fixed and flexible dose antidepressants clinical trials: an analysis of the Food and Drug Administration Summary Basis of Approval reports. Neuropsychopharmacology 2003; 28:552–557.

INDUSTRY-SUPPORTED SYMPOSIUM 35—TRANSCENDING EFFICACY: EFFECTIVE TREATMENT OF PSYCHOSIS ACROSS DISORDERS, PART 1
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) describe the many forms of psychosis across neuropsychiatric disorders, (2) better manage psychosis and agitation in dementia, (3) myriad manifestations of movement disorders, (4) presentation and management of Lewy body dementia, (5) metabolic consequences of antipsychotic treatment, (6) practice management strategies for patients with these disorders.

No. 35A
MANAGING PSYCHOSIS AND AGITATION IN DEMENTIA

J. Michael Ryan, M.D., *Department of Psychiatry, Monroe Community Hospital, 435 E. Henrietta Rd., Rochester, NY 14620*

SUMMARY:

The commonest cause of incident psychosis in late life is delirium, while that persistent psychosis is dementia. The presentation will begin with a brief review of the differential diagnosis of psychosis in the elderly, and then drill down to patients with dementia as the prime example. A practical approach to treatment will emphasize clarification of target symptoms, as well as managing comorbid medical disorders. The goal of treatment is to achieve symptom reduction without causing unnecessary side effects or exacerbating underlying cognitive impairment. The evidence regarding effectiveness, rather than just efficacy, of conventional and atypical antipsychotics will be reviewed, including up-to-the-minute data from placebo-controlled clinical trials from around the world. The punchline is that atypical antipsychotics are efficacious for treatment of agitation and psychosis in dementia, and are generally better tolerated than the conventional agents. Modest differences in effectiveness exist among the different agents, rationalizing the importance of individualized treatment decisions. The presentation will close with a brief review of the NIMH CATIE AD trial.

No. 35B
MOVEMENT DISORDERS IN THE ELDERLY: HOW SAFE ARE THE ATYPICAL NEUROLEPTICS?

Richard N. Trosch, M.D., *26400 W. 12 Mile Road, Suite 110, Southfield, MI 48034*

SUMMARY:

The elderly are at greater risk for the neurologic adverse effects following neuroleptic use, particularly drug-induced parkinsonism and tardive dyskinesia. Despite this susceptibility, neuroleptic use in geriatric patients has increased dramatically in recent years. This may be partly explained by a general impression among psychiatrists of greater safety associated with the atypical neuroleptics, as compared with older conventional agents. Unfortunately, data supporting this assumption are limited and may be flawed. Additionally, few psychiatrists receive extensive training in the recognition of movement disorders and fewer routinely perform a neurologic examination as part of their typical psychiatric evaluation. Alarmingly, this combination of increased patient susceptibility, tenuous assumptions of drug safety, and limited prescriber clinical skills in the recognition of neuroleptic-induced movement disorder places the geriatric population at risk. This lecture will present a neurologic paradigm for understanding the relation of various neuroleptic-induced movement disorders, explore the risk of neuroleptic-induced movement disorders from typical and atypical neuroleptics, consider several widely-held myths about these conditions, describe the clinical presentation of the full spectrum of neuroleptic-induced neurologic adverse effects, and examine the methodologies used in psychiatric clinical trials and their interpretation. With an increased understanding of the risk associated with neuroleptic use in the elderly and improved clinical monitoring for emerging adverse effects, the clinician should be able to develop prescribing practices to minimize the risk to this population.

No. 35C
LEWY BODY DEMENTIA: WHAT THE PSYCHIATRIST NEEDS TO KNOW

Andrius Baskys, M.D., *5901 East 7th Street, 06/116A, Long Beach, CA 90822*

SUMMARY:

Neurodegeneration underlies disorders such as Alzheimer's, Parkinson's, or Lewy body disease (LBD). LBD is now thought to be the second most common cause of dementia after Alzheimer's disease. Postmortem findings of neuropathological markers, such as α-synuclein, ubiquitin, torsin A in patients with dementia suggest that LBD may account for as many as 15% to 25% of all dementia cases and is often underdiagnosed. While clinical diagnostic criteria for LBD continue to evolve, its salient characteristics include the dementia syndrome, fluctuations in cognition, presence of perceptual abnormalities, of which visual hallucinations are the most common, and mild parkinsonism. Other symptoms include frequent falls, nighttime agitation, and mild depression. Hallucinations and delusions are present in approximately 90% of LBD patients and are leading causes of psychiatric referrals. However, treating the psychotic symptoms of LBD is difficult. Patients are particularly sensitive to developing extrapyramidal symptoms and consequently are vulnerable to the side effects of conventional antipsychotics. Neuroleptic sensitivity affects approximately 50% of LBD patients and represents a potentially fatal complication. This presentation will review recent studies on the use of atypical antipsychotics in treating psychiatric symptoms of LBD.

REFERENCES:

1. Schneider LS, Tariot PN, Lyketsos CG, et al: National Institute of Mental Health Clinical Antipsychotic Trials in Intervention Effectiveness (CATIE)—Alzheimer's Disease Trial Methodology. Am J Geriatr Psychiatry 2001; 9:346–360.
2. Friedman JH: Atypical antipsychotics in the EPS-vulnerable patient. Psychoneuroendocrinology 2003; 28(suppl 1):39–51.
3. Lopez OL, Becker JT, Kaufer DI, et al: Research evaluation and prospective diagnosis of dementia with Lewy bodies. Arch Neurol 2002; 59:43–46.

INDUSTRY-SUPPORTED SYMPOSIUM 36—BPD: REGULATION OF AFFECT AND IMPULSE CONTROL
Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the latest research findings on the neurobiology

of borderline personality disorder and its corresponding spectrum-targeted psychopharmacological management.

No. 36A
NEW FINDINGS ON THE BIOLOGY OF BPD

Martin Bohns, M.D., *Hauptstrasse5, Freiburg, Germany 79104*; Christian G. Schmahl, M.D.

SUMMARY:

There is ample empirical evidence that BPD results from repeated transactions between genetic factors and traumatic experiences typically beginning in childhood and continuing over time (Skodol et al., 2002a, 2002b). This results in a severe disorder of the affect regulation system. Recently, empirical evidence has emerged to support a model where both structural and functional alterations of the CNS interact with dysfunctional behavioral patterns. This presentation will provide an overview of the current neurobiological findings in patients with BPD including neuroimaging, neurophysiology, and endocrinology. The impact of the diverse findings on emotional processes and dysfunctional behavior will be discussed.

No. 36B
BPD AND MOOD DISORDER SPECTRUM

Pablo Goldberg, M.D., *515 Cathedral Parkway #6B, New York, NY 10025-2050*; Maria A. Oquendo, M.D.; Barbara H. Stanley, Ph.D.

SUMMARY:

Bipolar Disorder, especially Bipolar II and NOS, and Borderline Personality Disorder share multiple clinical features including mood symptoms, perceptual distortion, impulsivity, and suicidal behavior. In addition, comorbid diagnoses such as substance abuse or anxiety disorders are often present in both. This has led investigators to search for distinguishing characteristics in these disorders and to question whether they are distinct entities or spectrum of disorders. Further, the possibility that the shared symptoms provide the substrate for common neurobiological features has recently been the focus of investigation. We will describe clinical, behavioral and neuropsychological characteristics that will assist the treatment team in the delineation of a diagnosis and the development of a treatment plan. Pharmacologic, psychologic and family interventions for these often difficult to manage patients will be discussed. Special attention will be given to the management of suicidality in these conditions and to interventions that may be useful when the diagnosis remains unclear. Finally some preliminary data on neurobiological findings about both disorders will be presented.

No. 36C
BPD AND THE IMPULSE-CONTROL SPECTRUM

Emil F. Coccaro, M.D., *5841 South Maryland Avenue, MC#3077, Chicago, IL 60637*

SUMMARY:

Impulsive aggression is one of the more critical endophenotypes of borderline personality disorder (BPD). Moderately severe levels of impulsive aggression are highly prevalent among patients with BPD, and presence of BPD increases the family risk of impulsive aggression in the first-degree relatives by two-fold. Biologically, measures of impulsive aggression correlate with various measures of serotonin, norepinephrine, GABA, and vasopressin. Impulsive aggression responds pharmacologically to a number of agents, including SSRIs and mood stabilizers. Curiously, SSRIs may be more effective in moderately aggressive individuals (and those with more intact serotonergic system function), while mood stabilizers may work better in more severely aggressive individuals (and those with less intact serotonergic system function). This presentation will review existing and new data regarding the biology and treatment of impulsive aggression in the context of personality disorders. Studies reviewed will include data related to clinical epidemiology, family history, pharmaco-challenge and CSF neurochemical studies, and pharmacology treatment studies. The biology of impulsive aggression is complex but critical to strategies regarding treatment.

No. 36D
EVIDENCE-BASED PSYCHOTHERAPY FOR BPD

Glen O. Gabbard, M.D., *6655 Travis, Suite 500, Houston, TX 77030*

SUMMARY:

While in years past there have been significant questions about whether borderline personality disorder (BPD) was treatable through psychotherapy, recent empirical data have emerged suggesting that there is reason for optimism in the psychotherapeutic treatment of BPD. Two types of psychotherapy have been tested in randomized controlled trials: dialectic behavior therapy and psychoanalytic psychotherapy. Both suggest that treatment of 1 year or longer is necessary to see optimal results. Possible mechanisms of action will be discussed.

No. 36E
PHARMACOLOGICAL TREATMENT OF BPD: CURRENT AND FUTURE STRATEGIES

Jeffrey A. Lieberman, M.D., *7025 Neurosciences Hospital, CB#7160, Chapel Hill, NC 27599-7160*

SUMMARY:

The rationale for the pharmacologic management of borderline personality disorder (BPD) derives in part from the assumption that the pathophysiology of this disorder overlaps with that of other primary psychiatric disorders, including schizophrenia. Thus, medications ranging from mood stabilizers and antidepressants to antipsychotic drugs have been employed. However, there have been few large controlled clinical trials to determine the effectiveness of these treatments. The inconsistency of the approaches and the lack of clarity regarding the effectiveness of these treatments may stem from the heterogeneity of patients diagnosed with this condition. In addition, the variable symptomatic expression of the disorder may contribute to the differential therapeutic needs of patients. This presentation will review the different strategies for the pharmacologic management of BPD and will present new approaches that are currently under investigation or being proposed.

REFERENCES:

1. Skodol AE, Siever LJ, Livesley WJ, Gunderson JG, Pfohl B, Widiger TA: The borderline diagnosis II: biology, genetics, and clinical course. *Biological Psychiatry* 2002; 51:951–963.
2. Oldham JM, Phillips KA, Gabbard GO, et al: Practice Guideline for the Treatment of Patients with Borderline Personality Disorder. Washington, DC, American Psychiatric Association, 2001.
3. Links PS, Boggild A, Sarin N: Psychopharmacology of personality disorders: review and emerging issues. Curr Psychiatry Rep. 2001; 3(1):70–6.
4. Oquendo MA, Mann JJ. The biology of impulsivity and suicidality. Ed: J. Paris. In: Psychiatric Clinics of North America. W.B. Saunders Co., Philadelphia, 2000; 23(1):11–25.
5. Coccaro EF, Siever LJ: Pathophysiology and treatment of aggression, in Psychopharmacology: The Fifth Generation of Progress. Edited by Davis KL, Charney D, Coyle JT, Nemeroff C. Philadelphia, Lippincott Williams & Wilkins, 2002.

INDUSTRY-SUPPORTED SYMPOSIUM 37—INTERFERON-INDUCED DEPRESSION: CONSEQUENCES OF TREATING CHRONIC HEPATITIS C Supported by Roche Laboratories

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to appreciate the neuropsychiatric effects of interferon (IFN), particularly depression, understand biological and treatment issues that are associated with the use of interferon, and recognize strategies for preventing and/or treating IFN-induced depression.

No. 37A
INTERFERON-INDUCED DEPRESSION: AN OVERVIEW AND ANALYSIS

Gregory M. Asnis, M.D., *111 East 210 Street, Bronx, NY 10467*

SUMMARY:

Hepatitis C is a prevalent viral illness effecting 1%–2% of the population worldwide, with rates as high as 20% in psychiatric patients. A significant subgroup develop chronic hepatitis and can subsequently develop cirrhosis and hepatic carcinoma. Due to the latter complications, hepatitis is the main cause for liver transplantation. Fortunately, interferon (IFN), the FDA-approved treatment for hepatitis C, can cause remission in a majority of cases. Unfortunately, most patients develop IFN-induced neuropsychiatric effects, with depression being a frequent adverse event in approximately 30%–45% of cases. The latter is the most frequent reason for noncompliance and discontinuation of treatment. This presentation reviews various prevalence studies indicating the extent of this phenomenon. The high rates of IFN-induced depression, along with a number of reported suicide attempts and completed suicides, have led physicians to deny treatments to those that have psychiatric histories or who are currently depressed or taking methadone. This presentation addresses the debate about "who should be denied treatment" and examines the longitudinal course of IFN-induced depression and whether the type, dose, duration, and route of IFN affects the characteristics of depression.

No. 37B
PATHOPHYSIOLOGICAL MECHANISMS OF INTERFERON ALPHA-INDUCED NEUROPSYCHIATRIC SYMPTOMS

Lucile Capuron, Ph.D., *1639 Pierce Drive Suite 4000, Atlanta, GA 30322*

SUMMARY:

Neuropsychiatric symptoms are frequent in patients receiving the cytokine, interferon (IFN)-alpha, for the treatment of malignant melanoma or chronic hepatitis C. In addition to having an effect on the patient's quality of life and compliance with treatment, these symptoms may also compromise treatment efficacy. The mechanisms by which IFN-alpha induces these symptoms, as well as the vulnerability factors for these effects, have yet to be elucidated. Clinical studies combining biochemical approaches, neuroimaging, and clinical/therapeutic intervention in medically ill patients undergoing IFN-alpha therapy have been conducted to assess the phenomenology and preventive strategies of the neuropsychiatric effects of IFN-alpha. Results indicate differential characteristics and treatment responsiveness of the neurovegetative and mood/cognitive symptoms induced by IFN-alpha, suggesting distinct underlying mechanisms. Impaired neuroendocine function and altered serotonin metabolism appear to contribute to the development of IFN-alpha-induced mood and cognitive symptoms. Changes in basal ganglia activity, possibly related to dopamine alterations, may be involved in the development of psychomotor slowing and anhedonia. These findings provide important information relative to the pathophysiology of IFN-alpha-induced neuropsychiatric symptoms in medically ill patients.

No. 37C
PEGYLATED INTERFERON: THERAPY OF HEPATITIS C WITH FEWER DEPRESSIVE EFFECTS

John F. Reinus, M.D., *111 East 210th Street, Bronx, NY 10467*

SUMMARY:

The most effective therapy currently available for the treatment of hepatitis C virus infection is subcutaneous pegylated interferon injections given once a week in combination with oral ribavirin twice daily. Two forms of pegylated interferon are FDA-approved for the treatment of hepatitis C: peginterferon alfa-2b and peginterferon alfa-2a. Each represents the modification of a previously approved interferon molecule by its attachment to a polyethylene glycol (PEG) moiety. The intention of this structural change is to increase the drug's *in vivo* half life, thereby making fewer injections necessary to achieve a therapeutic benefit. An important corollary effect of pegylation is that it results in fewer and less radical serum drug level fluctuations in treated patients, a change that may reduce the incidence and severity of side effects. Among the many side effects of interferon therapy, neuropsychiatric problems are some of the most common and significant. Depression and irritability exacerbated or caused by therapy with interferon often threaten to prevent successful completion of treatment. There is some suggestion in the literature of a reduction in the incidence of depression and irritability in patients treated with pegylated interferon instead of the unpegylated equivalent. For example, in one study, only 22% of patients treated with peginterferon alfa-2a experienced depression as compared to 30% of patients treated with interferon alfa-2b, a significant reduction. Management of the neuropsychiatric side effects will continue to be essential to the successful outcome of interferon treatment.

No. 37D
DIAGNOSIS AND TREATMENT OF INTERFERON ALPHA-PSYCHIATRIC SIDE EFFECTS IN PATIENTS WITH HEPATITIS C VIRUS

Charles Raison, M.D., *1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

Data from recent studies highlight the importance of patient compliance in achieving an optimal response to interferon alfa (IFN-alfa)/ribavirin treatment for chronic hepatitis C virus (HCV) infection. With the growing recognition that viral response early in treatment strongly correlates with sustained viral remission, the attention of clinicians and researchers is being drawn to ways in which patients can be encouraged to remain on full doses of both IFN-alfa and ribavirin during the critical first months of treatment. In this regard, the risks posed by IFN-alfa-induced neuropsychiatric symptoms to patient compliance are increasingly appreciated. These symptoms, especially depression, have repeatedly been shown to be a risk factor for treatment noncompliance and discontinuation. Fortunately, IFN-alfa-induced depression can usually be treated successfully, allowing patients to continue therapy. This presentation reviews frequently observed neuropsychiatric complications of IFN-alfa/ribavirin therapy, discusses clinical risk factors for the development of depression, and describes strategies for treating depression and other symptoms,

including fatigue, which appears to be only minimally responsive to traditional antidepressant therapy and which represents a significant cause of treatment discontinuation. Other topics to be discussed include selection of an antidepressant based on differing symptom profiles, as well as the recognition and treatment of IFN-alfa-induced mania.

REFERENCES:

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INDUSTRY-SUPPORTED SYMPOSIUM 38—CONCEPTUALIZING AND TREATING ADHD ADULTS
Supported by Shire US, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the emerging executive function model of adult ADHD impairment and recognize the neurobiological, genetic, and neuropsychological substantiation for the disorder. A thorough understanding of the various pharmacologic treatment options should also be gleaned from the program.

No. 38B
ADULT ADHD: A CONCEPTUAL MODEL

Russell A. Barkley, Ph.D., *171 Ashley Avenue, Charleston, SC 29425*

SUMMARY:

This presentation will summarize a contemporary model of executive functioning and its development and the implications of extending this theory to adults with ADHD. The model holds that inhibition supports the development and effective execution of four executive abilities. These abilities are conceptualized as forms of behavior to the self that become gradually internalized over development as means of self-regulation toward the social future. ADHD disrupts this developmental process by limiting the inhibitory ability of the individual and thus impairing the capacity to direct behavior effectively toward future events and deferred gratification. Numerous implications flow from this model for both understanding adults with ADHD and managing their disorder.

No. 38C
NEUROBIOLOGY OF ADULT ADHD

Francisco Castellanos, M.D., *577 First Avenue, New York, NY 10016*

SUMMARY:

Notwithstanding the absence of consensus regarding the appropriate diagnostic criteria for ADHD in adults, there is compelling evidence for continuity of impairment from ADHD symptoms into adulthood in many cases. Neuropsychological investigations also document comparable deficits in executive function for adults as well as for children/adolescents with ADHD. The neurobiology of ADHD in adults is generally less well described than in younger probands. However, approaches using positron emission tomography or single photon emission computed tomography are almost exclusively conducted in adults with ADHD, and these techniques are the only ones that allow rigorous explorations of the neuropharmacology of ADHD. This presentation will review the results of published and ongoing neuropsychological and electrophysiological studies, with a major focus on non-invasive neuroimaging and on neuroimaging using radio-labeled tracers.

No. 38D
ADULT ADHD: A FAMILY-GENETIC PERSPECTIVE

Stephen V. Faraone, Ph.D., *15 Parkway Street, Boston, MA 02114*

SUMMARY:

Family, twin, and adoption studies from around the world show ADHD to be a highly heritable disorder. Although most of these studies have focused on childhood ADHD, a growing body of literature is clarifying the genetic basis of adult ADHD. Two family studies show very high rates of ADHD among siblings and children of ADHD adults. Similarly, data from a longitudinal family study will show that, when ADHD persists into adolescence and young adulthood, it is more familial than when it remits in childhood. We will also review psychometric data from family studies that suggest that, from a genetic perspective, the diagnosis of ADHD in adulthood may be more valid than the diagnosis made in childhood in the sense that the childhood diagnosis is more prone to false positive diagnoses. Molecular genetic data are consistent with this idea. We also review psychometric studies that assess the possibility that findings of familial transmission in adult ADHD are due to reporter biases.

No. 38E
ADULT ADHD: WHAT DOES NEUROPSYCHOLOGY TELL US?

Larry J. Seidman, Ph.D., *74 Fenwood Road, Boston, MA 021115*

SUMMARY:

Follow-up studies show that ADHD persists into adolescence and young adulthood in 10% to 60% percent of cases. Despite these findings, the diagnosis of adult ADHD continues to be controversial. Perhaps the most prominent reason fueling the controversy is the retrospective nature of the diagnosis, which requires the recollection of distant childhood events that may not be accurate. Because cognitive-neuropsychological functions, particularly attentional and executive processes, are frequently impaired in ADHD children, the demonstration of such deficits in adults with ADHD would provide additional external validation of the adult syndrome. Cognitive performance measures are useful validating criteria for ADHD because they do not share method variance with other measures and they directly assess performance. Identification of core neuropsychological deficits in adults with ADHD is also important both as an empirical study of performance relevant to adaptive functioning and as a window into hypothesized alterations in brain functioning in frontostriatal systems. In this presentation, we summarize the literature on the neuropsychology of adult ADHD, including what is known about the pharmacological reversibility of impairments. The use of neuropsychological testing in clinical assessment and treatment of adult ADHD will be addressed.

No. 38F
PHARMACOLOGIC TREATMENT OF ADULT ADHD

Timothy E. Wilens, M.D., *15 Parkman Street, WACC 725, Boston, MA 02114*

SUMMARY:

Objective. Practitioners are increasingly called upon to diagnose and treat attention deficit hyperactivity disorder (ADHD) in adults. Although medication therapy is well studied in treating ADHD in children and adolescents, the use of pharmacotherapeutics for adults with ADHD remains less well established. In this session, the efficacy and adverse effect profiles of the various agents investigated for adult ADHD are reviewed.

Methods. A systematic review of the literature identified 44 studies comprising 1,916 subjects including stimulant and non-stimulant medications including amphetamines, methylphenidate, antidepressants, noradrenergic reuptake inhibitors (NRIs), antihypertensives, amino acids, and wake promoting agents for the treatment of ADHD in adults.

Results. Controlled clinical trials with stimulants, antidepressants, and NRIs demonstrated significant short-term improvement in ADHD symptoms compared with placebo in adults. The two longer-term trials with methylphenidate (MPH) in adults support the ongoing effectiveness and tolerability of stimulants. There was a trend to a dose-dependent improvement with amphetamine and MPH. MPH and amphetamine had an immediate onset of action whereas the ADHD response to pemoline, antidepressants, and NRIs appeared delayed. All catecholaminergic agents had a mild pressor and chronotropic effect on cardiovascular vital signs. Controlled data on wake promoting and nicotonic/cholinergic compounds appear promising. Considerable variability was found in diagnostic criteria for ADHD in adults, dosing, and response rates between the various studies.

Conclusions. Under controlled conditions, the aggregate literature comprised mainly of short-term studies shows that the stimulants, NRIs, and specific antidepressants had a clinically and statistically significant beneficial effect on treating ADHD in adults. Wake promoting and cholinergic agents appear promising. Further studies are necessary to evaluate longer-term effectiveness, functional and neuropsychological outcome, tolerability and effectiveness, and use in specific subgroups.

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INDUSTRY-SUPPORTED SYMPOSIUM 39—PLOTTING A COURSE TO REMISSION: NAVIGATING THE INTERSECTION OF MIND, BRAIN, AND BODY
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss the epidemiology of the physical and emotional symptoms associated with depression, identify the link between neurotransmitter activity and efficacy for symptoms, explain the gender difference in symptoms of depression and response to antidepressant treatment, provide considerations for treatment selection in the elderly patient with depression, and describe the effects of painful physical symptoms in depression on health care utilization.

No. 39A
DOES EVERYBODY HURT? EPIDEMIOLOGY OF PHYSICAL SYMPTOMS AND DEPRESSION

Maurice Ohayon, M.D., *3430 West Bayshore Road, Palo Alto, CA 94303*

SUMMARY:

Physical symptoms are often present in patients with depression. This relationship was explored in a large sample of 18,980 subjects between 15 and 100 years old. These participants were representative of the general population of the United Kingdom, Germany, Italy, Portugal, and Spain. The interviews were conducted by telephone using the Sleep-EVAL system.

A diagnosis of major depressive disorder (MDD) was observed in 4% of the sample. Physical symptoms were frequently reported by the patients with MDD, such as insomnia (71.3%), fatigue (52%), weight loss (43.9%), psychomotor retardation (26.7%), psychomotor agitation (24.8%), hypersomnia (19%), and weight gain (15.2%). Finally, pain, a symptom not included in the DSM-IV classification of MDD, was present in 43.4% of the group with MDD. When the logistic regression model was calculated, pain multiplied the risk of MDD by four (odds ratio: 3.6-5.2). Links between physical and emotional symptoms must be explored and analyzed in terms of contributing factors to MDD as they can jeopardize the decision-making process during treatment of MDD.

No. 39B
COMORBIDITY WITH PAINFUL PHYSICAL SYMPTOMS: UNDERSTANDING THE INTERSECTION OF BRAIN AND BODY

Bruce A. Arnow, Ph.D., *401 Quarry Road, Room 1326, Stanford, CA 94305-5722*

SUMMARY:

While depression and chronic pain frequently coexist, relatively few studies have examined the magnitude of the association in primary care settings, where a majority of such patients present for treatment. Recent data, gathered in primary care with large sample sizes, reveal rates of comorbid chronic pain as high as 67% among patients with major depression. Compared to those with pain only, those with depression plus chronic pain present higher pain-related disability, somatic symptom severity, lower quality of life, and report both higher use and overuse of prescribed pain medication. Histories of childhood sexual abuse and other forms of maltreatment have been shown to be associated with high rates of depression as well as painful syndromes in adults. Some studies have reported particularly high emergency room utilization for pain-related complaints among those with symptoms of depression or psychological distress and a history of child maltreatment. Recent findings examining relationships among child maltreatment, the prevalence of depression, and pain-related medical illness among adults in a large primary care sample will also be presented.

No. 39C
5HT AND NOREPINEPHRINE: NAVIGATING THE BROAD RANGE OF SYMPTOMS

Pedro L. Delgado, M.D., *11100 Euclid Avenue, Cleveland, OH 44105-5080*

SUMMARY:

Major depression includes a wide range of common physical, emotional, and cognitive symptoms. The neural circuits underlying these symptoms and the complex role of specific neurotransmitters in modulating the symptoms of depression are beginning to be more fully understood. Additionally, the specific changes in brain neurotransmitters that underlie the therapeutic effects of different antidepressants are also beginning to be more completely understood. This presentation will review brain research on the specific brain areas and circuits that are likely to be involved in the physical, emotional, and cognitive symptoms of depression. The role of specific neurotransmitter systems in modulating the target symptoms of depression will also be reviewed from the perspective of possible differences between antidepressant medications. The data presented will highlight the importance of understanding the broad range of symptoms involved in depression and the possible differences between antidepressants with different pharmacological profiles. A conceptual model will be presented for understanding the complex interrelationship between underlying biological vulnerability to depression and external life events and how pharmacological and psychosocial treatments may converge on similar endpoints.

No. 39D
PLOTTING THE COURSE TO REMISSION: BALANCED STRATEGIES TO IMPROVE OUTCOMES

Vivien K. Burt, M.D., *10921 Wilshire Boulevard #403, Los Angeles, CA 90021*

SUMMARY:

Although depression is treatable, most depressed people are not diagnosed, and even when diagnosed, most do not achieve full remission of depression. This lecture will review evidence supporting the superiority of dual-acting agents over selective serotonin-reuptake inhibitors for treating a broad array of depressive symptoms. Data will be presented to show that the use of the dual-acting agent, Duloxetine, rapidly improves negative mood, associated anxiety, and physical discomfort, thus enhancing the likelihood of remission from depression.

No. 39E
LOOKING BEYOND THE SYMPTOMS OF DEPRESSION: CONSIDERATIONS FOR SPECIAL POPULATIONS

Ruta M. Nonacs, M.D., *15 Parkman Street, WACC 815, Boston, MA 02114*

SUMMARY:

The concept of efficacy that we have developed from clinical trials data and the advertising strategies employed for marketing antidepressant medications may lead us to believe that treatment of major depression will work for everyone. However, the art of bringing our patients to the point of full symptom remission requires the consideration for the individual nuances of each patient. How do these differences influence how well treatments work, and which features are important towards developing the correct treatment? A growing body of research has highlighted a variety of ways in which men and women differ in their treatment-related behaviors and preferences, symptom and side effect profiles, and clinical responses to antidepressant medications. For example, depression arising in women during transitions from one stage to another across the lifespan (e.g., puberty, peripartum, perimenopause) may influence decisions regarding the most appropriate treatment modality. The many social and physiological correlates of geriatric status confer special considerations for the selection and implementation of most suitable antidepressant treatment. This presentation will review and assess the available data regarding the treatment of depression in two special populations: women and the elderly. Evidence will also be provided on the efficacy of various therapies in these special populations.

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INDUSTRY-SUPPORTED SYMPOSIUM 40—PHARMACOTHERAPY OF ADDICTIONS: FROM CLINICS INTO OFFICE PRACTICE
Supported by Reckitt Benckiser Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand illicit and prescription opiate dependence, and its neurobiology, and pharmacotherapy using buprenorphine for pain, depression, and AIDS management.

No. 40A
A PATIENT PERSPECTIVE ON OFFICE-BASED OPIATE TREATMENT

Walter Ginter, *25 Vineyard Lane, Westport, CT 06880*

SUMMARY:

Mr. Walter Ginter is a middle-aged, successful New York businessman who has built up a series of businesses over the last 18 years after overcoming the challenges of stigma from drug dependence. He was drafted into the Army in 1970 and as many other veterans, began to use heroin. In 1978 he entered methadone maintenance. Within a year on methadone his life stabilized and he rose rapidly as a successful businessman. Although he had hidden his methadone treatment, when he was asked to become a national manager and travel extensively, he needed to tell his employer. This travel would be impossible with the several times per week required to pick up his methadone at the clinic. His employer advised him to leave the methadone clinic, because of the stigma and limitations of this treatment. Unfortunately, Mr. Ginter left and relapsed to heroin use. He again successfully returned to methadone treatment, but due to stigma at jobs he repeated this pattern five times before starting his 15 years of stable medical maintenance, including a year on office-

based buprenorphine and now a year of office-based methadone. This office-based treatment has had led to success in business, family and community life.

No. 40B
PRESCRIPTION DRUG ABUSE AND PSYCHIATRIC COMORBIDITY

H. Westley Clark, M.D., *5600 Fishers lane, Suite 615, Rockville, MD 20857*

SUMMARY:

Substance abuse treatment need is overwhelming the availability of pharmacotherapies. At least three million Americans are dependent on heroin and/or stimulants, another three million abuse prescription opiates, and opiate management of chronic pain involves another four million. In spite of this clinical need, highly effective opiate dependence pharmacotherapies such as methadone have not become available in the physician's office. New opportunities for treating opiate dependence in a physician's office are available using buprenorphine, and this symposium provides the first half of training needed for physicians to qualify to use it. Psychiatrists are particularly well suited for using buprenorphine in their offices, where they can treat not only heroin or oxycodone abuse, but also opiate dependence in chronic pain patients. The advantages of buprenorphine include low abuse potential, excellent safety, and high patient acceptability. Finally, in spite of the higher cost of buprenorphine compared with methadone, buprenorphine can be quite cost effective because of patients' ability to have less frequent treatment visits and the lower overhead costs of treatment in a physician's office compared with highly structured methadone clinics. Dr. Clark will present the process for notifying HHS of your intention to use buprenorphine in the office.

No. 40C
OPIATE PHARMACOTHERAPY AND THE NEUROBIOLOGY OF OPIATE ABUSE AND DEPENDENCE

Thomas R. Kosten, M.D., *950 Campbell Avenue, Building 35, West Haven, CT 06516*

SUMMARY:

This presentation reviews opiate pharmacology including partial agonists (e.g., buprenorphine-BUP). Partial agonists at lower doses (BUP <8 mg daily) relieve opiate withdrawal, like methadone. However, at higher dosages, BUP precipitates withdrawal, if heroin addicts take it. BUP also blocks itself at higher doses, thereby producing minimal respiratory suppression and overdose risk and very low abuse potential. Opiates produce their effects by binding to mu opiate receptors and inhibiting the cyclic AMP second messenger system. With chronic opiate use the cyclic AMP system becomes hyperactive, contributing to withdrawal symptoms. Opiate antagonists can reverse these neurobiological changes by increasing mu opiate receptor availability. BUP when given at high doses (>12 mg daily) may also increase this receptor availability, which may contribute to its milder withdrawal symptoms and reduced physical dependence compared with methadone. BUP is also superior to either agonists (methadone) or antagonists (naltrexone) in treating comorbid depression and in managing AIDS. The advantage with AIDS includes few interactions with AIDS medications (eg AZT) and lack of the immuno-suppression observed with methadone.

No. 40D
PAIN AND DEPRESSION: GATEWAY TO ADDICTION AND OPPORTUNITY FOR TREATMENT

Walter Ling, M.D., *11075 Santa Monica Boulevard, #200, Los Angeles, CA 90025-3556*

SUMMARY:

The availability of buprenorphine is changing our way of treating illicit and prescription opiate abuse and it affords us an opportunity to rethink the complex relationship between opiate addiction, pain, especially chronic nonmalignant pain, and depression. Opiates are one of our best tools for combating pain and were once widely used for the treatment of depression. Fear of addiction has led to underutilization of opiates for management of pain and the modern antidepressants have largely supplanted their use for treatment of depression. Because of the worldwide outcry for better pain management, opiates have become more widely available, but unfortunately this has also led to the recent increase in prescription drug abuse and related deaths. Moreover, the recent elucidation of opioid-induced hyperalgesia demands rethinking the consequences of chronic opiate exposure either by way of pain treatment or addiction. Despite the availability of several generations of antidepressants, there may still be refractory cases for which buprenorphine would prove useful. This presentation will examine some of the distinct, yet related, issues in this complex set of clinical concerns.

No. 40E
BUPRENORPHINE FOR OPIATE ADDICTION TREATMENT: PHARMACOLOGY AND CLINICAL USE

Laura F. McNicholas, M.D., *University and Woodland Avenues, Philadelphia, PA 19104*

SUMMARY:

The basic and clinical pharmacology of buprenorphine will be covered in this presentation. The nature of a partial agonist for treating opioid dependence will be discussed. The pharmacodynamics and pharmacokinetics of buprenorphine will be addressed, as will the implications for clinical use. Induction and maintenance protocols using buprenorphine for treating opioid dependence will be described. The use of buprenorphine in opioid withdrawal protocols will be addressed.

No. 40F
CULTURAL SENSITIVITY IN ADDICTIONS TREATMENT

Gerado Gonzalez, M.D., *950 Campbell Avenue, Bldg 36, West Haven, CT 06516*

SUMMARY:

Hispanics have become the largest minority group in America, but are underrepresented in addictions treatment compared to the magnitude of addiction problems in this population. Engaging Hispanic patients involves many factors including language, family support, and perceptions about medications such as methadone for opiates. Language barriers can be addressed using bilingual staff, but this poses challenges for the psychiatrist who does not speak Spanish and must evaluate subtle psychiatric or even drug withdrawal symptoms. Family support is often strong for Hispanic patients and non-drug using parents can be a major asset to treatment. With office-based buprenorphine, family members such as a mother can act as support for medication adherence as well as monitoring use of illicit drugs and alcohol. Daily family contact is common among adult Hispanic males which will facilitate family therapy for these

patients even when multi-generational alcoholism is a problem. Many Hispanic patients are unwilling to enroll in methadone maintenance, but in our local experience these patients are willing to take buprenorphine, because its discontinuation is substantially easier than from methadone. Thus, cultural sensitivity is enhanced by recognizing the strong family support and perceived dependence difference between methadone and buprenorphine among Hispanic patients.

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INDUSTRY-SUPPORTED SYMPOSIUM 41—HORMONES, MOOD, AND COGNITION: TREATMENT CONSIDERATIONS IN OLDER WOMEN

Supported by Wyeth Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant will have an appreciation for the impact of reproductive hormones on mood and cognitive function and potential treatment emergent side effects noted in subpopulations of patients.

No. 41A
GONADAL STEROIDS AND THE BRAIN: IMPLICATIONS IN AGING WOMEN

Meir Steiner, M.D., *St. Joseph's Hospital, 301 James Street S, Hamilton, ON Canada L8P 3B6*

SUMMARY:

The differences in prevalence, course, and response to treatment of major mood and anxiety disorders between men and women are believed to be affected by hormonal, reproductive, and genetic factors. These differences are further highlighted by differential exposure/response to environmental influences and by physiological differences. The role and potential relevance of sex hormones to female specific psychiatric disorders is even more obvious. Levels of estrogen (E) and progesterone (P) vary significantly across the female lifespan. Behaviors such as moodiness, irritability, and relationship conflicts around the time of puberty may in part reflect increased sensitivity of neurotransmitter systems to changes in sex hormone levels. The constant flux of E and P levels continues throughout the reproductive years. When women are approaching menopause, the loss of modulating effects of E and P may underlie the development of perimenopausal mood disturbances. Differences caused by genetic polymorphism, combined with the flux of the hormonal milieu, may determine how women react to environmental stress and predict the development of mood disorders. This presentation will provide a conceptual framework for understanding the basis by which gonadal steroids may affect central nervous system modulation—and consequently mood and behavior—in women approaching menopause.

No. 41B
DEPRESSION IN PERIMENOPAUSAL WOMEN: WOMEN AT RISK AND RESPONSE TO ANTIDEPRESSANTS

Lee S. Cohen, M.D., *15 Parkman Street, WAC 812, Boston, MA 02114*

SUMMARY:

Several epidemiological studies describe the increased risk for major depression in women compared with men. However, risk for depression in younger versus older populations of women has not been adequately addressed, particularly with reference to women transitioning to the menopause. While several studies have described increased risk for depressive symptoms in perimenopausal women, prospective data regarding risk for major depression in this population of patients have not been delineated. This presentation will describe results from the Harvard Study of Moods and Cycles in which a large community-based cohort of women were prospectively followed from the late premenopausal years across the perimenopausal transition. The perimenopausal transition was associated with an increased risk for major depression. Results of this investigation will be complemented by presentation of their findings describing differences in response to treatment in premenopausal versus perimenopausal and postmenopausal women. Implications of these findings for antidepressant selection as well as risk for recurrent depression associated with discontinuation of hormonal therapy will be discussed.

No. 41C
MENOPAUSE AND MOOD DISTURBANCES: FROM THEORY TO NOVEL TREATMENT STRATEGIES

Claudio N. Soares, M.D., *15 Parkman Street, WAC 812, Boston, MA 02114*

SUMMARY:

The impact of sex hormones on brain functioning has been frequently cited as one of the factors that strengthen gender differences observed in the prevalence, outcome, and response to treatment of mental disorders. The development of clinical symptoms associated with abrupt hormonal changes and their relationship with the onset of mood disturbance may be particularly complex. For example, it has been speculated that sex steroids exert a significant modulation of brain functioning during the perimenopause; it is therefore intuitive that abrupt alterations of these hormones, commonly observed during menopausal transition, would interfere with mood and behavior. On the other hand, accumulating data suggest that hormonal interventions may also promote relief or even remission of depressive symptoms in perimenopausal women.

This presentation will explore existing data on the complex interactions between sex hormones and mood during the perimenopause, with focus on treatment strategies. The recent controversy involving hormone therapy strengthens the need for novel hormonal and nonhormonal treatment alternatives for the range of symptoms experienced by the growing population of menopausal women. Thus, data on the efficacy of antidepressants, herbal supplements, and treatment combinations for menopause-related symptoms will be critically reviewed.

No. 41D
ASSESSMENT AND TREATMENT OF HOT FLASHES IN MENOPAUSAL WOMEN

Hadine Joffe, M.D., *15 Parkman Street, WACC 812, Boston, MA 02114*

SUMMARY:

Hot flushes are the most common menopausal symptom, occurring in up to 75% of perimenopausal and recently postmenopausal women. Symptoms of hot flushes disrupt quality of life by interfering with daytime activities and interrupting sleep repeatedly throughout the night. Hot flushes are also linked to fatigue, mood disturbance, and cognitive difficulties in menopausal women.

Erratic fluctuations and declining levels of estrogen that occur with reproductive aging are thought to precipitate hot flushes through the effect of estrogen on the thermoregulatory region in the hypothalamus. Serotonin and norepinephrine also have inputs to the hypothalamus, and, like estrogen, these neurotransmitters may play important roles in hot flushes.

Recent reports on hormone replacement therapy (HRT) by the Women's Health Initiative have changed the risk: benefit ratio on HRT use for postmenopausal women. Because long-term use of HRT can have rare but serious health risks, the primary indication for HRT use is now short-term treatment of menopausal hot flushes. Although HRT remains the first-line treatment for hot flushes, there has been increasing attention to non-hormonal treatments of hot flushes for women who are unable or unwilling to take HRT.

In light of the Women's Health Initiative findings on HRT risks, this presentation will discuss emerging trends in the assessment and treatment of hot flushes in menopausal women. Data supporting the use of serotonin-reuptake inhibitors and other psychoactive medications in the treatment of hot flushes will be reviewed.

No. 41E
THE WOMEN'S HEALTH INSTITUTE MEMORY STUDY: UPDATES ON THE EFFECT OF ESTROGEN PLUS PROGESTIN ON THE INCIDENCE OF DEMENTIA AND COGNITIVE IMPAIRMENT IN MENOPAUSAL WOMEN

Sally A. Shumaker, Ph.D., *2000 West First Street Piedmont Plaza II, Winston-Salem, NC 27104*; Claudine Legault, Ph.D.

SUMMARY:

Postmenopausal hormone therapy has been associated with beneficial effects on cognition in animal studies; observational epidemiologic cohort studies suggest that hormone therapy reduces women's risk for Alzheimer disease. Clinical trial evidence to date, however, has been equivocal. The WHI Memory Study (WHIMS) is a randomized, double-blind, placebo-controlled clinical trial designed to evaluate the impact of E+P on the incidence of dementia and mild cognitive impairment relative to placebo. A total of 4,532 women, 65 years of age and older, were followed for an average of four years. They were randomized to receive either conjugated equine estrogen, 0.625 mg, plus 2.5 mg medroxyprogesterone acetate (N = 2,229), or a matching placebo (N = 2,303). The main outcomes were probable dementia and mild cognitive impairment (MCI) identified through a structured clinical assessment. Overall, 61 women were diagnosed with probable dementia, 40/2,229 in the E+P group compared with 21/2,303 in the placebo group. The hazard ratio for probable dementia was 2.05 (95% CI = 1.21–3.48, 45 vs 22 per 10,000 person-years, p = 0.01). Alzheimer disease was the most common classification of dementia in both study groups. There were no differences in treatment effects on mild cognitive impairment. No interactions were found between treatment and risks for dementia (e.g., age, education, prior history of stroke, prior hormone or statin use). In addition, controlling for adherence to study protocol did not alter the findings. E+P did not prevent mild cognitive impairment in these women. These data will be discussed within the context of prior studies suggesting a potential benefit of hormone therapy on cognition and dementia prevention.

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INDUSTRY-SUPPORTED SYMPOSIUM 42—REACHING BEYOND ALZHEIMER'S DISEASE WITH CHOLINERGIC THERAPY
Supported by Novartis Pharmaceuticals Corporation

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize diagnostic criteria and treatment options for dementia with Lewy bodies, Parkinson's disease dementia and vascular dementias, recognize strategies for maximizing use of cholinesterase inhibitors, and identify potential future applications of cholinergic therapy.

No. 42A
DEMENTIA WITH LEWY BODIES WITHIN OUR GRASP

Ian G. McKeita, M.D., *NewCastle General Hospital, Westgate Rd., NewCastle, England NE46BE*

SUMMARY:

This presentation reviews the identification and treatment of dementia with Lewy bodies (DLB), with emphasis on cholinergic therapy. DLB is challenging to diagnose and manage in part due to shared neurochemical and symptomatic characteristics with Alzheimer's disease (AD). Accurate diagnosis and differentiation from related dementia conditions is crucial, however, due to specific management needs. Recent consensus criteria suggest fluctuating cognition, recurrent visual hallucinations, and parkinsonism to be hallmark characteristics of DLB. Widespread cholinergic loss in DLB and sensitivity to neuroleptics indicate that cholinesterase inhibitors (ChE-Is) may represent a rational therapeutic choice. DLB appears to be more responsive to ChE-Is than AD, perhaps due to the greater cholinergic deficit in DLB. Behavioral benefits include improvements in apathy, indifference, anxiety, delusions, hallucinations, and aberrant motor behavior. Inhibition of butyrylcholinesterase (BuChE) may contrib-

ute to the observed long-term clinical response, with variations in BuChE genotype possibly affecting both disease progression and response to cholinergic therapy.

No. 42B
PARKINSON'S DISEASE BEYOND DOPAMINERGIC THERAPY

Amos Korczyn, M.D., *Sackler Faculty of Medicine, Ramataviv, Israel 69978*

SUMMARY:

This presentation explores neurochemical and clinical characteristics of Parkinson's disease dementia (PDD) and evaluates the benefits of cholinesterase inhibitors (ChE-Is). Cholinergic deficits observed in PDD have been related to both cognitive and noncognitive decline, providing a rationale for the use of ChE-Is. Studies have shown ChE-Is to be effective in the symptomatic management of PDD, improving cognition, activities of daily living, and behavioral symptoms without worsening motor function. In a double-blind, randomized, placebo-controlled crossover study (N=14), patients with parkinsonism and cognitive impairment receiving donepezil experienced improved cognition without worsening parkinsonism. In a group of 12 patients with advanced Parkinson's disease, hallucinations, sleep disturbances, caregiver distress, and cognitive performance were all significantly improved by rivastigmine, without a worsening of underlying motor symptoms. These results are similar to those reported in patients with DLB. Preliminary evidence indicates that treatment with ChE-Is improves cognitive and behavioral function in patients with PD and PDD. Additional data are needed to determine whether ChE-Is will provide benefits to PDD patients that are similar to those reported in patients with Alzheimer's disease.

No. 42C
EXPLORING AND MANAGING VASCULAR FEATURES OF DEMENTIA

Martin K. Farlow, M.D., *CL583 541 Clinical Drive #299, Indianapolis, IN 46202-5111*

SUMMARY:

This presentation provides an overview of vascular dementias (VaD) and examines the symptomatic efficacy of cholinesterase inhibitors (ChE-Is). VaD poses a significant health care problem worldwide, ranking behind Alzheimer's disease (AD) as the most common dementia in Western countries. The onset of VaD is often sudden, following a transient ischaemic attack or stroke. Thereafter, the clinical course may be unchanging, remitting, or progressive. ChE-Is are emerging as integral treatments for VaD. In a 6-month double-blind study, patients with probable "pure" VaD who received galantamine showed greater improvement on Alzheimer's Disease Assessment Scale–cognitive subscale and global functioning than patients with probable "pure" VaD who received placebo. A 22-month study of patients with subcortical VaD receiving rivastigmine (3–6 mg/day) showed improved executive function and behavioral symptoms, compared with cardioaspirin-treated control subjects. A subanalysis of data for AD patients with or without vascular risk factors (VRF) showed that rivastigmine improves cognition and performance of activities of daily living with significantly greater benefits in patients with VRF. Two 24-week placebo-controlled studies showed that donepezil significantly improved cognitive function in patients with probable or possible VaD. Although data are limited, studies suggest that ChE-Is may provide symptomatic benefits to patients with VaD.

No. 42D
EXTENDING TREATMENT OPTIONS AND NOT LETTING GO

Gustavo Alva, M.D., *101 The City Drive South, Orange, CA 92868-3201*

SUMMARY:

The full potential of cholinesterase inhibitors (ChE-Is) in the management of patients with Alzheimer's disease (AD) and related dementias has not been realized, possibly because historically ChE-Is were associated with high levels of nonserious, titration-related adverse events (AEs), such as nausea, vomiting, and diarrhea. However, more cautious dosing strategies reduce the incidence of such AEs and minimize noncompliance. As dementia progresses, the efficacy of ChE-Is may decline. Recent studies indicate that switching to a ChE-I with an alternate pharmacologic profile may restore symptomatic benefits. Future indications for ChEIs may include Down's syndrome, autism, traumatic brain injury, ADHD, and schizophrenia. Studies are underway. Combination therapies may also provide avenues for maximizing and extending the clinical utility of ChEIs. Although ChE-Is already demonstrate significant benefit and symptomatic relief to patients with AD and related dementias, their full potential is not being realized. Strategic administration and proper management of ChE-Is could impart further clinical and quality-of-life benefits for patients with various dementias and related conditions.

REFERENCES:

1. McKeith I, Del Sor T, Spano P, et al: Efficacy of rivastigmine in dementia with Lewy bodies: a randomised double-blind, placebo-controlled international study. Lancet 2000; 356:2031–2036.
2. Reading PJ, Luce AK, McKeith IG, et al: Rivastigmine in the treatment of parkinsonian psychosis and cognitive impairment: preliminary findings from an open trial. Mov Disord 2001; 16:1171–1174.
3. Erkinjuntti T, Kurz A, Gauthier S, et al: Efficacy of galantamine in probable vascular dementia and Alzheimer's disease combined with cerebrovascular disease: a randomised trial. Lancet 2002; 359:1283–1290.
4. Emre M: Switching cholinesterase inhibitors in patients with Alzheimer's disease. Int J Clin Pract 2002; 127(suppl):64–72.

TUESDAY MAY 4, 2004

INDUSTRY-SUPPORTED SYMPOSIUM 31—NEW ADVANCES IN THE TREATMENT OF PSYCHOSIS, PART 2
Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium, the participant should be able to understand the special characteristics of geriatric patients with dementia and how they impact treatment options, optimize the management of geriatric patients with dementia who present with common comorbidities, discuss the key criteria influencing the choice of the most appropriate antipsychotics for the pediatric patient with psychotic symptoms, and understand the need for and the clinical implications of early antipsychotic pharmacotherapy in first-episode patients.

No. 31A
ANTIPSYCHOTIC THERAPIES IN GERIATRIC PATIENTS: THE IMPORTANCE OF SAFETY AND TOLERABILITY

J. Michael Ryan, M.D., *435 East Henrietta Road, Rochester, NY 14620*

SUMMARY:

Effective pharmacotherapy for geriatric patients with dementia and psychosis may be hindered by the increased sensitivity of this fragile population to extrapyramidal symptoms (EPS) and the anticholinergic and sedating adverse effects associated with many antipsychotics. Furthermore, concomitant medical conditions, such as cognitive impairment, osteoporosis, diabetes, dyslipidemias, and cardiovascular conditions, are an important concern in this population. Because of comorbid medical conditions, the geriatric patient is often prescribed multiple medications, generally a situation in which the adverse effect profile of the antipsychotic agent becomes particularly important. Relevant differences in safety and tolerability profiles exist not only between classes of antipsychotics but also among agents in the same class. Different agents may vary in EPS liability, metabolic effects, and associated cardiovascular risk. When assessing the effectiveness of antipsychotic therapy, it is crucial to consider the full spectrum of a drug's efficacy, as well as its tolerability profile.

No. 31B
UNIQUE CHALLENGES IN THE PHARMACOTHERAPY OF FIRST-EPISODE SCHIZOPHRENIA

Diana O. Perkins, M.D., *1052 Neuroscience's Hospital, Chapel Hill, NC 27514*

SUMMARY:

The longer the symptoms of first-episode schizophrenia are allowed to persist unchecked, the more likely patients will suffer lasting impairment. Early, effective pharmacologic intervention to relieve symptoms and prevent relapse has been shown to improve the long-term clinical outcomes. Most patients with schizophrenia will experience multiple episodes. The first psychotic episode in patients with schizophrenia is generally viewed as the most responsive to treatment. However, first-episode patients are generally treatment-naive and are more likely to develop motor side effects, even at lower medication doses, than multiepisode patients. First-episode patients are also often particularly reticent to commit to treatment, and any distressing adverse effects can curtail adherence and lead to treatment discontinuation. The effectiveness of antipsychotic pharmacotherapy for first-episode schizophrenia is dictated by the full range of a drug's effects, and differences in adverse-effects profiles may have a significant effect on treatment outcomes.

REFERENCES:

1. Katz IR, Jeste DV, Mintzer JE, Clyde C, Napolitano J, Brecher M: Comparison of risperidone and placebo for psychosis and behavioral disturbances associated with dementia: a randomized, double-blind trial. Risperidone Study Group. J Clin Psychiatry 1999; 60(2):107–115.
2. Finding RL, Schulz SC, Reed MD, Blumer JL: The antipsychotics: a pediatric perspective. Pediatr Clin North Am 1998; 45(5):1205–1232.
3. Koro CE, Fedder DO, L'Italien GJ, et al: Assessment of independent effect of olanzapine and risperidone on risk of diabetes among patients with schizophrenia: population based nested case-control study. BMJ 2002; 325:243.
4. Strakowski SM, Williams JR, Sax KW, Fleck DE, DelBello MP, Boume MI: Is impaired outcome following a first manic episode due to mood-incongruent psychosis? J Affect Disord 2002; 61(1–2):87–94.

SYMPOSIUM 32—CURRENT ALZHEIMER'S DISEASE TREATMENTS AND BEYOND: ADVANCES IMPACTING CLINICAL PRACTICE, PART II
Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize how current findings in AD genetics provide insights for new treatments; evaluate alternative therapeutic options for possible treatment and prevention of AD; discuss the assessment and treatment of AD-associated neuropsychiatric symptoms; understand the impact of emerging neuroimaging techniques.

No. 32A
NEUROIMAGING IN ALZHEIMER'S DISEASE: DIAGNOSIS, TREATMENT AND PREVENTION

P. Murali Doraiswamy, M.D., *3350 Hospital South, Box 3018, Durham, NC 27710*

SUMMARY:

Contemporary neuroimaging techniques offer great potential not just for the diagnostic work-up of suspected Alzheimer's disease (AD), but also for monitoring disease progression and studying treatment effects. Volumetric magnetic resonance imaging (MRI) measurements of the hippocampus and entorhinal cortex may offer diagnostic or prognostic value in preclinical or prodromal stages of AD. Voxel compression serial MRI techniques are being developed to quantify serial changes in brain atrophy in normal and AD brains. Magnetic resonance spectroscopy can provide an in-vivo window into brain metabolism. Routine positron emission tomography (PET) scans have been shown to have prognostic value in a multicenter AD study. PET imaging may also provide an indication of disease prior to the onset of full clinical symptoms. A PET probe has been developed to image amyloid, and emerging evidence suggests that this technique offers diagnostic promise. In addition, newer techniques such as functional MRI and diffusion tensor imaging are also being used to study brain mechanisms in AD. MRI and PET measures are increasingly utilized as outcome measures in drug studies of AD or mild cognitive impairment. In addition to providing an update on these developments, this talk will also summarize the application of neuroimaging techniques in routine clinical practice.

REFERENCES:

1. Lyketsos CG, Steinberg M, Tschanz JT, et al: Mental and behavioral disturbances in dementia: findings from the Cache County Study on Memory in Aging. Am J Psychiatry 2000; 157:708–14.
2. Krishnan KRR, Doraiswamy PM (Eds.): Brain Imaging in Clinical Psychiatry Marcel Dekker, Inc., 1997; pp 63–101.

No. 32B
NEW TREATMENT STRATEGIES FOR ALZHEIMER'S DISEASE: THE ROLE OF EARLY DIAGNOSIS

Trey Sunderland, M.D., *9000 Rockville Pike, Bethesda, MD 20892*

SUMMARY:

Alzheimer's disease therapy has focused for years on the cholinergic hypothesis as the major therapeutic strategy. Now that there are

multiple cholinesterase inhibitors and there has been modest success with this strategy, the field is searching for additional therapeutic approaches that go beyond the cholinergic hypothesis. Other options include the use of hormonal agents, anti-oxidants, NMDA-receptor antagonists and other neurotransmitter modulators, anti-inflammatory agents, statins, and the upcoming new class of secretase inhibitors. While there is not yet consensus as to the best long-term therapy, we will review the growing body of basic and clinical literature supporting each of these approaches alone or possibly in combination. Perhaps of even greater interest is the question of when treatments are best started and whether earlier diagnosis can also lead to early and even prophylactic treatment of this condition. Current therapeutic options are becoming more complicated and growing faster than the scientific community can fully test the validity of each approach, so it will soon be the clinician who becomes the front line researcher with individual patients.

REFERENCES:

1. Tanzi RE, Bertram L: New frontiers in Alzheimer's disease genetics. Neuron 2001; 32:181–4.
2. Doraiswamy PM: Non-cholinergic strategies for treating and preventing Alzheimer's disease. CNS Drugs 2002; 16(12):811–824.

INDUSTRY-SUPPORTED SYMPOSIUM 33—RECOGNIZING THE MANY FACES OF BIPOLAR DISORDER, PART 2
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should be able to recognize the presentation of bipolar disorder in childhood and late life, understand the functional outcomes of the illness and new directions in medication development.

No. 33A
OPTIMIZING FUNCTIONAL OUTCOME IN BIPOLAR DISORDER

Deborah Yurgelun-Todd, Ph.D., *115 Mill Street, Belmont, MA 02478*

SUMMARY:

Bipolar affective disorder is often associated with significant and persistent impairment in cognitive functioning. Although overall general intellectual functioning appears relatively unaffected, recent studies of patients with bipolar disorder indicate that these patients display diffuse cognitive deficits involving executive control, attention, memory, and psychomotor speed. Furthermore, these patients demonstrate persistent cognitive deficits that do not abate even with clinical improvement of the affective symptoms. Assessment of neurocognitive function provides a reliable objective assessment of higher cortical brain functions and may therefore be a more valid indicator of functional recovery, rehabilitation, and reintegration than pure measures of mood. Some studies have found an association between progressive decline in cognitive abilities and the total duration of affective symptoms, suggesting that these cognitive deficits are due to residual effects of recurrent or prolonged affective episodes. Recent studies of first-episode patients with bipolar disorder report the presence of cognitive deficits early in the course of illness, underscoring their primary role in the disorder. The administration of atypical antipsychotic agents yields improvement in the cognitive deficits noted in bipolar disorder and indicates that assessment and treatment of both cognitive and affective domains may optimize functional outcome.

No. 33B
NEUROIMAGING FINDINGS IN BIPOLAR DISORDER

Stephan Heckers, M.D., 115 Mill Street, Belmont, MA 02478

SUMMARY:

Patients with bipolar disorder may present with the signs and symptoms of mania, depression, or psychosis. This constellation of clinical features overlaps with unipolar depression and several psychotic illnesses, including schizophrenia, schizoaffective disorder, and drug-induced psychoses. When followed over time, many patients with bipolar disorder can be diagnosed accurately based on the characteristic time course of manic and depressive episodes. For some patients, however, the differential diagnosis can be challenging, especially when both affective and psychotic symptoms are prominent.

The presentation will address the clinical challenges in the differential diagnosis of bipolar disorder. We will review whether the timing, the degree, or the constellation of affective and psychotic symptoms are helpful in the differential diagnosis of bipolar disorder. In addition, neuroimaging and genetic studies have provided new insights into the etiology and neural mechanisms of bipolar disorder. We will outline how these novel findings can assist in the differential diagnosis of bipolar disorder.

No. 33C
NEW DIRECTIONS IN MEDICATION DEVELOPMENT FOR BIPOLAR DISORDER

Bruce M. Cohen, M.D., *115 Mill Street, Belmont, MA 02478*; William Carlezon, Ph.D.; Perry F. Renshaw, M.D.; Andrew L. Stoll, M.D.

SUMMARY:

Treatments for bipolar disorders have improved, but there are still unmet needs, including the need for antidepressants less likely to induce mania or medications which are true mood stabilizers. In addition, better methods are needed to match individual patients with medications which will be effective for them. Fortunately, rich opportunities for advances in treatment are opening up as a consequence of technical revolutions in molecular genetics and brain imaging. Current molecular techniques are leading to the identification of factors mediating risk, pathophysiology, and response. These factors, in turn, suggest potential new targets for therapeutic compounds. In addition, transgenic animals bearing human genes related to illness will soon serve in the testing of new drugs. Providing complementary information, brain imaging allows the determination of levels of drug in the brain and of the effects of drugs on brain function in living people receiving treatment. Examples will be given of (1) the use of these new technologies in drug design, (2) new targets for medication treatment of bipolar disorders, and (3) new compounds at various stages of testing. The particular issue of finding faster acting, better tolerated, and more effective agents for treating mania and depression and stabilizing mood will be discussed. Lastly, not all treatment approaches under development are drugs, and alternative means of correcting brain dysfunction will be presented.

REFERENCES:

1. Quraishi S, Frangou S: Neuropsychology of bipolar disorder: a review. J Affect Disord 2002; 72(3):209–26.
2. Cohen BM: Mind and medicine: Drug treatments for psychiatric illness. Social Research 2001; 68:697–713.

INDUSTRY-SUPPORTED SYMPOSIUM 34—EVIDENCE-BASED MEDICINE: THE NEXT GENERATION, PART 2
Supported by Wyeth Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize how judgments are made under conditions of uncertainty and how to use evidence in the treatment of depression and anxiety.

No. 34A
PSYCHOTHERAPY FOR TREATMENT OF DEPRESSION: RECENT DEVELOPMENTS

Thomas Lynch, M.D., *4323 Ben Franklin Suite 700, Durham, NC 27704*

SUMMARY:

Depression is a common and debilitating psychiatric disorder. Most people who become depressed will have multiple episodes and the course of the disorder is frequently chronic in nature. In addition, depression is a leading cause of suicide. Treatment strategies must take into account not only intervention for the acute episode but also methods to protect the patient from subsequent relapse. Interpersonal psychotherapy and cognitive behavior therapies have been shown to relieve acute distress and reduce the risk for relapse and recurrence long after the treatment is over. In addition, psychotherapy augmentation of antidepressant medication has been shown to have additional palliative effects. In the past 10–15 years psychotherapy researchers have increasingly begun to study interventions that are designed not only to change problem behaviors but also to help patients learn to better tolerate emotional pain and/or effectively accept problems that cannot be changed. Evidence regarding the effectiveness of psychotherapy for depression are presented, and recent developments in psychotherapeutic approaches related to acceptance and change are discussed. Additionally, evidence is reviewed regarding the effectiveness of interventions designed to treat depression with comorbid problems (e.g., comorbid anxiety or personality disorder) and for preventing depressive relapse.

No. 34B
PHARMACOLOGICAL TREATMENT OF AGITATION IN DEMENTIA: EVIDENCE-BASED RECOMMENDATIONS

Warren D. Taylor, M.D., *DUMC 3903, Durham, NC 27710*

SUMMARY:

The elderly population is increasing rapidly and with it is a corresponding increase in the prevalence of dementia. The management of dementia presents many challenges, however it is the presence of agitation and inappropriate behaviors that may impose a significant toll emotionally and financially on caregivers. Many factors may contribute to the development of dementia, and both pharmacologic and nonpharmacologic approaches have been proposed for managing this problem. Most approaches that have been rigorously studied demonstrate only modest improvement in behavior. This issue is a great problem in providing optimal health care to the aging population and supporting the caregivers of individuals with dementia. Common causes of agitation will be discussed and the evidence supporting various pharmacological interventions will be reviewed.

REFERENCES:

1. Kindermann SS, Dolder CR, Bailey A, Katz IR, Jeste DV: Pharmacological treatment of psychosis and agitation in elderly patients with dementia: four decades of experience. Drugs Aging 19(4): 257–276, 2002.

INDUSTRY-SUPPORTED SYMPOSIUM 35—TRANSCENDING EFFICACY: EFFECTIVE TREATMENT OF PSYCHOSIS ACROSS DISORDERS, PART 2
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) describe the many forms of psychosis across neuropsychiatric disorders, (2) better manage psychosis and agitation in dementia, (3) myriad manifestations of movement disorders, (4) presentation and management of Lewy body dementia, (5) metabolic consequences of antipsychotic treatment, (6) practice management strategies for patients with these disorders.

No. 35A
AVOIDING COMORBIDITIES IN TREATMENT

John W. Newcomer, M.D., *660 South Euclid Avenue, Box 8134, St. Louis, MO 63110-1002*

SUMMARY:

Individuals treated with antipsychotics have an increased prevalence of overweight and obesity as compared with the general population. While multiple factors contribute to this problem, antipsychotic medications cause weight gain and increased adiposity. Increased adiposity, plasma glucose, and lipids are independent and modifiable risk factors for diabetes mellitus (DM) and cardiovascular disease. Additional risk factors can include age, family history, racial and ethnic status, hypertension, and dyslipidemia. Similar factors may increase the risk of developing hyperglycemia and DM during antipsychotic treatment, offering important targets for pretreatment screening. Population-based studies suggest that antipsychotic treatment can be associated with exacerbations of existing type 1 and type 2 DM, new-onset cases of type 2 DM, and infrequent cases of diabetic ketoacidosis. Long-term complications include macrovascular disease events, such as myocardial infarction and stroke, increasing in frequency with increasing plasma glucose. Multiple techniques, of varying sensitivity, can be used to assess treatment-related disturbances of glucose and lipid metabolism in vivo. Techniques will be reviewed and results critically presented. Increased adiposity is a prevalent condition associated with hyperglycemia, hyperinsulinemia, and dyslipidema, which all predict cardiovascular risk. Enhanced screening and management of individuals at risk may help to reduce adverse outcomes during antipsychotic treatment.

No. 35B
TRANSCENDING EFFICACY IN PSYCHOSIS: WHERE THE RUBBER MEETS THE ROAD

Jeanne Jackson-Siegel, M.D., *60 Washington Avenue, Suite 203, Hamden, CT 06518*

SUMMARY:

Over the last few years we have rapidly increased our understanding of less common types of dementia, such as Lewy body dementia

(LBD). As shown in earlier sessions, differences in clinical presentation, motor symptoms, and idiosyncratic symptoms allow us to make a more definitive diagnosis. As this precise diagnosis helps the clinician both avoid and seek specific interventions, we are compelled to translate the newest scientific information into clinical practice. LBD serves as an excellent example of how our knowledge base has outstripped our current standard of practice. In this presentation, the unique aspects of considering LBD in differential diagnosis are discussed. The details of what we as psychiatrists must do in our practice approach in order to capture and optimally treat this disorder are outlined. The need for routine screening measures for cognition, behavioral disturbances, and depression will be highlighted, including the diagnostic tools useful in clinical practice. The need to focus on parkinsonism symptoms early in the diagnostic process and the rating tools that can readily be added to the AIMS form will be explained. Components to be reviewed include a discussion of the limitations of ICD-9 and DSM-4 terminology as regards OBRA regulations and Medicare billing. Finally, suggestions in how we might change our educational process to bring our newest clinicians up to speed will be explored.

REFERENCES:

1. Haupt DW, Newcomer JW: Abnormalities in glucose regulation associated with mental illness and treatment. J Psychosom Res 2002; 53:925–33.
2. McKeith IG, Burn DG, Ballard CG, et al: Dementia with Lewy bodies. Semin Clin Neuropsychiatry 2003; 8:46–57.

INDUSTRY-SUPPORTED SYMPOSIUM 43—EMOTION REGULATION AND PLASICITY OF UNDERLYING CIRCUITRY: IMPLICATIONS FOR DEPRESSION, ANXIETY, AND LONG-TERM BRAIN FUNCTION

Supported by Wyeth Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the importance of the relation between maladaptive emotion regulation and anxiety and depression, interactions between prefrontal cortex and limbic regions as a substrate for emotion regulation, environmental influences that promote and impair neurogenesis in brain regions associated with emotional regulation, and the influences of stress and depression on hippocampal structure.

No. 43A
AMYGDALA AND PREFRONTAL CORTICAL INTERACTIONS IN EMOTION REGULATION AND PSYCHOPATHOLOGY

Ned H. Kalin, M.D., *6001 Research Park Boulevard, Madison, WI 53719*

SUMMARY:

The amygdala and prefrontal cortex are hypothesized to interact in critical ways that modulate the adaptive and maladaptive regulation of emotion. Studies in nonhuman primates demonstrate that monkeys provide excellent models for studying emotion regulation in humans as it relates to adaptive responses and psychopathology. Studies using monkeys have characterized the behavioral, hormonal, and electrophysiological characteristics of the anxious endophenotype, which is analogous to anxious temperament in humans and is a risk factor for the later development of anxiety disorders. Studies using selective lesions of the central nucleus of the amygdala revealed that this structure modulates some, but not all, of the characteristics of the anxious endophenotype. Furthermore, FDG PET findings demonstrated functional connectivity of the amygdala and prefrontal cortex. For example, when exposed to anxiety-inducing situations, monkeys with amygdala lesions failed to activate prefrontal cortical regions. Human functional imaging studies also implicate these regions in emotion regulation. fMRI data have shown changes in emotion-related activation of these regions associated with successful treatment in patients with depression and anxiety disorders. These data help to explain how dysregulation of the neural circuitry underlying emotion can result in anxiety and depressive psychopathology.

No. 43B
HIPPOCAMPAL SIZE IN DEPRESSION: CAUSE AND EFFECT

Alan F. Schatzberg, M.D., *402 Quarry Road, Stanford, CA 94305-5717*

SUMMARY:

In recent years, considerable attention has been given to the significance of smaller hippocampi in various psychiatric disorders, including depression. The smaller hippocampi in depressed patients have been thought to reflect atrophy due to the presence of excessive glucocorticoids or suppression of neurogenesis. This presentation reviews previous data in support and against these hypotheses and data from a study in nonhuman primates suggesting that genetics, but not early stress, has an effect on hippocampal size in early adulthood. Twin studies in humans also indicate a strong genetic component to hippocampal size, suggesting smaller hippocampi may represent a risk factor for serious psychiatric disorders. Last, findings are presented from another recent study of patients with psychotic major depression, patients with nonpsychotic major depression, and controls subjects that raises questions regarding the relationships between elevated cortisol levels and hippocampal volumes.

No. 43C
EXPERIENCE-DEPENDENT EFFECTS ON STRUCTURAL PLASTICITY IN LIMBIC AND CORTICAL STRUCTURES INVOLVED IN EMOTION REGULATION

Elizabeth Gould, Ph.D., *1-S-12 Green Hall, Princeton, NJ 08544*

SUMMARY:

Adaptive regulation of emotion is critical for normal functioning. Conversely, maladaptive emotion regulation may contribute to or characterize psychopathology. This symposium will present new ways of characterizing psychopathology based on different types of maladaptive emotion regulation and will present data on brain mechanisms and neuronal plasticity associated with emotion regulation. Dr. Whalen will discuss individual differences in the reactivity of the amygdala and their relationship to normal and dysregulated anxiety responses. Dr. Schatzberg will review monkey and human data addressing stress and depression-related morphometric changes in the hippocampus and prefrontal cortex and their association with alterations in emotion regulation. Dr. Gould will discuss structural plasticity in primates, particularly the influences of early stress exposure and environmental enrichment on structural plasticity, in limbic and cortical circuitry. Finally, Dr. Kalin will present data from monkeys, elucidating functional connectivity between the amygdale and the prefrontal cortex and will present functional imaging data from depressed humans, demonstrating changes in these processes with successful treatment. This symposium will emphasize the importance of mechanisms underlying adaptive and maladaptive emotion regulation, the relevance of maladaptive emotion regulation to anxiety and

depressive disorders, and the consequences of long-term stress and depression for the plasticity of the normal circuits underlying these phenomena.

No. 43D
THE HUMAN AMYGDALA: VIGILANCE, THREAT ASSESSMENT, AND PSYCHOPATHOLOGY

Paul Whalen, Ph.D., *6001 Research Park Boulevard, Madison, WI 53719*

SUMMARY:

Recent studies of the human amygdala support decades of animal research implicating this brain system in threat assessment and aversive conditioning. This presentation considers a broader role for the amygdala in vigilance associated with biologically-relevant predictive uncertainty. Human neuroimaging studies demonstrating differential responses across the amygdaloid region are presented. Specifically, the findings can be used to differentiate between regions of the amygdaloid complex that respond to stimuli providing a clear prediction of threat versus those that respond to stimuli that leave this prediction unclear. Research using facial expressions of emotion as presented stimuli allows these ideas to be tested. Implications of these results for the study of mood and anxiety disorders are discussed.

REFERENCES:

1. Davidson RJ, Jackson DC, Kalin NH: Emotion plasticity, context, and regulation: perspectives from affective neuroscience. Psychological Bulletin 2000; 126:890–906.
2. Lyons DM, Yang C, Sawyer-Glover AM, Moseley ME, Schatzberg AF: Early life stress and inherited variation in monkey hippocampal volumes. Arch Gen Psychiatry 2001; 58:1145–1151.
3. Gould E, Gross CG: Neurogenesis in adult mammals: some progress and problems. J Neurosci 2002; 22:619–623.
4. Davis M, Whalen PG: The amygdala: vigilance and emotion. Mol Psychiatry 2001; 6:13–34.

INDUSTRY-SUPPORTED SYMPOSIUM 44—CHALLENGES IN TREATING BIPOLAR ILLNESS AND COMORBID DISORDERS
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) discuss the impact of differential diagnosis and comorbid disorders on the clinical course of bipolar disorder, and (2) implement pharmacologic treatment strategies for bipolar disorder and comorbid disorders.

No. 44A
EVIDENCE-BASED UTILIZATION OF ANTIEPILEPTIC DRUGS

S. Nassir Ghaemi, M.D., *1493 Cambridge Street, Cambridge, MA 02139*

SUMMARY:

Antiepileptic drugs (AEDs) have potent psychotropic effects. In bipolar disorder, randomized evidence supports the benefit for valproate (divalproex), carbamazepine, and oxcarbazepine in acute mania and lamotrigine in acute and maintenance treatment of bipolar depression. Clinical evidence of benefit with these agents in other phases of the illness also exists, though generally not at the level of randomized clinical trials (RCTs). Other novel AEDs have either been shown to be ineffective in RCTs for acute mania or have not been studied in RCTs. Biological and clinical evidence outside of RCTs raise the possibility of benefit with some of these agents in some phases of bipolar disorder, or possibly in comorbid conditions such as eating disorders and anxiety disorders. Further RCTs are needed to examine these possibilities. Using principles of evidence-based medicine, the levels of clinical evidence will be reviewed for AEDs currently used in the treatment of bipolar illness and comorbid psychiatric disorders. Recommendations for interpreting the empirical evidence will be made.

No. 44B
INTEGRATED TREATMENT OF BIPOLAR DISORDER IN CHILDREN AND ADOLESCENTS

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

SUMMARY:

Bipolar disorder (BD) in children and adolescents is a chronic, debilitating disorder affecting whole families and interfering with normal childhood development. The incidence of pediatric BD is significant with perhaps >1% of children and adolescents developing bipolar spectrum disorders. Early-onset BD differs from later-onset BD, being less episodic with more mixed episodes and rapid cycling. Furthermore, symptoms of BD vary and must be considered in an age-appropriate manner. Because of their unique status as developing humans, children and adolescents require attention to multiple facets of treatment, involving pharmacotherapeutic, psychosocial, and educational interventions. While well-controlled studies of antimanic agents in pediatric BD are scarce, emerging data suggest that mood stabilizers used in adult BD may also be the first line treatment for children. Due to the high comorbidity with other disorders in pediatric BD, combination pharmacotherapy is the rule rather than the exception. There are few data regarding the effects of multiple medications in this population; therefore, combined treatments should be implemented with caution. Psychosocial and educational interventions are also important, involving the family and community in active treatment. Successful treatment of pediatric BD relies on integration of these various treatment modalities. Strategies and current studies will be discussed.

No. 44C
BIPOLAR DISORDERS IN WOMEN: CLINICAL AND METABOLIC CORRELATES

Natalie L. Rasgon, M.D., *401 Quarry Rd, Room 2360, Palo Alto, CA 94305-5723*

SUMMARY:

Some studies suggest that the course of bipolar disorder may vary by gender. In fact, women may have a higher incidence of bipolar II disorder and may be more likely to develop a rapid cycling course and mixed episodes. Studies have shown that women were depressed more frequently, reported more severe symptoms, and had large fluctuations in mood, approximately twice as often as men. Women experience repeated fluctuations of reproductive hormones during the menstrual cycle, which may impact the clinical course of bipolar disorder. A high prevalence of menstrual abnormalities in women with bipolar disorder, in many cases preceding the diagnosis of bipolar disorder, suggests the likelihood of reproductive dysfunction in these women. Anticonvulsant drugs that are routinely used to treat epilepsy and bipolar disorder have been shown to influence serum levels of reproductive hormones in women with epilepsy, and to

some extent in women with bipolar disorder. These clinical data and treatment strategies will be reviewed.

No. 44D
RECOGNIZING AND TREATING COMORBID DEPRESSION AND ANXIETY IN BIPOLAR DISORDER

Lori L. Davis, M.D., *3701 Loop Road East (151C), Tuscaloosa, AL 35404*

SUMMARY:

Bipolar disorder commonly occurs with comorbid conditions. The presence and complication of a comorbid anxiety disorder is frequently under-appreciated and represents a significant unmet need in the treatment of bipolar disorder. Studies show that comorbid anxiety disorders are correlated with an earlier age of onset of bipolar disorder and have a significant psychosocial impact on the clinical course of illness for bipolar patients. The prevalence and impact of anxiety as well as depression on bipolar severity will be delineated. GABAergic and glutamatergic dysfunctions may explain psychiatric symptom overlap and the response to anticonvulsants. These underlying mechanisms and the response to mood stabilizer therapy will be discussed. The treatment of bipolar depression and comorbid anxiety disorders, such as panic disorder and posttraumatic stress disorder, will be highlighted specifically.

No. 44E
THE CHALLENGE OF TREATING BIPOLAR DISORDER AND SUBSTANCE ABUSE

Mark A. Frye, M.D., *300 UCLA Medical Plaza, Suite 1544, Los Angeles, CA 90095-6968*

SUMMARY:

It has long been recognized that bipolar disorder and alcoholism commonly co-occur. The ECA Study reported a 60.7% lifetime prevalence rate for substance abuse or dependence in persons with bipolar I disorder; among substances, alcohol was the most common substance abused. A subscale analysis of the ECA study showed that BPI and BPII populations had the highest lifetime prevalence rate of alcoholism (46.2% and 39.2%, respectively) followed by schizophrenia (33.7%), panic disorder (28.7%), unipolar depression (16.5%), and the general population (13.8%). Thus, by prevalence data alone, this comorbidity represents an enormous public health problem. Furthermore, this comorbidity has been associated with a greater illness burden as represented by an increased number of past hospitalizations (predominately for mania) and a higher prevalence rate of dysphoric mania, rapid cycling, suicidality, treatment noncompliance, health care utilization, and poor treatment response. This presentation will review treatment strategies that are focused both on mood stabilization and alcohol withdrawal/relapse prevention.

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3. Rasgon N, Bauer M, Glenn T, et al: Menstrual cycle related mood changes in women with bipolar disorder. Bipolar Disord 2003; 5(1):48–52.
4. Henry C, Van Den Bulke D, Bellivier F, et al: Anxiety disorders in 318 Bipolar patients: prevalence and impact on illness severity and response to mood stabilizer. J Clin Psychiatry 2003; 64(3):331–335.
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INDUSTRY-SUPPORTED SYMPOSIUM 45—DOES THE PHARMACOLOGY OF ANTIDEPRESSANT DRUGS MATTER?
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be familiar with the pharmacological differences across antidepressants, the clinical implications of such differences in terms of efficacy and tolerability, and the most common pharmacological strategies to boost the effect of antidepressants.

No. 45A
ANTIDEPRESSANT TREATMENT AND THE EFFECT OF MEDICAL AND PSYCHIATRIC COMORBIDITY

Dan V. Iosifescu, M.D., *15 Parkman Street, WACC 812, Boston, MA 02114*

SUMMARY:

This presentation discusses the overall effect of medical and psychiatric comorbidity on antidepressant treatment outcome in major depressive disorder (MDD). The presence of medical and psychiatric illnesses has been associated with higher rates of MDD in epidemiological samples. Moreover, the presence of comorbid medical and psychiatric illness has been associated with lower recovery rates, as well as increased chronicity of depression in MDD. In this context the presenter describes several studies recently completed in his research group. Among 384 MDD subjects from one study, the total burden of medical illness and the number of organ systems involved by medical illness were associated with lower rates of clinical improvement and with lower rates of remission of depressive symptoms. In two separate studies, the presence of either comorbid anxiety disorders or subsyndromal panic symptoms significantly predicted poorer treatment outcomes among outpatients with MDD. Several hypotheses regarding the mechanisms by which medical and psychiatric illnesses may affect clinical response in MDD are discussed. Clinical strategies recommended in light of the literature reviewed include 1) an increased index of suspicion for depression in subjects with medical and psychiatric illnesses, 2) more aggressive antidepressant treatment in depressed subjects with medical and psychiatric comorbidity, and 3) suggestions for specific antidepressant treatments for depressed individuals with such comorbidities.

No. 45B
RESPONSE VERSUS REMISSION: ARE THERE MEANINGFUL DIFFERENCES AMONG ANTIDEPRESSANTS?

Michael E. Thase, M.D., *3811 O'Hara Street, Pittsburgh, PA 152132593*

SUMMARY:

Definitions of favorable outcomes in randomized clinical trails of antidepressant medications evolved in the 1960s. Typically responders experience at least a 50% decline in a standardized depression score after 4 to 8 weeks of therapy or a treating clinician's global judgement of "much" or "very much" improvement. Although response so defined is a valid indicator of benefit, it does not represent

an optimal outcome. There is, for example, ample evidence that responders who continue to manifest a number of residual depressive symptoms have persistent psychosocial impairments and a greater risk of relapse. Other more severely depressed patients may improve sufficiently to be declared responders, yet still met syndromal criteria for a major depressive episode! As a result of these limitations, there has been growing interest in the use of a more complete level of improvement, i.e., remission of the depressive episode, as the primary indicator of antidepressant efficacy. This presentation reviews the evidence from both naturalistic and controlled studies that underpins the validity of the remission definition and illustrates the utility of this approach in comparisons between selective serotonin reuptake inhibitors and other antidepressants that simultaneously and directly affect noradrenergic and serotoninergic neural systems.

No. 45C
SHORT- AND LONG-TERM TOLERABILITY ISSUES WITH ANTIDEPRESSANTS

Anita L.H. Clayton, M.D., *2955 Ivy Road, Northridge Suite 210, Charlottesville, VA 22903*

SUMMARY:

Major depressive disorder may be associated with neurovegetative behaviors affecting cating/appetite, sleep, sexual/reproductive function, cognition, and sensation/pain. These same behaviors may be affected by antidepressant therapy. Side effects are the most common reason for patient discontinuation of antidepressant medications in primary care, accounting for two-thirds of discontinuations before and after 30 days of treatment. Acute adverse events such as GI disturbance, agitation, and headache begin with initiation of therapy, before therapeutic effects are evident. Adverse effects that begin early in treatment but may be sustained even after remission of depressive symptoms include sexual dysfunction, sleep disturbance, weight changes, and cognitive/emotional blunting. Potential long-term side effects must be monitored from diagnosis through treatment, as these complaints may also represent residual symptoms of depression. The mechanism of action of the antidepressant medications may explain differential effects on these neurovegetative behaviors. Education about the pattern of emergence of anticipated side effects may improve adherence to the recommended antidepressant regimen. Management strategies include education about healthy behaviors such as good sleep hygiene, an appropriate diet, and regular exercise, minimizing the use/dose of other medications or substances, maximizing treatment of comorbid conditions and the depression to remission, lowering the dose of the antidepressant or changing the timing of the dose, drug substitution, and/or adding another agent to counteract the adverse effect. Depressive remission and improved tolerability are associated with improved compliance and subsequent enhanced quality of life.

No. 45D
AUGMENTATION AND COMBINATION STRATEGIES IN DEPRESSION: WHAT IS THE EVIDENCE?

Maurizio Fava, M.D., *15 Parkman Street, WACC-812, Boston, MA 02114*

SUMMARY:

A substantial proportion of patients with major depressive disorder (MDD) show only partial or no response to antidepressants, and even among responders to antidepressant treatment, residual symptoms are rather common. When depressed patients do not respond adequately to treatment with an antidepressant, clinicians may choose to keep the same antidepressant and add another "augmenting" compound. Such augmentation strategies involve the use of a pharmacologic agent that is not considered to be a standard antidepressant but may boost or enhance the effect of an antidepressant. Alternatively, clinicians may choose combination strategies, in which they combine the antidepressant that did not produce adequate response with another antidepressant, typically of a different class. There are only a few controlled clinical trials of these two treatment strategies among patients with treatment-resistant depression or among patients who have only partially benefited from antidepressant treatment. Most of the time, clinicians' decisions are therefore guided by anecdotal reports, case series, and by some relatively smaller, uncontrolled clinical trials. These augmentation and combination strategies typically aim at obtaining a different neurochemical effect than the one obtained with the antidepressant that has not produced adequate response. While drug-drug interactions may limit the use of some of these strategies, the potential loss of partial benefit from the failed drug inherent in switching may increase the acceptability of augmentation and combination strategies among partial responders. This presentation reviews the evidence supporting the efficacy of combination and augmentation strategies among depressed patients who do not achieve remission and discusses the possible advantages and disadvantages of such treatment approaches in MDD.

No. 45E
TRANSLATING MECHANISMS OF ACTION INTO CLINICAL OUTCOME OF DEPRESSION

J. Craig Nelson, M.D., *401 Parnassus Avenue, Box 0984F, San Francisco, CA 94143*

SUMMARY:

For nearly five decades, theories of antidepressant action have focused on the major neurotransmitters—serotonin (5-HT), norepinephrine (NE), and to some extent dopamine (DA). Although several abnormalities in these neurotransmitters have been described in depression, research in this area has been unable to determine which of these findings are primary and which are secondary, compensatory, or just incidental. These neurotransmitters do appear to mediate antidepressant action. Studies using tryptophan depletion and alpha-methylparatyrosine suggest that depleting 5-HT or NE can reverse the effects of a drug that facilitates the action of the respective amines. These studies raised several questions, such as do NE and 5-HT have similar efficacy? Do they treat the same symptoms? A previous review of 15 studies of selective NE and 5-HT antidepressants found that these agents have similar efficacy. A limited number of studies suggest that bupropion, a dopaminergic agent, has similar efficacy to an SSRI. This previous review of selective agents found no consistent pattern of symptoms that predicted response to NE or 5-HT agents or that was responsive during treatment. An analysis of pooled date from two studies of bupropion versus sertraline found that neither anxiety nor insomnia predicted response to these agents. To pursue this question further, two studies comparing fluoxetine and reboxetine were examined to determine if there were differences in the symptoms responding to a 5-HT and NE selective agent. The results of this analysis are presented, and its implications for drug selection and a theory of drug action are discussed.

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2. Clayton AH, Pradko JF, Croft HA, Montano B, Leadbetter RA, Bolden-Watson C, Bass KI, Donahue RMJ, Jamerson BD, Metz A: Prevalence of sexual dysfunction among newer antidepressants. J Clin Psychiatry 2002; 63:357–366.

3. Fava M: Augmentation and combination strategies in treatment-resistant depression. J Clin Psychiatry 2001; 62(suppl 18):4–11.
4. Nelson JC. A review of the efficacy of serotonergic and noradrenergic reuptake inhibitors for treatment of major depression. Biol Psychiatry 1999; 46:1301–1308.

INDUSTRY-SUPPORTED SYMPOSIUM 46—PANIC ANXIETY: UNDERSTANDING ITS NATURE AND NURTURING RECOVERY
Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the incidence, risk and treatment of panic disorder.

No. 46A
BORN OR MADE ANXIOUS? THE ROLE OF TEMPERAMENT AND ENVIRONMENT

Murray B. Stein, M.D., *8950 Villa La Jolla Drive, Suite 2243, La Jolla, CA 92037*

SUMMARY:

While some research studies suggest that patients with panic disorder may have experienced psychological trauma in early life, a large body of evidence points to a temperamental predisposition to anxiety that almost certainly has a genetic basis. This talk will examine the interrelationship between panic disorder and temperament, and their relationship to childhood-onset anxiety disorders. The relationship between panic and post-traumatic stress disorder will also be examined, reviewing recent research studies suggesting that traumatic events may precipitate the later development of panic disorders. Alternative hypotheses will also be explored.

No. 46B
BORN OR MADE ANXIOUS? ANXIETY DISORDER GENE MAPPING AND IDENTIFICATION

Joel Gelernter, M.D., *VA CT-Psych 116 A2 - 950 Campbell Ave., West Haven, CT 06516-2770*

SUMMARY:

The major anxiety disorders are genetically influenced, and appear to be genetically related as well. We have completed genomewide linkage scans of several anxiety disorders, including panic disorder, agoraphobia, and simple phobia; the results of these studies suggest that there are both shared and specific genetic loci that influence risk for these disorders, a result that is consistent with earlier genetic epidemiology studies. Recent findings from Icelandic families (Thorgeirsson, et al, 2003) provided strong statistical evidence for existence of a chromosome 9 susceptibility locus for panic disorder. Additionally, one research group has presented linkage evidence for the existence of a genetically-distinct "panic syndrome" that includes specific medical symptoms. This presentation will review basic principles of gene mapping, and discuss recent evidence regarding the genetic risk for panic disorder and related anxiety disorders. The possibility of shared susceptibility for panic disorder and related syndromes will be explored.

No. 46C
EXTREME ANXIETY AND SUICIDE

David C. Purselle, M.D., *1639 Pierce Dr. Suite 4000, Atlanta, GA 30322*

SUMMARY:

Suicide is often considered to be the act of a depressed individual; however, recent data indicate that suicide is especially high in patients with anxiety disorders. Due to the extreme intensity of anxiety symptoms in patients with panic disorder, it might be expected that the rate of suicide is particularly high in these individuals. This talk will explore the incidence of suicide in patients with panic disorder relative to the rate of suicide in patients with depression and other anxiety disorders, and will evaluate whether the presence of concomitant depression with panic disorder is a necessary prerequisite for suicidality. The biological basis for suicidal behavioral will also be explored.

No. 46D
UNDERSTANDING AND TREATING PRIMARY CARE PANIC DISORDER USING A COLLABORATIVE CARE APPROACH

Peter P. Roy-Byrne, M.D., *325 Ninth Avenue, Box 359911, Seattle, WA 98104*

SUMMARY:

Patients suffering from panic disorder frequently present in the primary care setting, often under the belief that they are suffering from a different medical problem. Studies have shown that panic is under-recognized and under-treated in primary care, due largely to the acute-care focus and model used in this setting. This talk will discuss the identification and management of panic by the primary care physician, and will discuss strategies for collaborative patient management by PCP, psychiatrist, and other health care workers.

No. 46E
CHOOSING MEDICATIONS FOR PANIC DISORDER

Jonathan R.T. Davidson, M.D., *Trent Drive, Room 4082 - Yellow Zone, Durham, NC 27710*

SUMMARY:

Primary pharmacological treatments for panic disorder consist of SSRIs, SNRIs, and high-potency benzodiazepines. Secondary drugs include tricyclic antidepressants, and MAOI and mood stabilizers. This talk will discuss when it is appropriate to initiate medication as part of a comprehensive treatment plan for panic disorder. The evidence supporting the use of different medications for the treatment of panic will be examined, and maintenance treatment to prevent the future occurrence of panic attacks will also be discussed. The advantages and disadvantages of each type of drug will be discussed, along with issues of discontinuation, and combined drug and psychotherapy approaches.

REFERENCES:

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5. Ballenger JC, et al: Consensus Statement on Panic Disorder From the International Consensus Group on Depression and Anxiety. J Clinical Psychiatry 1998; 59(suppl 8):47–54.

INDUSTRY-SUPPORTED SYMPOSIUM 47—ADULT ADHD DIAGNOSIS AND TREATMENT
Supported by Shire US, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the scientific substantiation and diagnostic scales used in adult ADHD. An understanding of the validity and use of cognitive therapy and evidence supporting the use of stimulant and non-stimulant treatments should also be gained.

No. 47A
ADULT ADHD: CLINICAL OVERVIEW

Thomas J. Spencer, M.D., *55 Fruit Street, Warren 705, Boston, MA 02114*

SUMMARY:

In recent years, evidence has been accumulating that the syndrome of attention deficit-hyperactivity disorder (ADHD) persists into adulthood in approximately one half of cases, indicating that up to 4% of adults may also have the disorder. Data on the persistence of ADHD is confounded by the definition of remission, and the developmental changes of the symptom clusters of ADHD. Longitudinal and cross-sectional studies have consistently reported that the persistence of ADHD into adulthood is associated with high rates of academic and occupational impairment. Likewise, ADHD persistence is associated with high rates of psychiatric comorbidity including mood, anxiety, antisocial, and substance-use disorders. Important differences in neuropsychological and neuroimaging have been recently reported between ADHD and nonADHD adults. In this talk, a comprehensive overview of ADHD into adulthood will be presented attending to presentation, course, and associated impairments.

No. 47B
UNDERSTANDING AND UTILIZATION OF DIAGNOSTIC RATING SCALES

Lenard A. Adler, M.D., *530 First Avenue HCC 5A, New York, NY 100166497*

SUMMARY:

Adult attention deficit hyperactivity disorder (ADHD) is a common and impairing neuropsychiatric disorder, affecting about 4% of adults. Adult ADHD is vastly under-recognized and under-treated. Therefore, further understanding of the process of diagnosing an adult with ADHD is critical. This presentation will review recent advances in the clinical diagnosis of adult ADHD, with the focus centering on the clinical evaluation of adults presenting with ADHD. The following topics will be presented: (1) the change in diagnostic criteria of adult ADHD over time and the current specific DSM-IV criteria, (2) critical aspects of making the diagnosis in adults, (3) clinical vignettes of patients presenting for ADHD evaluations, and (4) pitfalls in the evaluation process and the role of rating scales and neuropsychological testing in making the diagnosis. Specific emphasis will be placed upon two recently developed scales, one a self-report scale, the Adult ADHD Self-Report Scale (ASRS) and the other a clinician-administered instrument, the Adult ADHD Investigator Symptom Rating Scale (AISRS). The validation process, along with the appropriate ways to utilize these scales will be reviewed.

No. 47C
COGNITIVE-BEHAVIORAL THERAPIES: TREATMENTS AND OUTCOMES

Stephen P. McDermott, M.D., *15 Parkham Street ACC 725, Boston, MA 02114*

SUMMARY:

Although psychopharmacology remains the mainstay of therapy for adults with ADHD, a significant minority of patients either does not respond to medication treatment alone, or only sustains a partial response. While cognitive-behavioral therapies (CBT) have been the best studied and most efficacious psychotherapies for children, there has been a dearth of CBT outcome studies for adults. The application of CBT for adults with ADHD will be reviewed, and results from three outcome studies will be presented.

Results: To date, two open (one controlled [N=16], one not [N=26]) and one randomized, controlled study (N=43) have been undertaken in ADHD. Two studies used protocols of two-hour sessions—one used 13 sessions, the other used eight. The mean number of sessions in the open, uncontrolled study was 36±24. Only the randomized, controlled study had post treatment follow-up—at two months and one year. All studies had some subjects who were medicated. All studies showed significant improvement in ADHD symptomatology with the controlled study showing gains maintained up to one year post treatment. All studies showed significant improvement in depression, anxiety, and/or anger. No differences were observed between medicated and nonmedicated subjects in the randomized study and both open studies showed gains in ADHD symptomatology beyond medication stabilization.

Conclusion: Cognitive therapy appears to be an effective treatment for adults with ADHD. Studies evaluating the longer-term outcome in medicated and unmedicated adults with ADHD are necessary.

No. 47D
TREATMENT WITH STIMULANTS

Timothy E. Wilens, M.D., *15 Parkman Street, WACC 725, Boston, MA 02114*

SUMMARY:

Objective: With the increasing recognition of attention deficit hyperactivity disorder (ADHD) in adults, clinicians need to be more familiarized with the role of pharmacotherapy in the treatment of this condition. Within the armamentarium of agents available, the stimulant medications are among first-line agents. In this session, the mechanism of action, efficacy, adverse effect profile, and use in special groups of amphetamine and methylphenidate (MPH) are reviewed.

Methods: A systematic review of the literature identified 16 studies (MPH-9; AMPH-5, pemoline-3) including 737 subjects of stimulants in the treatment of ADHD. In addition to short-term trials, the results of two longer-term trials of MPH were identified. Recently derived data on the cardiovascular profiles of the medications are also reviewed.

Results: Controlled clinical trials of the stimulants, including a recent large multisite study of amphetamine, demonstrated signifi-

cant short-term improvement in ADHD symptoms and functioning compared with placebo in adults. Similarly, two six-month trials with methylphenidate (MPH) in adults support the ongoing effectiveness and tolerability of stimulants. There was a linear dose-response trend with the stimulants. In general, stimulants were well tolerated in subjects with dry mouth, reduced appetite, and mild increases in blood pressure/pulse as the most commonly observed events. Controlled data on the use of stimulants in comorbid substance abusers do not demonstrate increased craving, improvement, or worsening of substance use.

Conclusions: Under controlled conditions, the aggregate literature support strongly the use of stimulant agents in adults with ADHD. Monitoring of stimulants includes periodic blood pressure measurement. The use of stimulants in comorbid conditions with ADHD in adults remains less well studied. Further studies evaluating the functional and neuropsychological outcome over time and use in specific subgroups are necessary.

No. 47E
TREATMENT WITH NONSTIMULANTS

James G. Waxmonsky, M.D., *888 Delaware Ave, Buffalo, NY 14209*

SUMMARY:

A variety of compounds with a common noradrenergic / dopaminergic activity have shown documented anti-ADHD activity. Randomized clinical trials of the tricyclic antidepressant desipramine and the atypical antididepressant bupropion support their efficacy in the treatment of adults with ADHD. Recently, the novel specific norepinephrine re-uptake inhibitor atomoxetine has gained FDA approval for the treatment of ADHD in adults. Despite these promising results, more research is needed to further document the short-and long-term safety and efficacy of pharmacologic treatments for adults with ADHD.

REFERENCES:

1. Biederman J, Spencer T, Wilens T: Approach to the patient with attention-deficit/hyperactivity disorder. Practical Guide to Psychiatry, Little, Brown and Company, Boston, 2001.
2. Adler LA, Chua H: Management of ADHD in Adults. Journal of Clinical Psychiatry 2002; 63 Suppl 12:29–35.
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5. Wilens T, Spencer T, Biederman J, Prince J: Pharmacotherapy of ADHD in adults: a review of the literature J Att Disorders 2002; 5:189–202.

INDUSTRY-SUPPORTED SYMPOSIUM 48—BINGE-EATING DISORDER: GENES, TREATMENTS, AND CONSEQUENCES
Supported by Ortho-McNeil Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to 1) understand the neurobiology of binge eating and obesity, 2) understand family and genetic studies of binge eating disorder, 3) review new treatment options for binge eating disorder, 4) understand psychiatric comorbidity associated with binge eating disorder, and 5) address medical comorbidity associated with binge eating disorder.

No. 48A
THE NEUROBIOLOGY OF BINGE-EATING AND OBESITY

James F. List, M.D., *320 Wellman, MGH, 55 Fruit Street, Boston, MA 02114*

SUMMARY:

The worldwide prevalence of overweight and obesity is increasing at a dramatic rate, and with it there is an associated increase in medical and psychiatric comorbidities. Body weight is a function of energy balance. A number of hormones provide feedback to the central nervous system to regulate energy balance, including the pancreatic hormone insulin, the gut hormones ghrelin and peptide YY, and the adipose tissue-derived hormone leptin. These hormones alter the balance of orexigenic and anorexigenic neuropeptide signals emanating from neurons of the arcuate nucleus. Mutations affecting these pathways can result in an obesity phenotype. One such anorexigenic effector, α-melanocyte-stimulating hormone, signals through the melanocortin 4 receptor (MC4R). Mutations in MC4R are associated with obesity and may play a role in the genesis of binge eating disorder.

No. 48B
FAMILY AND GENETIC STUDIES OF BINGE-EATING DISORDER

James I. Hudson, M.D., *115 Mill Street, Belmont, MA 02478*

SUMMARY:

This presentation reviews family and genetic studies of binge eating generally and of binge eating disorder. Family studies have suggested that binge eating disorder may aggregate in families, although studies published to date have had modest sample sizes and have had methodologic limitations. Such studies have also raised the possibility that binge eating disorder may travel together with mood disorders in families. Preliminary results from a larger, ongoing family study that addresses these questions are presented. Twin studies have demonstrated that there are genetic factors involved in binge eating behavior. Binge eating appears to be highly heritable but shows low reliability. Recently, genetic studies have reported that mutations of the melanocortin 4 receptor are associated with binge eating disorder. The presentation also reviews current genetic epidemiologic research in binge eating disorder and discusses future directions.

No. 48C
TREATMENT OF BINGE-EATING DISORDER

B. Timothy Walsh, M.D., *1051 Riverside Drive, Unit #98, New York, NY 10032-2603*

SUMMARY:

This presentation summarizes the existing information on the treatment of binge eating disorder and discusses approaches to the selection of treatment modalities. The last decade has witnessed the development of effective psychological and pharmacological treatment approaches for binge eating disorder. Several different psychological approaches, including cognitive behavior therapy and interpersonal therapy, are effective in reducing binge frequency but less successful in weight reduction. Dietary approaches that focus more directly on weight loss also appear to be useful in reducing binge frequency. Binge eating disorder is associated with increased rates of mood and anxiety disturbances, and several studies have documented that SSRIs are more effective than placebo in reducing binge frequency and improving mood; however, effects on weight are minimal. Recent studies have indicated that the antiobesity agent sibutramine and the

antiepileptic topiramate are associated with improvement in binge eating, weight, and psychological state.

No. 48D
PSYCHIATRIC COMORBIDITY ASSOCIATED WITH BINGE-EATING DISORDER

Justine K. Lalonde, M.D., *115 Mill Street, Belmont, MA 02478*

SUMMARY:

This presentation reviews findings on the psychiatric comorbidity of binge eating disorder. The most common other psychiatric disorder found in individuals with binge eating disorder is major depressive disorder. A high prevalence of lifetime major depressive disorder has been reported not only in clinical samples but also in community samples. Several studies have suggested that there is an elevated prevalence of other conditions in binge eating disorder, including anxiety disorders and substance use disorders. In addition, high levels of perfectionism and impulsivity have also been found in binge eating disorder. Some conceptualizations of binge eating disorder have linked it to other disorders with behavioral dyscontrol, such as bipolar disorder and impulse-control disorders. The practical treatment implications of comorbidity of psychiatric disorders and symptoms in individuals with binge eating disorder are discussed, including recognition of comorbidity and tailoring treatment to address it.

No. 48E
ADDRESSING MEDICAL COMORBIDITY ASSOCIATED WITH BINGE-EATING DISORDER

Louis J. Aronne, M.D., *1165 York Avenue, New York, NY 10021*

SUMMARY:

Overweight and obesity represent a substantial public health issue in the United States. Approximately 65% of the adult population in the United States is overweight or obese, where overweight is defined as a body mass index (BMI) of ≥ 25 and obesity is defined as a BMI ≥ 30. Patients with binge eating disorder are at risk for developing overweight and obesity. Overweight and obesity increase the risk for developing many serious chronic diseases, such as cardiovascular disease, type 2 diabetes, hypertension, dyslipidemia, sleep apnea, and breast, endometrial, colon, and prostate cancers. The morbidity from obesity-associated disorders increases with increasing body mass index and begins within the normal weight range. An increase in abdominal fat further increases the risk. Adipose tissue is a multiendocrine organ, secreting hormones such as TNF- alpha, IL-6, PAI-1, angiotensinogen, leptin, and free fatty acids, which are important for normal bodily function, but when present in excess because of obesity, cause diseases recognized as complications of obesity. Evidence supports the benefit of weight loss for preventing and treating type 2 diabetes, reducing blood pressure, improving dyslipidemias, sleep apnea, and quality of life. Weight loss should improve the medical comorbidities associated with binge eating disorder.

REFERENCES:

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INDUSTRY-SUPPORTED SYMPOSIUM 49—EXPLORING THE TRUE MORBIDITY OF INSOMNIA
Supported by Neurocrine Biosciences Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to assess sleep quality in patients, discuss the impact of sleep deprivation on metabolic/endocrine functions, recognize the bidirectional relationship of psychiatric disorders and insomnia, the impact of sleep disorders on individuals' lives and its economic impact on the population and compare current and future pharmacologic and nonpharmacologic treatments for insomnia.

No. 49A
ASSESSING THE COMPLAINT OF INSOMNIA

Mary B. O'Malley, M.D., *Maple Street, Norwalk, CT 06856*

SUMMARY:

According to current surveys, over one-half of the adults in the general population report experiencing occasional difficulties in sleeping, and over 15% of adults have chronic sleep problems. Among those with psychiatric illnesses, problems initiating and/or maintaining sleep is the rule, rather than the exception. Despite its prevalence, the problem of chronic sleeplessness has received scant clinical attention. Because insomnia is a complaint, not a diagnosis, the initial work-up should be focused on defining its cause. Even in the psychiatrically ill, comorbid medical illnesses, underlying sleep disorders, and the effect of medications or substances, can contribute significantly to the symptoms of sleeplessness. A comprehensive medical history and physical examination may be necessary to identify these comorbid conditions. Often, however, the likely etiology is identified by taking a thorough sleep history, and having the patient complete sleep diaries. Questions should address both sleep and daytime functioning, since the presence of sleepiness usually indicates a nonpsychiatric cause of the sleep disturbance. In addition, effective tools that measure the quality and patterns of sleep, such as the Pittsburgh Sleep Quality Index (PSQI) help differentiate "poor" from "good" sleep over time. Knowing the patient, their life circumstances, and psychological vulnerabilities, and especially the circumstances concurrent with the change in their sleep habits, are essential before a precise diagnosis and treatment strategy can be made.

No. 49B
METABOLIC AND ENDOCRINE EFFECTS OF SLEEP DEPRIVATION

Eve Van Cauter, M.D., *5841 South Maryland Avenue, Chicago, IL 60637*

SUMMARY:

Sleep curtailment is a hallmark of modern society. In the United States, "normal" sleep duration has decreased from approximately nine hours in 1910 to an average of seven hours in 2002. Today, many individuals are in bed five to six hours per night on a chronic basis. Although well-controlled animal studies have demonstrated that total sleep deprivation for extended periods of time leads to death, until a few years ago, the consensus was that sleep is for the brain, not for the rest of the body. It was thought that sleep loss

results in increased sleepiness and decreased cognitive performance but has little or no effect on peripheral function. In this presentation, we will discuss evidence indicating that sleep curtailment in young adults is associated with a constellation of metabolic and endocrine alterations, including decreased glucose tolerance, decreased insulin sensitivity, elevated sympatho-vagal balance, increased concentrations of evening cortisol, abnormal profiles of nocturnal growth hormone secretion, abnormal regulation of hunger and appetite, and reduced response to influenza vaccination. We will also review the evidence suggesting that sleep loss may play a role in the current epidemic of obesity.

No. 49C
PSYCHIATRIC MORBIDITY OF INSOMNIA

Ruth M. Benca, M.D., *6001 Research Park Boulevard, Madison, WI 53711*

SUMMARY:

Epidemiological studies show that almost one third of the U.S. adult population experiences insomnia, and that nearly 10% report it to be a serious or chronic problem. Sleep disturbance is strongly associated with comorbid medical and psychiatric illnesses, with up to half of adults with insomnia having concomitant psychiatric illnesses. The co-occurrence of insomnia and mental disorders constitutes the most prevalent diagnosis pattern found in sleep disorder clinics. Depression and/or anxiety are frequently present in insomniacs, and insomnia is more than twice as prevalent in depressed than in non-depressed individuals.

Not only are sleep disturbances common manifestations of many psychiatric disorders, including major depression and anxiety disorders, but they also appear to have predictive value in identifying individuals at risk for developing psychiatric disorders, particularly mood disorders. Sleep complaints may be among the most robust prodromal symptoms reflecting incipient depressive or anxiety disorders.

There is increasing evidence for a causal relationship between insomnia and mental health. This presentation will discuss the literature available on sleep in psychiatric disorders and highlight the importance of appropriate diagnosis and treatment of insomnia, which may lessen the associated psychiatric morbidities as well as related healthcare costs.

No. 49D
QUALITY OF LIFE AND HEALTH CARE COSTS IN INSOMNIA

Daniel J. Buysse, M.D., *3811 Ohara St, Pittsburgh, PA 15213-2593*

SUMMARY:

Insomnia has a substantial impact on health-related quality of life and health care utilization. The total direct, indirect, and related costs of insomnia are estimated at $35 billion annually. This amount represents the total costs of direct and indirect economic and professional consequences, which affect daytime functioning, behavior, and quality of life. Insomniacs have a higher rate of absenteeism, missing work twice as often as good sleepers. They also have more problems at work (including decreased concentration, difficulty performing duties, and more work-related accidents). Compared with good sleepers, severe insomniacs reported more medical problems, had more physician-office visits, were hospitalized twice as often, and used more medication. Even after correcting for comorbid conditions, individuals with insomnia have reductions in health-related quality of life comparable in magnitude to those seen major depression and congestive heart failure. Although one adult out of four has insomnia, only one out of four individuals with insomnia has ever presented this problem to their physician during an office visit for another problem. Proper diagnosis and treatment may help to reduce the health care costs as well as improve overall quality of life for the patient.

No. 49E
CURRENT AND FUTURE TREATMENTS OF INSOMNIA

John W. Winkelman, M.D., *1400 Centre Street, Newton Center, MA 02459*

SUMMARY:

Current treatments for insomnia include both pharmacologic and non-pharmacologic management. Behavioral strategies (e.g., cognitive restructuring, relaxation therapy, sleep hygiene) appear to provide more sustained effects than medication use. Benzodiazepine receptor agonists are the most commonly prescribed hypnotic agents, but their use may be associated with tolerance and central nervous system adverse effects, including residual sedation, rebound insomnia, and psychomotor and memory impairment. The ideal pharmacological strategy must achieve a balance between these sedative and adverse effects.

Newer hypnotic agents have shown significant promise in Phase III clinical trials in alleviating difficulties with falling asleep, staying asleep, and quality of sleep. Agents with favorable half-lives, with unique mechanisms of action, and those with benefits for next-day functioning will be all be discussed. These advances may help address the limitations of currently available treatments, and when combined with proven behavioral therapy, offer successful results in the management of insomnia.

REFERENCES:

1. Schenck CH, Mahowald MW, Sack RL: Assessment and Management of Insomnia. JAMA 2003; 289(19):2475–2479.
2. Spiegel K. Leproult R, Van Cauter E: Impact of sleep debt on metabolic and endocrine function. Lancet 1999; 354(9188):1435–9.
3. Benca R: Consequences of insomnia and its therapies. J Clin Psychiatry 2001; 62(suppl 10):33–38.
4. Leger D: Public health and insomnia: economic impact. Sleep 2000; 1:23 Suppl 3:S69–76.
5. Roth T, Hajak G, Ustun TB: Consensus for the pharmalogical management of insomnia in the new millennium. Int J Clin Pract 2001; 55(1):42–52.

WEDNESDAY MAY 5, 2004

INDUSTRY-SUPPORTED SYMPOSIUM 50—PTSD: SEARCHING FOR ANSWERS IN TRAUMATIC TIMES, PART 1
Supported by Cephalon, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to 1) understand the overall consequences of PTSD; 2) describe the impact of terrorist actions on mental health; 3) understand the neurobiology of PTSD, including the roles of GABA and glutamate; 4) recognize the nature of sleep disturbance and its treatment; and 5) review effective and ineffective forms of psychotherapy and pharmacotherapy.

No. 50A
PTSD: ITS BURDEN AND THE TOLL FROM TERRORISM

Randall D. Marshall, M.D., *1051 Riverside Drive, Unit 69, New York, NY 10032*

SUMMARY:

Posttraumatic stress disorder (PTSD) is associated with myriad negative consequences, including severe global impairment and disability, suicidal ideation, impairment in the workplace, medical illness, and impaired family and social relationships, with an estimated social cost of $3 billion annually. Its approximate lifetime prevalence of 10% for women and 5% for men in the United States makes it one of the most common severe psychiatric disorders, and a number of risk factors have been identified. After a community disaster, it is well-established that PTSD and major depression are the most common psychiatric disorders observed in directly exposed persons. Epidemiologic studies after the September 11, 2001, attacks revealed similar post-event psychopathology, but with an unusual, uniquely diffuse distribution of effects, compared to prior disasters. Attempts to explain this finding have emphasized the unusual modality of exposure (from a considerable distance or entirely through the media), but this effect may also be related to the disruption of culturally rooted, internalized assumptions about personal safety. There is a considerable gulf between what we know about the consequences of disaster and how little we know about interventions to reduce postdisaster morbidity. Preliminary data at the New York State Psychiatric Institute suggest that, even after attending intensive trainings, clinicians perceive multiple barriers to implementing evidence-based treatment for PTSD.

No. 50B
BRAIN IMAGING IN PTSD: GOING BEYOND 5HT

David J. Nutt, M.D., *School of Medical Sciences University Walk, Bristol, United Kingdom B531 1TD*

SUMMARY:

Imaging has already played an important role in the study of PTSD, and this role is likely to grow with the continuing evolution of neuroimaging technologies, especially new PET and SPECT ligands. So far, imaging studies in PTSD have identified a number of key regions that seem to define a circuit for the expression of the relived trauma. Structural studies have shown long-lasting volumetric reductions in limbic structures such as the hippocampus, although we await the complation of ongoing longitudinal studies to determine the magnitude of these changes and their relation to symptoms. Emerging techniques of receptor imaging are beginning to reveal localised reduction in GABA-A receptors in the brains of PTSD sufferers similar to those reported previously in panic disorder. The growing knowledge of the role of this primary inhibitory transmitter in regulating stress and anxiety makes such findings of potential pathophysiological significance. Moreover, understanding the molecular substructures of brain GABA-A receptors and the highly specific functional correlates of receptor subtypes generates new theories of stress learning and the possibility of new therapeutic interventions. Measuring regional GABA levels with MR spectroscopy and receptor expression with new subtype-selective tracers offers exciting future avenues for research.

No. 50C
SLEEP IN PTSD AND OTHER ANXIETY DISORDERS

Karl Doghramji, M.D., *1015 Walnut Street, Suite 319, Philadelphia, PA 19107*

SUMMARY:

Demographic data suggest that there is a close link between anxiety disorders and disturbed sleep. Anxiety disorders represent the most common psychiatric disorder among current insomniacs, and persistent insomnia is associated with an increased risk of the development of new anxiety disorders. Conversely, acute stress, anxiety states, and anxiety disorders are associated with complaints of sleep discontinuity. Sleep architectural changes include sleep discontinuity, a deterioration of slow-wave sleep, an increase in REM activity, and an increase in stage 1 sleep, among others. These changes in sleep are associated with higher psychopathology, and their resolution is predictive of successful adaptation to trauma. Although the neurophysiological mechanisms underlying the genesis of disturbed sleep in anxiety disorders are not completely understood, attention has been recently focused on the role of GABA, which is critically involved in the generation of delta waves during sleep. There is a paucity of data regarding the management of sleep difficulties in anxiety disorders. The most extensively utilized agents seem to be the benzodiazepines, which act through the recognition sites on the GABA-BZ receptor complex and produce an allosteric modulation of GABAergic neurons. Although their effects are potent and predictable, sole reliance on these agents for extended periods of time has raised the concern regarding tolerance and rebound, and the fears regarding the possibility of fomenting addictive behavior in vulnerable individuals. Data are also emerging on the potential benefits of the 5SRIs and SNRIs, which may be more reasonable for longer-term use, yet which also have been shown to induce impairments in sleep architecture in acute-term studies. Anticonvulsants are also being actively investigated, especially after pilot data have indicated the possibility that some in this class may induce enhancements of slow-wave sleep. The neuroleptic agents have also been shown to improve sleep architecture in highly distressed psychotic populations. Nonpharmacologic methods, such as sleep hygiene education and cognitive behavior therapies targeting sleep disruption and anxiety, should also be strongly considered.

REFERENCES:

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2. Nutt DJ, Malizia RL: New insights into the role of the GABA-A-benzodiazepine receptor. British Journal of Psychiatry 2001; 179:390–396.
3. Mellman TA, Kulick-Bell R, Ashlock LE, Nolan B: Sleep events among veterans with combat-related posttraumatic stress disorder. Am J Psychiatry 1995; 152:110–115.

INDUSTRY-SUPPORTED SYMPOSIUM 51—BIPOLAR DISORDER IN WOMEN: REPRODUCTIVE IMPLICATIONS OF TREATMENT, PART I
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant will be acquainted with the clinical management issues for women with bipolar disorder ranging from efficacy of treatment to the effect of treatment on reproductive endocrine function.

No. 51A
TREATMENT OF BIPOLAR ILLNESS DURING PREGNANCY

Lee S. Cohen, M.D., *15 Parkman Street, WAC 812, Boston, MA 02114*

SUMMARY:

While the postpartum period has typically been considered a period of risk for relapse of bipolar disorder, systematic data regarding the course of bipolar disorder during pregnancy are sparse. The management of women with bipolar disorder who plan to conceive or who are pregnant or puerperal poses significant challenges for clinicians who care for these patients. Recent data suggest that pregnancy is not "protective" against relapse of psychiatric disorder and that for women with bipolar disorder specifically, relapse is common after lithium discontinuation. This presentation reviews the major clinical dilemmas associated with management of pregnant bipolar patients with bipolar disorder and examines recent data on the course of bipolar disorder during pregnancy and the postpartum period. Treatment guidelines for the management of bipolar illness for women trying to conceive and during pregnancy are presented. An algorithm for assessment of risks and benefits of using both older and newer psychiatric medications across a variety of classes of compounds including antipsychotics and mood stabilizers is presented. Given the growing use of anticonvulsants to treat bipolar illness, particular attention is given to available reproductive safety data regarding these compounds.

REFERENCES:

1. Morrell MJ, Sarto GE, Osborne Shafer P, Borda EA, Herzog A, Callanan M: Health issues for women with epilepsy: a descriptive survey to assess knowledge and awareness among healthcare providers. J Womens Health Gend Based Med 2000; 8:959–965.
2. Ernst CL. Goldberg JF: The reproductive safety profile of mood stabilizers, atypical antipsychotics, and broad-spectrum psychotropics. J Clin Psychiatry 2002; 63:42–55.
3. Nonacs R, Viguera AC, Cohen LS: Psychiatric aspects of pregnancy, in Women's Mental Health. Edited by Kornstein SG, Clayton AH. New York, Guilford Publications, 2002.

No. 51B
BIPOLAR ILLNESS DURING THE POSTPARTUM PERIOD: UPDATE ON TREATMENT

Adele C. Viguera, M.D., *15 Parkman Street/WACC 815, Boston, MA 02114*

SUMMARY:

The postpartum period is a period of risk for emergence of new-onset psychiatric disorders and for substantial worsening of pregravid mood and anxiety disorders. Recent work suggests that many women with bipolar disorder are especially vulnerable to relapse during the postpartum period. Estimates for risk of relapse among women with bipolar disorder during the postpartum period are between 30% and 50%. Several investigators have evaluated the extent to which postpartum prophylaxis with lithium attenuates such risk. Results of this work point to a significant reduction in rates of relapse in women who receive lithium during the first 48 hours postpartum, compared with women who do not receive prophylactic treatment. However, there is no consensus on the best timing of prophylaxis and on whether lithium is superior to other mood stabilizers as a prophylactic agent. Other clinical issues to be addressed in this presentation include the incidence of neonatal toxicity with the use of mood stabilizers proximate to delivery, neurobehavioral outcome after exposure to mood stabilizers, and breastfeeding during treatment with mood stabilizers. The goal of this presentation is to review data on the epidemiology, course, and treatment of bipolar illness during the postpartum period as well as to highlight controversial clinical issues related to mood stabilizers and neonatal outcome, neurobehavioral outcome, and breastfeeding, which are areas requiring further research.

No. 51C
TREATMENT OF BIPOLAR ILLNESS IN ADOLESCENCE: IMPLICATIONS FOR YOUNGER WOMEN

Janet Wozniak, M.D., *55 Fruit Street, Boston, MA 02114*

SUMMARY:

An emerging literature characterizes a subtype of bipolar disorder with onset during childhood and adolescence. This disorder is highly comorbid with conduct disorder, oppositional defiant disorder, anxiety disorders, and cognitive dysfunction. Individuals present with high levels of irritability and aggression. Across various samples, pediatric-onset bipolar disorder has been noted to have a male preponderance (approximately 70% of patients are male) and high rates of comorbidity with attention-deficit/hyperactivity disorder (ADHD), also a male-preponderant disorder (2:1 male-to-female ratio). Work addressing gender heterogeneity in ADHD suggests that girls with ADHD are less likely to present with conduct disorder and executive functioning dysfunction. This presentation addresses aspects of gender heterogeneity in pediatric-onset bipolar disorder, including patterns of comorbidity, clinical characteristics of mood and cycling, and cognitive functioning.

REFERENCE:

1. Viguera A, Nonacs R, Cohen L, Tondo L, Murray A, Baldessarini R: Risk of recurrence of bipolar disorder in pregnant versus nonpregnant women after discontinuing lithium maintenance. Am J Psychiatry 2000; 157:179–184.

INDUSTRY-SUPPORTED SYMPOSIUM 52—OPTIMIZING ANTIPSYCHOTIC TREATMENT IN PATIENTS WITH SCHIZOPHRENIA AND BIPOLAR DISORDER
Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe current and emerging treatments for schizophrenia and bipolar disorder and discuss the efficacy and tolerability of each of these treatments, discuss how efficacy and tolerability should be balanced in treating diverse patient populations, review strategies optimizing antipsychotic treatment in individuals with schizophrenia and bipolar disorder in various clinical settings.

No. 52A
OPTIMIZING PHARMACOTHERAPY FOR MAXIMIZED OUTCOMES

Alan J. Mendelowitz, M.D., *7559 263rd Street, Glen Oaks, NY 11004-1150*

SUMMARY:

Over the last decade, the medication management aspect of the treatment of patients with schizophrenia, schizoaffective disorder, and bipolar disorder has changed dramatically. A new generation of atypical antipsychotics and mood stabilizers has offered patients and clinicians an increased number of potential treatment options with differing side-effects profiles. The ongoing examination of atypical antipsychotics in bipolar disorder continues to offer new potential treatment strategies in this cohort of patients. The methods by which clinicians select antipsychotic medications and the definitions of

clinical response will be examined. The consideration of changing expectations of efficacy by clinicians, patients, and families will be discussed. In addition, the definition of the partially responsive patient will be examined and the potential treatment options that are available to treat this group of patients will be considered.

No. 52B
KEEPING TOLERABILITY IN MIND: ENSURING ADHERENCE TO MAINTAIN RECOVERY

Henry A. Nasrallah, M.D., *231 Albert Sabin Way, P.O. Box 670559, Cincinnati, OH 45267-0559*

SUMMARY:

The key to successful pharmacotherapy is combining efficacy with tolerability. Unless tolerability is achieved, patients will inevitably discontinue (or only partially comply with) the medications, resulting in recurrence of symptoms and, eventually, relapse. Nowhere in clinical practice is this more true than among persons with lifelong psychiatric brain disorders, such as schizophrenia and bipolar disorder. Atypical antipsychotics have become widely accepted as the class of choice for the treatment of psychotic manifestations of the schizophrenia-bipolar continium. The 5 first-line atypicals (in order of appearance: risperidone, olanzapine, quetiapine, ziprasidone, and aripiprazole) are very similar in efficacy in acute schizophrenia as measured by the Positive and Negative Symptoms Scale (PANSS) in double-blind, placebo-controlled pivotal studies, which represent the evidence-based guidance for clinical practice. However, they do vary considerably in their safety and tolerability. For example, there are well-known iatrogenic differences in movement disorders, sexual dysfunction, obesity, hyperglycemia, and dyslipidemia among the members of the atypical class. Patients with impaired insight into the need for medications, as with many patients with schizophrenia and mania, tend to have erratic adherence due to their anosognosia, or, as with some bipolar patients, because they prefer the "highs." Thus, subjective tolerability issues become critical factors as to whether patients treated for schizophrenia or bipolar disorders will continue adhering to their medication regimen in the ambulatory setting after recovering from their acute episode in an inpatient setting. This presentation will focus on customizing antipsychotic selection to assure consistent adherence in the outpatient setting in order to maximize tolerability, to avoid relapses, and to sustain the social and vocational gains that follow recovery from a psychotic illness.

No. 52C
FINDING EFFECTIVENESS ACROSS PATIENT AGE GROUPS

Rajiv Tandon, M.D., *1500 East Medical Center Drive, Ann Arbor, MI 48109-0120*

SUMMARY:

Patients of all ages suffer from schizophrenia and bipolar disorder. As patients age, there are important changes that occur in their metabolism and physiology. Further, the incidence of comorbid conditions, risk factors, and other medical disorders varies as a patient grows, matures, and ages. These factors all influence the action of medications in patients, their sensitivity to adverse effects, and ultimately, the effectiveness of pharmacologic treatment. This presentation will examine factors that impact the comparative efficacy of various antipsychotic medications in schizophrenia and bipolar disorder and the unique aspects of each age group that must be considered when optimizing antipsychotic treatment of individuals with schizophrenia and bipolar disorder.

No. 52D
BALANCING THE EFFICACY AND TOLERABILITY FOR PEDIATRIC BIPOLAR DISORDER

Melissa P. DelBello, M.D., *231 Albert Sabin Way, PO Box 670559, Cincinnati, OH 45267-0559*

SUMMARY:

Pharmacological agents that are used to treat bipolar disorder have multiple side effects. Medical compliance rates of patients with bipolar disorder are poor, which has been shown to adversely impact outcome. Adolescents with bipolar disorder are at high risk for treatment noncompliance. Recent advances have identified a growing number of medications that have demonstrated efficacy, effectiveness, and tolerability for treating pediatric bipolar disorder. Specific pharmacological agents may have properties that make them more effective for treating particular children and adolescents with bipolar disorder and comorbid disorders. Moreover, each drug has specific adverse effects that may be less tolerable in particular patients. Clinicians who understand these different hallmark adverse effects will be better able to tailor their patients treatments for their individual needs, as well as balance the benefits and risks of possible adverse effects of a given drug. We will examine efficacy and tolerability of medications commonly used to treat children and adolescents with bipolar disorder, with particular attention to side effects that may occur more frequently in this population.

No. 52E
TREATMENT CONSIDERATIONS IN SPECIAL POPULATIONS: SEX DIFFERENCES

Diana O. Perkins, M.D., *1052 Neuroscience's Hospital, Chapel Hill, NC 27514*

SUMMARY:

The clinical manifestations and optimal treatment of schizophrenia vary for men and women. Despite the fact that schizophrenia affects similar proportions of men and women, there are sex-related differences in premorbid function, age of onset, response to antipsychotics, and outcomes. There is considerable interest in understanding biologic factors that underlie the sex-related difference in clinical features of schizophrenia. A number of causes have been postulated, including the potential impact of genes and hormones (especially estrogen) on brain development, maturation, and function. Central to the success of disease management are efforts to understand which specific pharmacotherapy is most effective for a particular patient. Women may have a better response to and require lower doses of antipsychotics than men. Women may also be differentially vulnerable to medication side effects. In particular, women are at greater risk for hyperprolactinemia associated with typical antipsychotics and the atypical antipsychotic risperidone. Differences between men and women in the clinical expression and treatment of schizophrenia will be critically discussed. Emerging data on sex-related differences in pharmacologic treatment response to antipsychotics and on the adjunctive use of estrogen in the treatment of woman with schizophrenia will also be presented.

REFERENCES:

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2. Kemp RA, David AS: Patient Compliance, in Comprehensive Case of Schizophrenia: A Textbook of Clinical Management. Edited by Lieberman JA, Murray RM, Martin Dunitz, London, 2001, pp. 269–280.

3. Emsley R: The new and evolving pharmacotherapy of schizophrenia. Psychiatr Clin North Am 2003; 26:141–63.
4. Strakowski SM, Adler CM, DelBello MP: Comparative efficacy and tolerability of drug treatment for bipolar disorder. CNS Drugs 2001; 15:701–18.
5. Berman I: Gender and treatment response to atypical antipsychotics. Schizophr Res 2000; 41:205–213.

INDUSTRY-SUPPORTED SYMPOSIUM 53—CORE SYMPTOM DOMAINS IN THE ANXIETY DISORDERS
Supported by Wyeth Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize symptom domains in the anxiety disorders, differentiate symptoms from disorders, and utilize an understanding of the neurobiology to select targeted treatments for anxiety disorders.

No. 53A
DIFFERENTIAL DIAGNOSIS AND BIOLOGY OF PANIC AND GAD

Jack M. Gorman, M.D., *One Gustave L. Levy Place, Box 1230, New York, NY 10029*

SUMMARY:

The differential diagnosis between generalized anxiety disorder (GAD) and panic disorder has undergone interesting changes since they were originally conceived of as separate disorders in the 1980 DSM-III. In that document, GAD was essentially an afterthought, or "residual diagnosis," carved out to handle patients with persistent and debilitating anxiety but no panic attacks. The expectation at the time was that GAD would be diagnosed only infrequently. Since then, several epidemiological studies have indicated that, if anything, GAD is more common than panic disorder. Many patients with GAD have at least an occasional panic attack and patients with panic disorder are frequent worriers. Furthermore, at least among treatment seeking individuals, panic disorder and GAD co-occur at a very high rate. It was also once thought that the conditions have fundamentally different pharmacologically response profiles, with GAD supposedly responding to benzodiazepines and panic disorder responding to antidepressants, but not the other way around. It is now clear that this is not true and that both conditions respond to both classes of medication, with antidepressants generally regarded as the preferred first-line pharmacological approach. Hence, clinicians are now advised to consider GAD and panic disorder to be co-occurring conditions in patients with anxiety disorder. It is possible, however, that distinctions exist between the two conditions in some aspects of neurobiology. Panic disorder may involve more activation of amygdala and sympathetic nervous system and less activation of prefrontal cortex than GAD. GAD may primarily involve prefrontal hyperactivity. As these similarities and differences are worked out in the coming years, it is likely that there will be further refinements in the diagnosis of panic disorder and GAD.

No. 53B
SYMPTOMS AND BIOLOGIC CORRELATES OF PTSD: FROM EARLY ADULTHOOD TO OLD AGE

Rachel Yehuda, Ph.D., *130 West Kingsbridge Road, #116A, Bronx, NY 10468*

SUMMARY:

Substantial progress has been made in understanding the psychological and biological factors that increase the risk for developing posttraumatic stress disorder (PTSD) following trauma exposure, and those that promote recovery, or resiliency. Prospective longitudinal studies of survivors in the immediate aftermath of trauma suggest that PTSD may result following trauma exposure as a result of an inadequate termination of the acute stress response (e.g., resulting from depressed cortisol levels that may fail to blunt the adrenergic response as well as intense psychological distress), which over time can lead to a progressive sensitization of the stress response and a prolonged arousal state. Such studies typically follow survivors for only several months, though it is of interest to know about predictors of the kind of PTSD known to last for decades. This presentation will highlight new data from longitudinal biologic studies of WTC survivors as well as new data from a recently completed ten-year longitudinal biologic study of Holocaust survivors. Data from the WTC cohort demonstrate a stronger association between biologic alterations and symptoms severity at earlier, rather than later times (e.g., from one to two years), following traumatization. Data from Holocaust survivors demonstrate substantial changes in circadian rhythmicity and other variables that may be associated with symptom expression. There is a tendency for reduced severity of discrete PTSD symptoms over time, particularly in very old persons, biologic alterations associated with PTSD (e.g., neuroendocrine, neurocognitive), are amplified. The clinical implications of these findings will be discussed.

No. 53C
THE SOCIAL ANXIETY SPECTRUM

Michael R. Liebowitz, M.D., *1051 Riverside Drive #54, New York, NY 10032-2603*; Franklin R. Schneier, M.D.; Jonathan E. Shaywitz, M.D.

SUMMARY:

Social anxiety disorder has received increasing research attention over the past decade, with substantial progress in understanding its phenomenology, pathophysiology, and treatment.

At the same time, these advances have led to new questions about the boundaries of the condition as well as its internal homogeneity and heterogeneity. This presentation will review recent advances in the field and use them to explore the following questions:

(1) How should social anxiety disorder be distinguished from normal anxiety and shyness?

(2) Are focal and generalized cases of social anxiety disorder best conceptualized as falling on a continuum or as distinct non-generalized and generalized subtypes?

(3) Should conditions such as social anxiety secondary to a medical condition, olfactory reference syndrome and related conditions where individuals withdraw socially because they fear they are making others uncomfortable, avoidant personality disorder, schizoid personality disorder, and body dysmorphic disorder be conceptualized as comprising a social anxiety disorder spectrum when looked at in terms of phenomenology, pathophysiology and treatment?

No. 53D
THE REPETITIVE BEHAVIOR DOMAIN IN OBSESSIVE-COMPULSIVE AND DEVELOPMENTAL DISORDERS

Eric Hollander, M.D., *One Gustave Levy Place, Box 1230, New York, NY 10029*; Stacey Wasserman, M.D.

SUMMARY:

Obsessive-compulsive disorder (OCD) is characterized by intrusive, disturbing thoughts, impulses or images that cause anxiety, and compulsive rituals designed to reduce anxiety or neutralize obsessive thoughts. Frontal-striatal-thalamic circuitry has been elucidated that appears to mediate repetitive thoughts and behaviors. Interventions that modulate this circuitry may modify the severity of such symptoms. Of interest, patients with OCD have increased comorbidity with, and increased family history of OC spectrum disorders, including body dysmorphic disorder, eating disorders, trichotillomania, Tourette's syndrome, and hypochondriasis. One consideration for DSM-V is removing OCD from the anxiety disorders, and grouping it with the OCD spectrum disorders described above.

Patients with developmental disorders such as autism have repetitive thoughts and behaviors, including rigid rituals and routines, narrow restricted interests, and perseverative/stereotypical and self-stimulatory behaviors. The higher-order OCD-like behaviors reduce anxiety, while the lower-order autistic-like behaviors are associated with arousal regulation. This symptom domain is increased in affected siblings and in parents of probands with high repetitive behaviors. The neurocircuitry of repetitive behaviors in autism is being elucidated, and antiobsessional treatments appear to improve this symptom domain.

Diagnostic boundary issues and neurocircuitry for repetitive behaviors are described across OC-related conditions, and treatment implications highlighted.

No. 53E
MIXED ANXIETY AND DEPRESSION: A GORDIAN KNOT

Joseph Zohar, M.D., *Tel Hashomer, Israel 52621*; Yehuda Sasson, M.D.

SUMMARY:

In the "real world," it is not always easy to disentangle depression from anxiety and vice versa. Moreover, long-life comorbidity of some of the anxiety disorders (eg., PTSD, OCD, social anxiety, etc.) with depression is actually above 50%.

The governing school of thought regarding this sizeable group of patients is the hierarchical or primary-secondary approach. The underlying hypothesis is that the affective component is secondary to the suffering induced by the anxiety disorder. According to this line of reasoning, only successful treatment of the primary cause will eventually lead to a subsequent resolution of the depression. Another conceptualization of mixed anxiety and depression is the symptomatic approach, i.e., treating equally (and appropriately) the different symptoms. Unfortunately, the way most studies in anxiety and depression were conducted does not give us good footing as they used to exclude depression in anxiety studies and vice versa.

Alexander the Great, so the legend says, being frustrated with the complex knot, used his sword to cut through it. The author will present less dramatic approaches, including functional brain imaging and genetic reasoning along with some practical therapeutic hints, in an attempt to explore (and treat) the anxiety-depression knot.

REFERENCES:

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INDUSTRY-SUPPORTED SYMPOSIUM 54—BACK TO THE FUTURE: THE ROLE OF GAMMA-AMINOBUTYRIC ACID IN PSYCHIATRIC DISORDERS AND TREATMENT

Supported by Cephalon, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the role of GABA in the pathophysiology of anxiety, sleep, and mood disorders and the potential role of GABAergic agents in their treatment.

No. 54A
GAMMA-AMINOBUTYRIC ACID IN THE CNS

Philip T. Ninan, M.D., *1841 Clifton Road, 4th Floor, Atlanta, GA 30329*

SUMMARY:

Gamma-aminobutyric acid (GABA) is the principle inhibitory neurotransmitter with a physiological role in the majority of the estimated 10 trillion to quadrillion synapses in the human brain. GABA acts on three receptor classes: $GABA_A$, $GABA_B$, and $GABA_C$. $GABA_A$ and $GABA_C$ receptors act on anion channels that mediate fast inhibitory inhibition via inhibitory post-synaptic potentials. At least 14 subunits of the mammalian $GABA_A$ receptor have been identified and cloned. Subunits differentially mediate the anxiolytic and sedative effects of benzodiazepines. $GABA_B$ receptors are metabotropic, acting via G-protein coupled mechanisms mediating slow inhibition. GABA neurons are also critical in another set of synapses—electrical coupling through gap junctions that provide a different mechanism for local inhibitory circuits. Their functional significance is becoming increasingly evident in the segregated cortico-basal ganglia-thalamic-cortical reverberating circuits relevant for executive control in motor responses and potentially in emotions. GABA interacts with various monoaminergic and peptidergic systems to have complex and multi-domain global as well as selectively nuanced inhibitory effects. These effects alter the functional activity of critical neurocircuits relevant to psychopathology and also mediate the therapeutic benefits of several pharmacological agents.

No. 54B
NEUROIMAGING AND ANXIETY

Justine M. Kent, M.D., *1051 Riverside Drive, Unit 41, New York, NY 10032*

SUMMARY:

A major focus within the field of anxiety in the past decade, and an area of intense ongoing interest, is the delineation of the basic neurocircuitry underlying normal and pathological anxiety. Through the work of preclinical researchers, animal models of normal fear responding have been developed and refined, leading to the definition of a basic "fear neurocircuitry." It is this amygdala-based "fear neurocircuitry" that has served as the basis for the human neurocircuitry models being explored through neuroimaging techniques today. In this presentation, neuroimaging findings contributing to current neuroanatomical models for posttraumatic stress disorder, panic disorder, social anxiety disorder, and generalized anxiety disorder are reviewed. Commonalities in the neuroanatomy emerging from the neuroimaging literature for these anxiety disorders are discussed, including how these findings converge with the preclinical "fear neurocircuitry." Results of magnetic resonance spectroscopy and

positron emission tomography neuroimaging studies aimed at elucidating the role of the $GABA_A$-benzodiazepine receptor in the etiology and pharmacologic treatment of anxiety are presented, and treatment implications are discussed.

No. 54C
GAMMA-AMINOBUTYRIC ACIDERGIC AGENTS IN ANXIETY TREATMENT: A LOOK BACK AND AHEAD

Mark H. Pollack, M.D., *15 Parkman Street, WACC-812, Boston, MA 02114*

SUMMARY:

Accruing evidence points to a critical role for the inhibitory neurotransmitter GABA in the pathophysiology of the anxiety disorders. Its influence is mediated through direct effects on critical brain regions involved in the initiation and maintenance of anxiety and through interactions with other key neurotransmitter systems modulating the relevant systems in the CNS. This presentation examine the role of GABA and GABAergic systems in specific anxiety syndromes and examines the role of GABAergic agents for the treatment of anxiety disorders. Benzodiazepines, acting to facilitate GABAergic transmission, have long been a mainstay in the treatment of anxiety, and evidence for their efficacy and the risks and benefits of their use will be reviewed. The potential role of novel agents acting through GABAergic systems for the treatment of anxiety disorders is explored.

No. 54D
EMERGING GAMMA-AMINOBUTYRIC ACIDERGIC TARGETS FOR INSOMNIA

John W. Winkelman, M.D., *1400 Centre Street, Newton Center, MA 02459*

SUMMARY:

Normal sleep is under the complex regulation of monoaminergic, cholinergic GABAergic, and the newly described orexin transmitter systems. For this reason, insomnia (the most prevalent sleep disorder) can be treated by a variety of medications with disparate mechanisms of action. The most effective currently available agents for the relief of insomnia bind to the benzodiazepine $GABA_A$ receptor complex, although such agents may interfere with motor function and memory consolidation and have the potential for both tolerance and withdrawal. This presentation describes the composition and the anatomical localization of $GABA_A$ receptor subtypes, as well as the potential interactions of this system with other relevant sleep regulatory systems. Current medications used to modulate the GABA system and their specific effects on sleep architecture are described. These include the GABA reuptake inhibitor tiagabine, nonspecific (benzodiazepine hypnotic) and specific (zaleplon, solpidem, sopielone) $GABA_A$ benzodiazepine receptor agonists, as well as agents that influence sleep via the steroid binding site on the $GABA_A$ receptor.

No. 54E
BEYOND ANXIETY DISORDERS: THE ROLE OF GAMMA-AMINOBUTYRIC ACID IN MOOD DISORDERS

Naomi M. Simon, M.D., *15 Parkman Street, WANG ACC 815, Boston, MA 02114*

SUMMARY:

Although the majority of the focus on neurotransmitters involved in mood disorders has been on serotonin and noradrenergic systems, there is emerging data suggesting a role for GABAergic systems in depression and bipolar disorder. This evidence comes from basic research directly examining these systems in patients suffering from unipolar depression or bipolar disorder and from emerging evidence for the efficacy of pharmacotherapeutic agents that act on GABAergic systems. In addition, many patients with mood disorders suffer from anxiety, which often impairs response to typical treatment interventions. Data suggesting a role for GABA in unipolar depression and bipolar disorder and its implication for potential treatment strategies in patients with mood disorders with and without comorbid anxiety are reviewed.

REFERENCES:

1. Galaereta M, Hostrin S: Electrical synapses between GABA-releasing interneurons. Nature Neuroscience Reviews 2001; 2:425–433.
2. Kent JM, Rauch SL: Neurocircuitry of anxiety disorders. Curr Psychiatry Rep 2003; 5:266–273.
3. Pollack MH, Otto MW, Rosenbaum JF (eds): Challenges in Clinical Practice: Pharmacologic and Psychosocial Strategies. New York, Guilford, 1996.
4. Mignot E, Taheri S, Nishino S: Sleeping with the hypothalamus: emerging therapeutic targets for sleep disorders. Nature Neurosci 2002; 5(suppl):1071–1075.
5. Tunnicliff G, Malatynska E: Central GABAergic systems and depressive illness. Neurochem Res 2003; 28:965–976.

THURSDAY MAY 6, 2004

INDUSTRY-SUPPORTED SYMPOSIUM 50—PTSD: SEARCHING FOR ANSWERS IN TRAUMATIC TIMES, PART 2
Supported by Cephalon, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to 1) understand the overall consequences of PTSD; 2) describe the impact of terrorist actions on mental health; 3) understand the neurobiology of PTSD, including the roles of GABA and glutamate; 4) recognize the nature of sleep disturbance and its treatment; and 5) review effective and ineffective forms of psychotherapy and pharmacotherapy.

No. 50A
TREATMENT AND PREVENTION OF CHRONIC PTSD: PSYCHOSOCIAL APPROACHES

Edna B. Foa, Ph.D., *3535 Market Street Suite 600 North, Philadelphia, PA 19104*

SUMMARY:

This presentation provides an overview of the efficacy of cognitive behavior treatments for PTSD that have been empirically validated. The outcomes of exposure therapy programs are discussed and compared with those of stress inoculation training, cognitive therapy programs, and eye movement desensitization and reprocessing. At present, exposure therapies can be viewed as the gold standard treatment for PTSD because of the large number of studies attesting to their efficacy and efficiency. Finally, current knowledge about interventions aimed at preventing the development of PTSD are discussed, with the caveat that although we know how to treat chronic PTSD, research is needed to know how to prevent its development.

No. 50B
NOVEL DRUG TREATMENTS FOR PTSD BEYOND SSRIS

Wei Zhang, M.D., *Box 3812, Durham, NC 27710*

SUMMARY:

Posttraumatic stress disorder (PTSD) is a complex psychiatric disorder that presents with many treatment challenges due to its chronicity, multiplicity of symptoms, and high relapse rate. Current drug therapy mainly involves treatments with antidepressants among which selective serotonin reuptake inhibitors (SSRIs) are the recommended first choice. However, the appeal of SSRIs has been limited by their side effects and limited efficacy in certain symptom domains and in certain patient populations. The search for novel pharmacotherapy beyond SSRIs is warranted, and research on treatments involving neurobiological systems other than serotonin or norepinephrine, e.g. GABA, is currently in progress. This presentation describes recent pharmacotherapy research in PTSD, including the roles of serotoninergic and noradrenergic medications, atypical neuroleptics, and drugs that act primarily via GABAergic pathways, both in short-term and long-term therapy.

REFERENCE:

1. Foa EB, Keane TM, Fricdman MJ (eds): Effective Treatments for PTSD. Practice Guidelines from the International Society for Traumatic Stress Studies. New York, Guilford, 2000.

INDUSTRY-SUPPORTED SYMPOSIUM 51—BIPOLAR DISORDER IN WOMEN: REPRODUCTIVE IMPLICATIONS OF TREATMENT: PART II
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVE:

At the conclusion of the symposium, the participant will be acquainted with the clinical management issues for women with bipolar disorder ranging from efficacy of treatment to the effect of treatment on reproductive endocrine function.

No. 51A
USE OF ANTIEPILEPTIC MEDICATIONS IN WOMEN

Martha J. Morrell, M.D., *710 West 168th Street, New York, NY 10032*

SUMMARY:

Some antiepileptic drugs (AEDs) have negative effects on fertility, gynecological health, contraceptive efficacy, and pregnancy outcome. Cytochrome P450 enzyme-inducing AEDs increase sex steroid binding and metabolism and reduce levels of estrogen and of androgens. AEDs that inhibit cytochrome P450 enzymes reduce metabolism and increase steroid concentrations. Some deficits are AED-specific: More than 40% of women with epilepsy who take valproate have polycystic ovaries and/or hyperandrogenism, and these abnormalities reverse when the women's medications were changed to lamotrigine. Children born to mothers with epilepsy taking AEDs have a 4% to 8% risk of a major malformation, in contrast to a 2% to 4% risk in the general population. Defects have been reported after exposure to all of the older AEDs used as monotherapy or in polytherapy and after exposure to the newer AEDs used in polytherapy. Since older AEDs have antifolate effects, the American Academy of Neurology recommends that women with epilepsy taking AEDs receive 0.8 to 1 mg/day of folic acid. A recent survey of health care providers documents a low level of knowledge and high degree of uncertainty regarding best practices in caring for women receiving AEDs. As use of AEDs grows, such knowledge is essential.

No. 51B
REPRODUCTIVE ENDOCRINE CONSEQUENCES OF TREATMENT

Hadine Joffe, M.D., *15 Parkman Street, WACC 812, Boston, MA 02114*

SUMMARY:

The use of psychotropic medications can have important implications for the reproductive-endocrine system in premenopausal women with bipolar disorder. Antipsychotics and mood stabilizers are commonly prescribed to women with bipolar disorder. Both have been associated with specific types of reproductive-endocrine dysfunction. Typical antipsychotics and the 'atypical' antipsychotic risperidone are known to increase levels of the pituitary hormone prolactin. Prolactin elevation is commonly associated with menstrual irregularities, which can lead to estrogen deficiency if menses are infrequent. If estrogen stores are reduced for a prolonged period of time, there is a substantial risk for osteoporosis in young women. Polycystic ovarian syndrome (PCOS) is a disorder of infrequent ovulation and either elevated levels of or increased sensitivity to male hormones. PCOS is a common disorder in premenopausal women that presents with infrequent and irregular menstrual cycles, excess facial-hair growth, acne, and male-pattern balding, and can be associated with elevated levels of androgens and obesity. The mood-stabilizer valproic acid has been reported to be associated with PCOS, particularly in women taking the medication for treatment of epilepsy. However, information to date on this possible relationship is limited, and results of several small studies in women with seizure and bipolar disorders are contradictory. This presentation reviews the disorders of prolactin elevation and PCOS. Data on the relationship between psychotropic treatments of bipolar disorder and these reproductive-endocrine disorders is discussed. Preliminary guidelines for the monitoring and management of prolactin disorders and PCOS in premenopausal women with bipolar disorder are addressed.

SCIENTIFIC AND CLINICAL REPORT SESSION 1—ISSUES IN SCHIZOPHRENIA

No. 2
RIVASTIGMINE AND GALANTAMINE TREATMENT OF SCHIZOPHRENIC COGNITIVE IMPAIRMENT

Mohammad Z. Hussain, M.D., *Prince Albert Health District, Mental Health Centre, 2727 2nd Avenue West, Prince Albert, SK S6V 5E5, Canada;* Zubaida A. Chaudhry, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize neurocognitive deficits in schizophrenia, management with rivastigmine and galantamine, and its impact on quality of life, social functioning, and functional recovery.

SUMMARY:

Despite the beneficial effects of second-generation neuroleptics on cognition, these improvements do not return the majority of schizophrenic patients to normative standards of cognitive functioning. Changes in cholinergic functions in schizophrenia provide the rationale to test the effectiveness of cholinesterase inhibitors in treating cognitive impairment.

A six-month, double-blind, placebo-controlled trial with rivastigmine 1.5 mg b.i.d. and galantamine 3 mg b.i.d. followed by six months open extension with rivastigmine 3 mg daily and galantamine 8 mg daily as adjunctive treatment in stable schizophrenics with cognitive impairment receiving clozapine, risperidol, or olanzapine was conducted in 26 males and 36 females, aged 20–58 (34.6), duration of illness 6–30, (14.92), years on clozapine 2–11 (6.12), olanzapine 2–5 years (4.03), risperidol 2–7 (6.84). Trial completion: galantamine 18, rivastigmine 17, placebo 19. Five withdrew consent, three discontinued medication due to side effects. Following a blind trial, half of the placebo patients changed to rivastigmine and half of galantamine. Patients on galantamine, rivastigmine, and one patient on placebo showed improvement in PANSS, cognition, and quality of life. Ten patients started working, four enrolled in educational upgrading, 23 reduced smoking. Results suggest usefulness of rivastigmine and galantamine in enhancing cognitive performance and improving social and work functioning.

REFERENCES:

1. Rosler M, Anand R, Cicin A, et al: Efficacy and safety of rivastigmine in patients with Alzheimers disease: international randomised controlled trial. British Medical Journal 1999; 318:633–638.
2. Raskind MA, Peskind ER, Wessel T, et al: Galantamine in AD: a 6-month randomized, placebo-controlled trial with 6-month extension. Neurology 2000; 54:2261–2268.

No. 3
DOSING OF SECOND-GENERATION ANTIPSYCHOTICS IN A LARGE STATE HOSPITAL SYSTEM

Leslie L. Citrome, M.D., *Nathan Kline Institute, 140 Old Orangeburg Road, Building 37, Orangeburg, NY 10962;* Ari B. Jaffe, M.D., Jerome Levine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that recommended dose ranges obtained during drug registration trials do not necessarily reflect clinical realities.

SUMMARY:

Objective: To describe the dosing of second-generation antipsychotics (clozapine, risperidone, olanzapine, quetiapine, ziprasidone, and aripiprazole) among inpatients in state-operated psychiatric centers in New York State, and to contrast this with dosing recommendations made in the manufacturers' product labeling.

Methods: Information on patients and their antipsychotic medication treatment was extracted from a database containing drug prescription information from the inpatient facilities operated by the New York State Office of Mental Health. The principal period covered was April 1, 2003 through June 30, 2003. Dosing trends were calculated by examining the second quarter of calendar years 1997–2003.

Results: There were marked difference in dosages used compared with the FDA-approved dosage ranges recommended in the product labeling. Specifically, the average daily dose of olanzapine was 22.63 mg (N=1463), exceeding the 20 mg maximum recommended by the manufacturer; 43.7% of patients prescribed olanzapine received a daily dose greater than 20 mg. Among the patients prescribed quetiapine (N=801), 28.5% received a daily dose exceeding 750 mg. In contrast, patients prescribed risperidone (N=1287) received an average daily dose of 4.53 mg, substantially lower than the maximum of 16 mg evaluated during the registration studies. Examining dose trends over time, it appears that the divergence from product label recommendations occurred gradually and is possibly reflective of additional clinical experience with patients not normally included in dose-finding registration studies.

Conclusions: Recommended dose ranges obtained during drug-registration trials do not necessarily reflect clinical realities. Phase IV clinical trials that specifically target more difficult-to-treat patients are needed.

REFERENCES:

1. Citrome L, Volavka J: Atypical antipsychotics—revolutionary or incremental advance? Expert Review of Neurotherapeutics 2002; 2:69–88.
2. Citrome L, Volavka J: Optimal dosing of atypical antipsychotics in adults: a review of the current evidence, Harvard Review of Psychiatry 2002; 10:280–291.

No. 4
THE MEANING OF RESPONSE IN ACUTE SCHIZOPHRENIA

Mary Anne Pressman, M.D., *Department of Psychiatry, New York Medical College, 286 Soundview Avenue, White Plains, NY 10606-3822;* Eric D. Peselow, M.D., Scott Solloway, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to evaluate the true meaning of response to treatment ii schizophrenic patients

SUMMARY:

Objective: To evaluate the meaning and quality of the response in schizophrenic patients with acute treatment.

Method: The sample drawn from 294 inpatients treated for acute psychotic symptoms in one of eight studies involving various antipsychotic medications including the atypicals (risperidone, olanzapine, geodone, seroquel, clozapine), typicals (chlorpromazine or haloperidol), and placebo. Though the studies varied, all patients as measured by the Brief Psychiatric Rating Scale (BPRS) and Clinical Global

Impressions Scale (CGI). Entry into the study required an initial BPRS of 36, a CGI of 4 or greater, plus a score of 4 or greater on two of the four core psychotic symptoms of the BPRS (unusual thought content, conceptual disorganization of thought, auditory hallucinations, and paranoid ideation). Response to treatment was defined as a 20% reduction in symptoms and a CGI improvement score of 1 or 2 (very much or much improved).

Results: 141 of the 294 patients met the criteria for response. However, only 77 of the 141 "responders" fell below a BPRS score of 36. Of these 77, 64 still had a score of 4 or greater on the two core psychotic items. Thus 64 patients could have reentered the study after meeting the technical criteria for response. In the 10 days following the end of the study, only 19/64 (30%) of the responders were felt to have been well enough to leave a psychiatric facility.

Conclusion: Response to treatment when one looks at simple improvement in symptoms may be misleading. The implications of these facts will be discussed.

There was no funding for this study

REFERENCES:

1. Zito JM, Provenzano G: Pharmaceutical decision making: pharmacoepidemiology or pharmacoeconomics—who's in the driver's seat. Psychopharmacology Bulletin 1995; 31:735–744.
2. Meltzer HY: Treatment of the neuroleptic nonresponsive patient. Schizophrenia Bulletin 1992; 18:515–542.

SCIENTIFIC AND CLINICAL REPORT SESSION 2—ANXIETY DISORDERS

No. 5
CARBON DIOXIDE TEST IN RESPIRATORY PANIC DISORDER: A CLONAZEPAM TRIAL

Antonio E. Nardi, M.D., *Department of Psychiatry, Federal University Rio de Janeiro, R. Visconde de Piraja, 407/702, Rio de Janeiro 22410-003, Brazil;* Alexandre M. Valenca, M.D., Fabiana L. Lopes, M.D., Walter A. Zin, M.D., Isabella Nascimento, M.D., Marco A. Mazzasalma, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the features of respiratory panic disorder subtype in a respiratory test and therapeutic response.

SUMMARY:

Objective: To compare two subtypes of panic disorder—respiratory and nonrespiratory—regarding the carbon dioxide (CO2) challenge test and the efficacy of clonazepam in blocking the response to the test.

Methods: 34 panic disorder patients participated in a CO2 test after one hour, two weeks, and six weeks of treatment with clonazepam 2 mg/day or placebo. The patients were classified in respiratory and nonrespiratory subtypes. Before and after the tests, the anxiety levels and the symptoms of panic were assessed.

Results: In the clonazepam group, by the end of sixth week there was a statistically significant blockade of the response to the CO2 test. In the clonazepam group there was no significant difference between respiratory and nonrespiratory subtypes. In the placebo group, the respiratory subtype was significantly more sensitive to the test.

Conclusion: Clonazepam was equally effective in the blockade of CO2 inducing panic attacks in the respiratory and nonrespiratory panic disorder subtypes. The respiratory subtype was more sensitive to the test in the placebo group.

Acknowledgements: Brazilian Council for Scientific and Technological Development (CNPq). Grant: 300500/93-9.

REFERENCES:

1. Nardi AE, Valenca AM, Nascimento I, et al: Double-blind acute clonazepam vs. placebo in carbon dioxide-induced panic attacks. Psychiatry Research 2000; 94:179–184.
2. Valença AM, Nardi AE, Nascimento I, et al: Early carbon dioxide test may predict clinical response in panic disorder. Psychiatry Research 2002; 112:269–272.

No. 6
CHILD ABUSE AND THE DEVELOPMENT OF PTSD IN A CANADIAN EPIDEMIOLOGICAL SAMPLE

Michael A. Van Ameringen, M.D., *Department of Psychiatry, McMaster University, 1200 Main Street, West, Hamilton, ON L8N 3Z5, Canada;* Catherine L. Mancini, M.D., Beth Pipe, B.S.C., Jonathan Oakman, Ph.D., Michael Boyle, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participation should be able to understand the relationship between childhood maltreatment and the subsequent development of PTSD in a Canadian epidemiological sample and to become aware of the prevalence of childhood maltreatment in Canada.

SUMMARY:

Objective: Childhood maltreatment has been found to be a risk factor for the development of many psychiatric illnesses in adult life. A history of childhood physical or sexual abuse appears to be a key risk factor in the development of posttraumatic stress disorder (PTSD). We examined the prevalence of childhood physical and sexual abuse in a population-based, epidemiological sample of 3006 Canadians.

Method: A telephone interview, designed to elicit diagnoses of PTSD and common comorbid conditions, as well as a history of childhood physical and sexual abuse was conducted.

Results: The prevalence of lifetime PTSD (PTSD-L) was 9.2%; childhood physical abuse, 33.4%; and childhood sexual abuse, 10.5%. Those who met criteria for PTSD-L were significantly more likely to have a history of physical abuse, [51.4% vs. 31.4%, (Chi square = 53.12, df=2, p=.000)], and sexual abuse, [34.8% vs. 8% (Chi square = 17.13, df=4, p=.002)] compared with respondents with no PTSD diagnosis. Individuals who reported childhood physical abuse appeared to be at particular risk for developing comorbid alcohol abuse and dependence.

Conclusion: Childhood physical and sexual abuse are highly prevalent in the Canadian population. Individuals with a history of childhood physical and sexual abuse are at significantly greater risk for the development of PTSD following a traumatic event later in life.

REFERENCES:

1. Breslau N: The epidemiology of posttraumatic stress disorder: what is the extent of the problem? J Clin Psychiatry 2001; 62[Suppl 17]:16–22.
2. Pine D: Developmental psychobiology and response to threats: relevance to trauma in children and adolescents. Biological Psychiatry 2003; 53:796–808.

No. 7
TIAGABINE TREATMENT OF SOCIAL ANXIETY DISORDER

Laszlo A. Papp, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, New York, NY 10032;* Philip T. Ninan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the therapeutic potential of tiagabine for the treatment of social anxiety disorder.

SUMMARY:

Objective: Gamma aminobutyric acid (GABA) plays a key role in anxiety. Tiagabine, a selective GABA reuptake inhibitor (SGRI), increases synaptic GABA availability via selective transporter inhibition. Preliminary reports suggest that tiagabine is a potent anxiolytic. This study evaluated tiagabine for the treatment of social anxiety disorder (SAD).

Methods: This 12-week, open-label study was designed to evaluate 50 adult patients diagnosed with SAD. Tiagabine was initiated at 2 mg bid and titrated until optimum response in 2-mg increments to a maximum dose of 8 mg bid. Assessments included the Liebowitz Social Anxiety Scale (LSAS), Social Phobia Inventory (SPIN), and Clinical Global Impression of Change (CGI-C).

Results: To date, 43 patients have received study medication; 40 were included in the LOCF analysis. Tiagabine reduced symptoms of SAD (mean SEM LSAS score: baseline, 72.34.0; endpoint, 46.25.3; $p<0.0001$). Similar changes were observed on the SPIN ($p<0.0001$). Twenty-nine patients (72%) were rated as improved on the CGI-C at endpoint. Mean final tiagabine dose was 10 mg/d (range 4–16 mg/d). Commonly reported adverse events were somnolence (n= 26), dizziness (n=19), cognitive problems, forgetfulness (n=12), and headache (n=12). Six patients discontinued the study due to adverse events. Updated dataset will be presented from this ongoing study.

Conclusions: These findings suggest that tiagabine may be a treatment option for SAD.

REFERENCES:

1. Crane D: Tiagabine for the treatment of anxiety. Depress Anxiety 2003; 18: 51–52.
2. Zwanzger P, Baghai TC, Schüle C, et al: Tiagabine improves panic and agoraphobia in panic disorder patients. J Clin Psychiatry 2001; 62:656–657.

SCIENTIFIC AND CLINICAL REPORT SESSION 3—SPECTRUM OF PERSONALITY DISORDERS

No. 8
CHILDHOOD PREVALENCE OF BPD

Mary C. Zanarini, Ed.D., *McLean Hospital, 115 Mill Street, Belmont, MA 02478;* Dieter Wolke, Ph.D., Jeremy Horwood, M.S.C., Andrea Waylen, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that BPD may be more common among late-latency children than adults.

SUMMARY:

Objective: The purpose of this study was to assess the prevalence of DSM-IV borderline personality disorder (BPD) and its component symptoms in the first segment of the ALSPAC birth cohort (UK-Bristol) of 10,000 11 year olds.

Method: The symptoms of BPD were assessed in 968 children using a structured interview (Childhood Interview for DSM-IV Borderline Personality Disorder or CI-BPD), which is based on a widely used adult interview for BPD.

Results: The prevalence of BPD was found to be 3.3%. Four symptoms, which are similar to behaviors common among late-latency children, were found to have relatively high prevalence rates: intense anger (18.9%), mood reactivity (10.4%), general impulsivity (12.8%), and intense, unstable relationships (14.2%). However, five symptoms that are more specific to psychiatric disturbance had lower prevalence rates: chronic feelings of emptiness (7.9%), serious identity disturbance (5.8%), stress-related paranoia/dissociation (5.5%), pattern of self-mutilation/suicide threats/suicide attempts (4.2%), and frantic efforts of avoid abandonment (4.9%).

Conclusions: Taken together, the results of this study suggest that the prevalence of BPD may be higher among 11 year olds than the 1%–2% of adults who are estimated to meet criteria for BPD.

REFERENCES:

1. Bernstein DP, Cohen P, Velez CN, et al: Prevalence and stability of the DSM-III-R personality disorders in a community-based sample of adolescents. Am J Psychiatry 1993; 150:1237–1243.
2. Swartz M, Blazer D, George L, Winfield I: Estimating the prevalence of borderline personality disorder in the community. J Personal Disord 1990; 4:252–272.

No. 9
APPARENT VERSUS REPORTED SADNESS: CORRELATION WITH PERSONALITY TRAITS

Anand Pandya, M.D., *NYU School of Medicine, 462 First Avenue, 20th Floor Adept PR, New York, NY 10016;* Eric D. Peselow, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to evaluate the meaning of reported vs. apparent sadness from the Montgomery-Asberg depression scale (MADRS) to see if differences between these items are related to personality disorders.

SUMMARY:

Objective: In rating depressed patients via numerous scales, the rater must depend on the impression of the patient to reliably report his symptoms. However, the Montgomery-Asberg depression scale (MADRS) has two-items reported sadness (reported by the patient) and apparent sadness (observed by the rater). Previous work noted that when reported sadness was two points greater than apparent sadness, there was no statistically significant drug/placebo difference. It is the purpose of this paper to evaluate whether differences between reported and apparent sadness on the MADRS affect the diagnosis of personality disorders.

Method: We evaluated 137 patients from two antidepressant/placebo studies that used the MADRS. In addition a Structured Interview for DSM-III personality disorders (SIDP-III) was done on these patients, The scoring for the SIDP-III rated all traits for all DSM-III personality disorders on a 0–2 point scale (rated 0-not present, 1-mild, 2-moderate). We compared dimensional personality traits for the DSM-III personality disorders for the group where there was no difference in MADRS reported sadness vs. apparent sadness (N= 83), the group where there was two point greater apparent sadness vs. reported sadness (N=25), and the group where there was two point greater reported sadness vs. apparent sadness (N=29).

Results: The major difference in dimensional personality traits was with the Cluster B group (antisocial, histrionic, narcissistic, and borderline). The group that had a greater reported sadness vs. apparent sadness had more deviant cluster B dimensional traits (11.72) than the group that had two point greater apparent sadness vs. reported sadness (7.68) vs. the group where there was no difference in MADRS reported sadness vs. apparent sadness (4.96). The difference was statistically significant ($P<.05$ and $P<.01$, respectively).

Conclusion: It appears that individuals with greater reported sadness vs. apparent sadness may show more cluster B traits and this may have an effect on treatment.

There was no funding for this study.

REFERENCES:
1. Montgomery SA, Asberg M: Montgomery-Asberg Rating Scale for Depression: a new depression scale designed to be sensitive to change. British Journal of Psychiatry, 1979; 134:382–389.
2. Peselow ED, Sanfilipo MP, Fieve RR, Gulbenkian G: Personality traits during depression and following clinical treatment. British Journal of Psychiatry 1994;164:349–354.

No. 10
HIGH-LETHALITY SUICIDE ATTEMPTS IN BPD

Paul H. Soloff, M.D., *Department of Psychiatry, University of Pittsburgh/WPIC, 3811 O'Hara Street, Pittsburgh, PA 15213-2593;* Anthony Fabio, Ph.D., Thomas M. Kelly, Ph.D., Kevin M. Malone, M.D., John J. Mann, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the particpant should be able to identify clinical risk factors associated with high lethality suicide attempts in patients with borderline personality disorder.

SUMMARY:

Objective: Recurrent suicidal behaviors in patients with BPD are often considered communicative gestures; however, 10% complete suicide. This study seeks to identify risk factors for suicide by comparing patients with high and low lethality attempts.

Method: 113 BPD attempters were recruited from inpatient, outpatient and community sources and assessed using structured interviews and standardized measures. High lethality attempters were identified by a score of 4 or more on the Beck Lethality Scale for any attempt. Forty-four high and 69 low lethality attempters were compared on demographic, diagnostic, and personality variables, clinical symptoms, suicidal behaviors, childhood, family and treatment histories, and social adjustment. Discriminating variables were entered in a multivariate logistic regression model to define predictors of high lethality status.

Results: In univariate analyses, high lethality attempters were older, with children, less education, and lower SES than low lethality attempters. They were more likely to have MDD, comorbid ASPD, and family histories of substance abuse. They reported greater intent to die, more lifetime attempts, hospitalizations, and time in hospital. In the multivariate model, high lethality status was best predicted by low SES, comorbid ASPD, extensive treatment histories, and greater intent to die.

Conclusion: Patients with specific risk factor profiles may be more vulnerable to high lethality attempts.

Supported by NIMH Grant MH048463.

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2. Mann JJ, Waternaux C, Haas GL, Malone KM: Toward a clinical model of suicidal behavior in psychiatric patients. Am J Psychiatry 1999; 156:181–189.

SCIENTIFIC AND CLINICAL REPORT SESSION 4—RECOVERY ISSUES WITH SCHIZOPHRENIA

No. 11
DO PATIENTS WITH SCHIZOPHRENIA SHOW PERIODS OF COMPLETE RECOVERY? A 20-YEAR FOLLOW-UP

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation participants will have a better understanding of what percent of schizophrenia patients show evidence of recovery and how consistent and how complete the recovery can be. They will also have knowledge of some of the factors that may contributc to recovery.

SUMMARY:

Objective: Contrary to older views, with modern treatment many schizophrenia patients may show periods of complete recovery. The current 20-year, prospectively designed, follow-up research comparing schizophrenia patients with other types of psychotic patients studied how many schizophrenia patients show periods of complete recovery, and explored factors involved in recovery.

Method: 218 patients from the Chicago Follow-up Study, including 64 schizophrenics, were assessed at the acute phase and then reassessed six times over a 20-year period. Patients were evaluated for complete recovery for one or more years, defined operationally as a) the absence of major symptoms *and* b) adequate work functioning for the year. This included assessments of major symptoms, social and work functioning, rehospitalization, and treatment.

Results: 1) 9% of schizophrenia patients were in complete recovery at the two-year follow-up vs. over 20% at the 15- and 20-year follow-ups. 2) Schizophrenics improved in several areas as they began to age ($p < .05$). By the 20-year follow-up, cumulatively, about 40% of schizophrenia patients had experienced one or more periods of complete recovery.

Conclusions: While schizophrenia is still a relatively poor outcome disorder, about 40% show the potential for periods of complete recovery during the first 20 years. This potential for periods of complete recovery could offer an optimistic outlook for rehabilitation programs. Fitting in with a neurodevelopmental theory, the schizophrenia patients who showed periods of recovery were more likely to have had better premorbid developmental achievements ($p < .01$).

Funding Source: NIMH RO1: MH26341

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No. 12
TWENTY-YEAR OUTCOME IN SCHIZOPHRENIA: WHAT'S SEX GOT TO DO WITH IT?

Linda S. Grossman, Ph.D., *Department of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, MC-913, Chicago, IL 60612;* Martin Harrow, Ph.D., Cherise Rosen, M.A., Ellen S. Herbener, Ph.D., Christopher G. Fichtner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to be familiar with data on gender differences in 20-year outcome of patients with schizophrenia, other psychotic disorders, and nonpsychotic disorders, based on a prospective followup study 20 years after index hospitalization.

SUMMARY:

Objective: To provide data on the potential influence of gender on clinical course and global outcome in patients with major psychiatric disorders, we evaluated a large sample of inpatients, and prospec-

tively reassessed them six times over the next 20 years, as part of the Chicago Follow-up Study.

Method: We evaluated 239 patients, including 69 schizophrenia patients, 56 patients with other psychotic disorders, and 114 nonpsychotic patients. All patients were assessed for global outcome, rehospitalization, positive and negative symptoms, psychosocial functioning, and medication treatment.

Results: The data indicated that women had significantly better global outcomes and fewer completed suicides than men ($P < .003$). Patients with schizophrenia and other types of psychotic disorders, when considered together, showed the same pattern ($P < .01$). However, among nonpsychotic patients, there were no significant gender differences. Twice as many female schizophrenia patients were able to stay out of the hospital, compared with men. This pattern did not emerge for the other two groups.

Conclusions: Female schizophrenia patients and patients with other types of psychotic disorders showed better clinical courses and global outcomes compared with men. No gender differences emerged in nonpsychotic patients. These patterns indicate that gender differences are found in psychotic disorders and are not specific to schizophrenia. These results emphasize the importance of gender analysis in studies of patients with major psychiatric disorders.

Funding Sources: NIMH RO1: MH26341

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No. 13
RECOVERY FROM SCHIZOPHRENIC PSYCHOSES UNTIL AGE 35

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to know the prognosis and recovery rate of schizophrenic psychoses.

SUMMARY:

Objective: Population-based cohorts are required to establish the prognosis of schizophrenic psychoses. Our aim was to find out if there are any patients who recover from schizophrenic psychoses before early middle age in a population-based birth cohort.

Method: We explored the outcome of 59 DSM-III-R schizophrenia and 12 "schizophrenia spectrum" cases in the Northern Finland 1966 Birth Cohort by using registers, medical records, and interviews and searched if among them are any recovered patients. Two categories were used: full and partial recovery. For assessing full recovery we used the CGI (Clinical Global Impressions), the PANSS (Positive And Negative Syndrome Scale), the SOFAS (Social and Occupational Functioning Assessment Scale), information about psychiatric hospitalizations, use of antipsychotic medication and occupational status; four first-mentioned criteria were also applied for assessing partial recovery.

Results: Only one (1.7%) case with DSM-III-R schizophrenia and four (33.3%) cases with "schizophrenia spectrum" were defined as fully recovered; one (1.7%) schizophrenia and one (8.3%) "schizophrenia spectrum" case experienced partial recovery.

Conclusions: Our results suggest that there are only few people who recover from DSM-III-R schizophrenia by the age of 35 and that recovery may be more prevalent in "schizophrenia spectrum" than in schizophrenia.

Founding source: This work was supported by the grants from the Finnish Academy, Sigrid Juselius Foundation, the Stanley Medical Research Institute, Oy H. Lundbeck Finland Ab and the University of Oulu.

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SCIENTIFIC AND CLINICAL REPORT SESSION 5—COMPLICATIONS WITH ATYPICAL ANTIPSYCHOTICS

No. 14
A PROGRAM FOR TREATING WEIGHT GAIN INDUCED BY ATYPICAL ANTIPSYCHOTICS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to apply an educational program for weight control focused on schizophrenia patients suffering from antipsychotics-induced weight gain.

SUMMARY:

Background: Long-term administration of antipsychotic drugs induces weight gain afflicting up to 50% of patients, impairs health, and reduces compliance. This undesirable side effect is more remarkable with the atypical antipsychotics (AA). The most commonly used AA for treatment of schizophrenia in Israel are olanzapine and risperidone.

Objective: In this study, the effectiveness of a healthy life style educational program for schizophrenia patients with olanzapine or risperidone-induced weight gain was evaluated.

Method: Patients who had been treated with olanzapine (N=6; 3 women, 3 men) or risperidone (N=5; 3 women, 2 men) and who had gained at least 7% of their pretreatment body weight, attended a 12-week course conducted by a clinical dietician. Body weight and body mass index (BMI) were assessed at baseline and at the end of the program. The participants were asked to endorse eating habits and satisfaction questionnaires.

Results: Mean body weight and mean BMI decreased significantly (−1.75 kg, −0.6 kg/m^2 respectively; p=0.03). Satisfaction rate was high.

Conclusions: A healthy life style educational program is effective in reducing weight among schizophrenia patients with weight gain induced by olanzapine or risperidone. According to participants' satisfaction rates and responses, the program also improved their well being through enhanced sense of control.

The program was supported by Eli Lilly and company.

REFERENCES:

1. Ganguli R: Weight gain associated with antipsychotic drugs. Journal of Clinical Psychiatry 1999; 60(suppl 21):20–24.
2. Ball MP, Coons VB, Buchanan RW: A program for treating olanzapine-related weight gain. Psychiatr Serv 2001; 52:967–9.

No. 15
INCREASED LIPID LEVELS AND ANTIPSYCHOTIC MEDICATION

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participants should be able to know what do we know about the effects of antipsychotic treatment on serum lipid levels and the impact of drug selection and the age at the onset of psychosis.

SUMMARY:

Objective: Antipsychotic medication may elevate serum lipid levels and hamper the long-term prognosis of schizophrenia. This study explored the impact of antipsychotic use and polypharmacy to the lipid levels.

Method. Data were collected prospectively from the Northern Finland 1966 Birth Cohort population. Diagnoses were obtained from the national register. The lipid levels at age 31 in patients with schizophrenia or other psychoses were compared with the other cohort population. In psychotic patient groups the lipid levels were compared according to the type of antipsychotic medication employed.

Results. The serum lipid levels were moderately elevated in psychotic patients (total cholesterol 214 mg/dl and triglycerides 135 mg/dl in schizophrenia patients, 213 and 121 mg/dl in patients with other functional psychoses versus 196 and 104 mg/dl in controls). There was a correlation between the early age of onset of the psychosis and high serum triglyceride levels. The lipid levels were highest in patients receiving both conventional and second-generation antipsychotics.

Conclusion. The proper selection and follow-up of lipid levels is warranted especially in patients with early-onset psychosis and long exposure to antipsychotics. Antipsychotic polypharmacy should be avoided.

Funding source: This work was supported by the grants from the Finnish Academy, Sigrid Juselius Foundation, and the Stanley Medical Research Institute.

REFERENCES:

1. Koponen H, Saari K, Savolainen M, Isohanni M: Weight gain and glucose and lipid metabolism disturbances during antipsychotic medication. a review. European Arch Psychiatry Clin Neurosci 2002; 252:294–298.

No. 16
QTC PROLONGATION ASSOCIATED WITH ZIPRASIDONE

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the potential cardiotoxic effects of antipsychotics and the risk factors for QTc prolongation and the indications for pretreatment EKG in patients to be prescribed ziprasidone or other antipsychotics.

SUMMARY:

Objective: To determine the proportion of inpatients receiving ziprasidone who have risk factors for QTc prolongation and the proportion with QTc>450 msecs.

Method: The records of consecutively admitted psychiatric inpatients treated with ziprasidone (n=167) were reviewed (demographics, diagnoses, whether or not an EKG was obtained, presence of known risk factors for QTc prolongation, and concurrent psychotropics).

Results: An EKG was ordered for 62.3% of patients, 11.5% (12) of whom had a QTc >450. A medical condition associated with QTc prolongation was present in 67.7% of patients (e.g., BMI>27 in 61.5% of patients). In all, 54.5% of patients received concurrent treatment with other drugs associated with QTc prolongation, the most common of which was an SSRI (42.5%). The median ziprasidone dose was 80mg/day. The most common diagnoses were schizophrenia/schizoaffective (43.7% of the sample) and mood disorders (41.9%).

Conclusion: An EKG was ordered for the majority of inpatients treated with ziprasidone. QTC >450 msecs was present in approximately 11% of patients, although in no one was it >500 msecs. Coexisting medical risk factors for QTc prolongation appear to be common in ziprasidone treated patients as is the concurrent use of drugs associated with cardiotoxicity.

REFERENCES:

1. Curtis LH, Ostbye T, Sendersky V, et al: Prescription of QT-prolonging drugs in a cohort of about 5 million outpatients. Am J Med 2003; 114:135–141.
2. Taylor D: Ziprasidone in the management of schizophrenia. The QT interval issue in context. CNS Drugs 2003; 17:423–430.

SCIENTIFIC AND CLINICAL REPORT SESSION 6—PSYCHOTHERAPY AND PSYCHOPHARMACOLOGY: DISSOLVING THE MIND-BRAIN BARRIER

No. 17
INTERPERSONAL PSYCHOTHERAPY FOR DEPRESSED ELDERS WITH COGNITIVE DYSFUNCTION

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will learn the advantages and limitations of applying IPT to depressed elders comparing outcomes in cognitively impaired vs. intact patients receiving combined treatment (antidepressants + IPT).

SUMMARY:

Objective: In the original Maintenance Therapies in Late Life Depression Study (MTLD-1) with depressed elders without cognitive impairment, a major outcome was the superiority of combination treatment with antidepressant medication and interpersonal psychotherapy (IPT) in achieving and maintaining remission. Cognitive impairment, however, is often a central feature of depression in late life. This communication will focus on the second Maintenance Therapies in Late Life Depression (MTLD-II) to assess the ability of this subgroup of depressed elders to benefit from IPT, despite their cognitive decline.

Methods: Subjects over age 70 with major depression and MMSE scores between 18 and 30 were treated with paroxetine and weekly IPT sessions. Weekly Hamilton Rating Scale scores were recorded.

Therapists' 5-point Likert ratings of IPT integrity were obtained for each session by rating the subject's ability to engage in therapy, maintain a focus for treatment, and recall pertinent clinical material from prior sessions. Data presented here are limited to the acute and continuation phases of the study. Subjects were grouped by Mattis Dementia Rating Scale Scores in three groups: those with no dementia, mild dementia, and moderate dementia (MDRS Scores >130, 120–130, and <120, respectively). Chi squared analyses were used between groups.

Results: The subjects' ability to engage, focus, and recall all declined steadily with worsening cognitive function ($p<0.005$); however, there was no statistical difference in response rates (achieving a HRS score of 10 or less for three consecutive weeks) between groups or time to response.

Conclusion: Response rates may reflect an overwhelming effect of drugs in this combination study. Alternatively, attempts to provide IPT to more cognitively impaired subjects may have succeeded as a variation of supportive psychotherapy. The involvement of caregivers in treatment, alternative techniques, and the implication of these findings will be discussed. (Supported by MH43832).

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1. Reynolds CF, Frank E, Perel JM, et al: Nortriptyline and interpersonal psychotherapy as maintenance therapies for recurrent major depression: a randomized controlled trial in patients older than 59 years. Journal of the American Medical Association, 281:39–45, 1999.
2. Miller MD, Cornes C, Frank E, et al: Interpersonal psychotherapy for late life depression: past, present and future. Journal of Psychotherapy Practice and Research, 10(4):231–238, 2001.

No. 18
INTEGRATING PSYCHOTHERAPY WITH MEDICATION TO IMPROVE OUTCOME

Ira D. Glick, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Suite 2122, Stanford, CA 94305-5490*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate ability to practice combined therapy and be aware of the data supporting these interventions.

SUMMARY:

Objective: Recent systematic investigation has revealed that combined medication and psychotherapy has become the norm for treating most Axis I and II disorders in clinical practice. Given the known efficacy of medication, the question has been raised, what does psychotherapy add to outcome above what medication provides? If it does improve outcome what does it add, i.e., which domains, for whom, under what circumstances, and for which disorders. Finally, what are the scientific data supporting the answers, i.e., the results, and how do you do it, i.e., "the guidelines?"

Method: This paper reviews the controlled literature and provides the rationale for, as well as the theoretical background of, combining and integrating medication with psychotherapeutic intervention.

Results: There are six Axis I disorders for which controlled studies of combined therapy support the added benefit of psychotherapy. They include schizophrenia, bipolar disorder, depressive disorders, sleep disorders, ADHD, and PTSD. General guidelines followed by more specific guidelines for medication, family intervention, and individual psychotherapies are detailed. An overview of the "questions," the studies and resultant guidelines, plus a proposed "quality treatment equation" aimed at improving outcome, is presented.

Conclusion: Psychotherapy combined with medication improves outcome for some Axis I disorders. Further controlled research on both Axis I and II disorders is urgently needed.

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1. Gabbard G, Kay J: The fate of integrated treatment: whatever happened to the biopsychosocial psychiatrist. Am J Psychiatry 2001; 158:1956–63.
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No. 19
REVIEW OF PSYCHOTHERAPY RESEARCH INVOLVING A PILL-PLACEBO CONTROL

Arthur Rifkin, M.D., *Hillside Hospital, 75–59 263rd Street, Glen Oaks, NY 11004*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the pitfalls of psychotherapy research and the need for pill placebo in most disorders.

SUMMARY:

Objective: To discuss when it is appropriate to test psychotherapy against an active medication and medication placebo in disorders with proven drug treatment and present the results of such studies.

Method: A review of all published reports of studies comparing psychotherapy to an active medication and medication placebo.

Results: The absence of a medication placebo arm prevents answering questions of how psychotherapy compares with drug therapy. The absence of a difference between psychotherapy and medication may mean that both or neither treatment works. If one treatment proves superior to another, we don't know if one treatment helps, or if the other worsens symptoms. With a drug placebo arm, if the active drug is superior to the pill placebo, which shows the sample was representative, and the comparison of the active drug to psychotherapy is valid? Evaluation of all available studies reveals no strong evidence that psychotherapy is equal to or better than active drug for all diagnoses tested.

Conclusions: A pill placebo group is desirable in psychotherapy studies in disorders for which there are proven drug treatments.

REFERENCES:

1. Elkin L, Shea T, Watkins JT, et al: National Institute of Mental Health treatment of depression collaborative research program: general effectiveness of treatments. Arch Gen Psychiatry 1989; 46:971–982.
2. Klein D: Flawed meta-analyses comparing psychotherapy with pharmacotherapy. American Journal of Psychiatry 2000; 157:1204–1211.

SCIENTIFIC AND CLINICAL REPORT SESSION 7—TREATMENT OF DEPRESSION

No. 20
DULOXETINE VERSUS PLACEBO IN THE PREVENTION OF RELAPSE OF MDD

Michael J. Detke, M.D., *Eli Lilly and Company, Lilly Corporate Center DC 6377, Indianapolis, IN 46285;* Inmaculada Gilaberte, M.D., David G. Perahia, M.D., Fujun Wang, Ph.D., Thomas C. Lee, M.S., Pierre V. Tran, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should recognize the remission and relapse prevention are the optimal out-

comes of antidepressant therapy for MDD and that duloxetine treatment results in high rates of remission and relapse prevention.

SUMMARY:

Objective: Duloxetine hydrochloride (Cymbalta) is a balanced and potent reuptake inhibitor of both serotonin (5-HT) and norepinephrine (NE). The efficacy and safety of duloxetine in the acute treatment of the emotional and physical symptoms of depression has been established in several studies. The present study compared duloxetine 60 mg once daily with placebo in time to relapse in patients with major depressive disorder (MDD).

Method: In this randomized, double-blind, multisite, placebo-controlled study conducted in Europe and the U.S., 533 outpatients with MDD received duloxetine 60 mg OD for up to 12 weeks. Responders were randomized to either duloxetine 60 mg OD or placebo for 26 weeks (continuation phase). The primary efficacy analysis compared time to relapse using log-rank test.

Results: During acute treatment, 260 (52.5%) responded, indicating they no longer met criteria for depression, and 276 entered the continuation phase. Time to relapse was significantly longer for patients treated with duloxetine 60 mg QD than for those treated with placebo (p=.004). Duloxetine-treated patients scored better on most secondary efficacy measures including assessments of depression, anxiety, painful physical symptoms, and quality of life; 11% and 4% of duloxetine-treated patients discontinued due to an adverse event in the acute and continuation phase, respectively.

Conclusions: Duloxetine significantly increased time to relapse and performed better than placebo on measures of depression, anxiety, painful physical symptoms, and quality of life. Duloxetine was safe and well tolerated.

REFERENCES:

1. Mallinckrodt CH, et al: Duloxetine: a new treatment for the emotional and physical symptoms of depression. Primary Care Companion J Clin Psychiatry 2003; 5(1):19–28.
2. Schmidt ME, et al: Treatment approaches to major depressive disorder relapse Part 1: dose increase. Psychother Psychosom 2002; 71:190–194.

No. 21
RESPONSE TO ANTIDEPRESSANTS IS INDEPENDENT OF GENDER

Tamar D. Wohlfarth, Ph.D., *Medicine Evaluation Board, Kalvermart 53, the Hague 2500 BE, Netherlands;* Jitschak G. Storosum, M.D., Andre J.A. Elferink, M.D., Barbara J. van Zwieten, Ph.D., Annemarie Fouwels, M.D., Wim Van Den Brink, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should have learned that there is conclusive evidence that TCAs are just as effective in women as they are in men in the treatment of major depression.

SUMMARY:

Objective: There is an ongoing debate whether tricyclic antidepressants (TCAs) have the same effect in male and female depressed patients. The aim of the study is to resolve this issue using a meta-analytic approach.

Method: A total of 30 randomized, placebo-controlled trials, including 3,886 patients (1,555 men and 2,331 women), that were submitted in order to obtain marketing authorization between 1979 and 1991 were included. Gender differences in response to treatment were tested in various multiple regression models using a variety of response definitions.

Results: Different response definitions all pointed to no gender difference in the efficacy of TCAs. In addition, the estimated effect size was similar for women younger and older than age 50 and for men. The estimates (with 95% confidence intervals) are: −2.38 (−3.21, −1.55) for men, −2.44 (−3.30, −1.58), for women younger than 50, and −3.04 (−5.08, −1.01) for women older than 50.

Conclusion: Response to TCA is independent of gender.

REFERENCES:

1. Kornstein SG, Schatzberg AF, Thase ME, et al: Gender differences in treatment response to sertaline versus imipramine in chronic depression. Am J Psychiatry 2000; 157:1445–1452.
2. Quitkin FM, Stewart JW, McGrath PJ, et al: Are there differences between women's and men's antidepressant responses? Am J Psychiatry 2002; 159:1848–1854.

No. 22
DEPRESSION AND BPD DURING THE IMMEDIATE PREPARTUM PERIOD

Gisele Apter-Danon, M.D., *Department of Perinatal Pschology, Aubier Erasme Hospital, 121 Bis Avenue General Leclerc, Bourg-La-Reine 92340, France;* Rozenn Graignic-Phillippe, Marina Gianoli-Valente, Emmanuel Devouche, Ph.D., Annick Le Nestour, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to recognize the necessity to assess comorbidity of borderline personality disorder with depression during the peripartum.

SUMMARY:

Objective: To provide better information on the nature of perinatal mood disorders and its links to borderline personality disorder (BPD) in order to assess psychiatric comorbidity during the peripartum and to develop adequate therapeutic strategies.

Methods: Forty-two women were screened and assessed during the immediate prepartum (two to four weeks preceding expected delivery) for both major depressive disorder (MDD) and for BPD with the Edinborough Postnatal Depression Scale (EPDS) and the Montgomery Asberg Depression Rating Scale (MADRS) and with the Structured Interview for Diagnosis of Personality Disorder for DSM-4 (SIDP4). All pregnancies were from a low-risk, community sample.

Results: In all, 15 mothers (35.7%) were found depressed with MADRS cut-off score>15) and 11/42 (26.2%) reached cut-off on EPDS. EPDS and MADRS were positively correlated at 67 (p<.0001). Correlations were then looked for between MADRS, EPDS, and subscores of SIDP4 for antisocial, narcissistic and borderline personality disorders (Same cluster PD). Analysis showed strongly positive correlation between MADRS and EPDS and borderline subscores in the immediate prepartum period (r=.57 and r=.54, p<.001).

Conclusion: Depression during the peripartum should not be considered as a simple entity automatically linked with gravidum. Comorbidity with BPD should be explored and assessed.

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2. Rothschild L, Zimmerman M: Borderline personality disorder and age of onset in major depression. J Pers Dis 2002; 16:189–99.

SCIENTIFIC AND CLINICAL REPORT SESSION 8—HEALTH SERVICES

No. 23
TREATMENT EFFECTIVENESS AND FUNCTIONAL RECOVERY IN SCHIZOPHRENIA

Henry A. Nasrallah, M.D., *Department of Psychiatry, University of Cincinnati Medical Center, 231 Albert Sabin Way, P.O. Box 670559, Cincinnati, OH 45267-0559*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to 1) distinguish efficacy from effectiveness; 2) state the characteristics of an effective treatment regimen, and 3) describe the use of the Global Outcome Assessment of Life in Schizophrenia (GOALS) as a measure of treatment effectiveness.

SUMMARY:

Objectives: Treatment expectations in schizophrenia are expanding beyond the usual control of psychotic symptoms to include functional recovery. This report proposes a new paradigm for defining the clinical effectiveness of treatment in achieving these objectives.

Methods: A comprehensive literature review established that there is a dearth of information about the meaning of the term "clinical effectiveness." To address this gap, a consensus conference of schizophrenia researchers was held to consider what the components of clinical effectiveness are in the "real world" of community practice and how to measure them.

Results: The consensus of the psychiatrists was that "effective" clinical treatment is characterized by four outcome domains: 1) significant and sustained reductions in acute psychotic symptoms, 2) consistent adherence and tolerability to treatment, 3) alleviation of the burden of disease, and 4) improved functional capacity as evidenced by restoration of social and vocational functioning. A clinical instrument to measure these four domains was constructed and labeled Global Outcome Assessment of Life in Schizophrenia (GOALS) in which each domain is rated on a scale of 1-7 ("very much improved" to "very much worse"). Field-testing of this instrument is planned.

Conclusions: Effective treatment interventions combining optimal pharmacotherapy and targeted psychosocial treatments are raising expectations about the prospects of the functional recovery in patients with schizophrenia. The GOALS is proposed as one paradigm to provide busy clinicians with a simple assessment tool to objectively measure the effectiveness and outcomes of the clinical treatment they provide patients suffering from schizophrenia.

The research was supported in part by AstraZeneca Pharmaceuticals LP.

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2. Streiner DL: The 2 E's of research: efficacy and effectiveness trials. Canadian J of Psychiatry 2002; 47:552–556.

No. 24
ETHNIC-MATCHED, CULTURALLY COMPETENT, MODEL-BASED ACT TEAM: EARLY OUTCOME REPORT

Samuel F. Law, M.D., *Mount Sinai Act Team, 260 Spadinia Avenue, Suite 204, Toronto, ON M6J 2E6, Canada;* Jian Yang, M.D., Rosalie Steinberg, M.S.C., Wendy Chow, M.S.W., Joel Sadavoy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the value of a culturally competent model based ACT team in serving ethnic minority/marginalized clients.

SUMMARY:

Objectives: To report the early outcome measures of an unique Assertive Community Treatment (ACT) team that is based on the classic ACT model, but incorporates ethnicity, culture, and language matching for hard-to-serve, chronically and severely mentally ill ethnic minority patients in a major urban center in Canada. Some merits and challenges of the model also warrant wider discussion.

Method: Outcome measures of days in hospital, number of admissions, dosage of medications, BPRS, and patent and family satisfaction survey are analyzed for the first year of ACT team.

Results: Overall positive outcome measures in close to 50% reduction of hospitalization rates and days of hospitalization, improved BPRS ($p>0.05$) scores on psychotic and mood symptom measurements, as well as significant client and family satisfaction. No significant medication dosage change is found. Some unique issues of interest are intra-team, cross-ethnicity coverage, family involvement, and community role.

Conclusion: Ethnic, culture, and language matching is a valid and meaningful approach for many of the unilingual, marginalized mental health patients who are ethnic minorities. Team structure and innovations of classic ACT model needs to be further studied and evaluated.

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1. Ziguras S, Klimidis S, Lewis J, et al: Ethnic matching of clients and clinicians and use of mental health services by ethnic minority clients. Psychiatric Services 2003; 54:535–41.
2. Mathews CA, Glidden D, Murray S, et al: The effects on treatment outcomes of assigning patients to ethnically focused inpatient psychiatric units. Psychiatric Services 2002; 53:830–835.

No. 25
WORK DISABILITY AND TREATMENT ACCESS IN PSYCHIATRY

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to increase awareness of rates of unemployment due to disability among patients treated by psychiatrists and patient subgroups vulnerable to mental or physical disabilities; to identify potential barriers to provision of vocational rehabilitation, social-skills training and case management services in this patient population.

SUMMARY:

Objective: Disabilities associated with mental disorders are equally or more debilitating than those associated with chronic general medical conditions (Von Korff 1994, Wells et al, 1989). This study examines unemployment rates due to disability and factors associated with work-disability among psychiatric patients and rates of vocational rehabilitation, social-skills training, and case management (i.e., psychosocial services) among work-disabled patients.

Methods: Data on 1,596 adults from the 1999 APIRE Practice Research Network Study of Psychiatric Patients and Treatments were used; SUDAAN adjusted for the sampling design and weights.

Results: 33% of patients were not working due to disability (i.e., work-disabled). Only 15% of the work-disabled received any of the psychosocial services studied. Highest rates of work-disability were observed among patients with schizophrenia (67%), substance use

(43%), bipolar (40%), personality (34%), anxiety (26%), and depressive (24%) disorders. Multiple logistic regression analyses indicate that patients with schizophrenia, bipolar disorder, co-occurring general medical conditions, psychosocial problems, public insurance, older age, and less education were more likely to be work-disabled. Among work-disabled patients, those with schizophrenia and public insurance were more likely to receive psychosocial services.

Conclusion: This study highlights a number of patient subgroups that may benefit from effective multifaceted employment and skills-development interventions, particularly since 85% of work-disabled patients were not receiving indicated psychosocial services.

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1. Von Korff, M: Methodological perspective: getting answers to the most important questions. In: Miranda J, Hohmann AA, Attkinsson C, Larson D, eds. Mental Disorders in Primary Care. San Francisco, Jossey-Bass, 1994.
2. Wells KB., Steward A, Hays RD. et al: The functioning and well-being of depressed patients: results from the Medical Outcomes Study. JAMA 1989; 262:914–919

TUESDAY, MAY 4, 2004

SCIENTIFIC AND CLINICAL REPORT SESSION 9—BUPRENORPHINE THERAPY

No. 26
CHALLENGES IN INCREASING ACCESS TO BUPRENORPHINE TREATMENT

Joyce C. West, Ph.D., *Department of Research, APIRE PRN, 1000 Wilson Boulevard, Arlington, VA 22209;* Thomas R. Kosten, M.D., Joshua E. Wilk, Ph.D., Dace Svikis, Ph.D., Elisa G. Triffleman, M.D., Donald S. Rae, M.A., William E. Narrow, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to increase understanding of specific barriers to buprenorphine treatment among psychiatrists and other clinicians; to understand national research initiatives currently being developed to help increase access to this important new treatment for opiate addiction.

SUMMARY:

Objective: Despite rising rates of heroin and other opiate dependence, only 20% of opiate-dependent persons receive treatment. Buprenorphine, a new pharmacologic treatment for opiate dependence, offers great potential for increasing treatment access in office-based settings. Whether this happens will depend on whether physicians and other mental health and substance abuse providers are knowledgeable, willing, and able to provide or facilitate provision of this new treatment. This study assesses psychiatrists' comfort using office-based opiate agonist treatment (OBOT) and identifies psychiatrists' characteristics associated with OBOT comfort.

Methods: A random sample of 2,323 psychiatrists from the AMA Physician Masterfile were surveyed through the 2002 APIRE National Survey of Psychiatric Practice (NSPP), with a 53% response rate (n=1,203).

Results: 80.6% (SE=1.8) of the psychiatrists were not comfortable providing OBOT. Males, addiction-certified psychiatrists, and those treating substance abuse patients were more comfortable providing OBOT.

Conclusion: These findings highlight significant barriers in providing buprenorphine treatment. Increasing understanding of specific financing and services delivery barriers clinicians face is needed to develop effective integrated services models and policies to facilitate OBOT. A model characterizing OBOT barriers and the APA research institute's plans to implement a national study to increase OBOT access will be highlighted.

REFERENCES:

1. Vastag B: In-office opiate treatment "not a panacea": physicians slow to embrace therapeutic option. JAMA 2003; 290:731–736.
2. Ling W, Wesson DR, Charuvastra C, Klett CJ: A controlled trial comparing buprenorphine and methadone maintenance in opioid dependence. Arch Gen Psychiatry 1996; 53:401–407.

No. 27
A DOUBLE-BLIND, DOUBLE-DUMMY, RANDOMIZED, PROSPECTIVE, EFFICACY STUDY OF THE PARTIAL MU OPIATE AGONIST BUPRENORPHINE FOR ACUTE DETOXIFICATION OF HEROIN ADDICTS

Michael R. Oreskovich, M.D., *Department of Psychiatry, VA Puget Sound HCS, 1660 S Columbian Way, Seattle, WA 98108;* Andrew J. Saxon, M.D., Meiling K. Ellis, B.S., Carol A. Malte, M.S.W., Joseph P. Reoux, M.D., Patricia C. Knox, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participate should be able to understand and utilize a safe and effective dosing strategy of buprenorphine for acute heroin detoxification.

SUMMARY:

Objective: The optimum dose of buprenorphine for acute inpatient heroin detoxification has not been determined. This randomized, double-blind, double-dummy, placebo-controlled, clinical trial compares two buprenorphine dosing schedules to clonidine.

Method: Heroin users (N=29, males=20; mean age=36.3 years [SD = 9.5]), who met DSM-IV criteria for opioid dependence and achieved a Clinical Opiate Withdrawal Scale (COWS) score of 13 (moderate withdrawal), were randomized to receive high-dose buprenorphine (HB, 8-8-8-4-2 mg/day on days 1–5), low-dose buprenorphine (LB, 2-4-8-4-2 mg/day on days 1–5), or clonidine (C, 0.2-0.3-0.3-0.2-0.1 mg qid on days 1–5). COWS scores were obtained qid.

Results: Twenty-four hours after randomization, the percentages of subjects without significant withdrawal, as defined by four consecutive COWS scores < 12 (with no subsequent increase in scores) were: C=11%, LB=40%, HB=60%. Generalized estimating equation regression models controlling for baseline COWS and time indicated that COWS scores over the course of five days were lower in both LB and HB compared with C [$\chi^2(2) = 13.28, p = 0.001$]. There were no discontinuations due to treatment-related adverse events.

Conclusions: Both high-dose and low-dose buprenorphine regimens are safe and efficacious treatment for acute opioid detoxification.

Funding source: Alcohol and Drug Abuse Institute, University of Washington.

REFERENCES:

1. Cheskin LJ, Fudala PJ, Johnson RE: A controlled comparison of buprenorphine and clonidine for acute detoxification from opioids. Drug and Alcohol Dependence 1994; 36:115–121.
2. Nigam AK, Ray R, Tripathi BM: Buprenorphine in opiate withdrawal: a comparison with clonidine. J Subst Abuse Treat 1993; 10:391–394.

No. 28
BUPRENORPHINE: AN EFFECTIVE TREATMENT FOR HEROIN ADDICTS

Paolo Marzorati, M.D., *Department of Dependence, SERT Distretto IV, Boifava 25, Milano 20762, Italy;* Livia Guglielmino, M.D., Rosella Silenzio, Pierluig Vigezzi, M.D., Filomena Corrado, M.D., Margherita De Chiara, M.D., Edoardo Cozzolino, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to show usefulness and efficacy of buprenorphine treatment.

SUMMARY:

Objective: To evaluate buprenorphine treatment effictiveness in heroin addicts in the latest 30 months.

Methods: A protocol with inclusion/exclusion criteria and a scheme dose timing for the beginning phase of buprenorphine therapy was established. A total of 117 patients (94 males) were consecutively recruited for overall 133 treatments. Mean age was 35 ± 6 yrs, and dependence mean time 13 ± 6,3 yrs. Fifty-nine patients were coming from MMT.

Treatments: 245 days (range: 1–824) was the mean period of treatment, and 11 mg/die ± 6 mean was the maximum dosage. The 42% of treatments were psychosocial integrated.

Results: VGF mean value at the beginning of therapy was 65 while the mean end-treatment result was 71 ($t = 2,1$; $p < 0,001$). Sixty-five patients are still in treatment, 13 therapies were completed, 21 dropped-out, 10 shifted to MMT, five continued in jail, and three in other centers. Significatively different resulted the outcomes of the patients coming from heroin or MMT ($P < 0,001$); the drop out was less in the group coming from MMT than those ones from heroin ($P< 0,001$). After 28 months of treatment 81.2% and 78.3% of total urine examinations (samples obtained once/week), respectively, for opiate or cocaine metabolites were negative.

Conclusion: Retention treatment rate with 117 treatments was 65.7% after 500 days (66.6% with 133 treatments). A significantly better retention rate was noted among treatments coming from MMT—85.7%—than from heroin—41.5% - (O.R. 8.4; IC 95% 6.3–8.1, $p = 0,0026$).

REFERENCES:

1. Ling W, et al: Buprenorphine maintenance treatment of opiate dependence: a multicenter randomized clinical trial. Addiction 1998; 93:475–486.
2. Pani PP, et al: Buprenorphine: a controlled clinical trial on the efficacy in the treatment of opioid dependence. Drug and Alcohol Dependence 2000; 60:39–50.

SCIENTIFIC AND CLINICAL REPORT SESSION 10—PANIC DISORDER

No. 29
EARLY DETECTION OF RELAPSE IN PATIENTS WITH PANIC DISORDER WITH AGORAPHOBIA

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the difficulty of predicting relapse and that early detection provides a viable alternative.

SUMMARY:

Objective: The one-year risk of relapse when serotonergic antidepressants are discontinued is less than 50% in panic patients who have responded well to treatment. It has been difficult to predict relapse reliably in such patients. An alternative to prediction would be the early detection of relapse when patients are still in remission off the drug.

Method: Forty-seven patients with panic disorder and agoraphobia, all responders to serotonergic antidepressants, who were randomized to double-blind placebo and who had valid data at four time points: pretreatment, randomization to placebo substitution, an assessment on placebo prior to the last assessment, or relapse (labeled as L-1 or R-1, respectively), and the last assessment (relapsers = 15, nonrelapsers N = 32) were analyzed. First, a growth curve analysis was used to test the hypothesis that relapsers followed a different change trajectory than the nonrelapsers on the seven variables selected on the basis of the t-test comparison between the R-1 and L-1. Then a variety of predictive models were tested. Logistic regression using any one of these variables and its linear change was the best method of prediction.

Results: The growth curve analysis confirmed that differences in change trajectories between relapsers (V-shaped) and nonrelapsers (L-shaped) were statistically significant on all seven variables. Logistic regression models correctly predicted relapse for 84.4% of the sample using the Family Disability Scale, 84.4% using Global Assessment of Severity, 79.5% using the Work Disability Scale, 78.7% using the Generalized Anxiety Symptom Scale, 78.7% using Self-Rating Severity of Phobias, 74.5% using the Beck Depression Inventory, and 74.5% using the anxiety sensitivity scale.

Conclusion: For clinical and research application of the findings, a sample program has been written in Excel that produces a patient's probability of relapse following an assessment (L/R-1) given that the values of any one of the selected variables are known at start of treatment discontinuation and at that assessment point.

REFERENCES:

1. Mavissakalian M., Perel, JM: Long-term maintenance and discontinuation of imipramine therapy in panic disorder with agoraphobia. Archives of General Psychiatry 1999; 56:821–827.
2. Mavissakalian M., Perel J: Duration of imipramine therapy and relapse in panic disorder with agoraphobia. Journal of Clinical Psychopharmacology 2002; 22:294–299.

No. 30
THREE-YEAR PROPHYLAXIS IN PANIC DISORDER: TO CONTINUE OR DISCONTINUE?

Yujuan Choy, M.D., *New York University Medical Center, 550 First Avenue, New York, NY 10016-9196;* Eric D. Peselow, M.D., Mary Paizis, M.D., Jamie A. Luff, M.D., Gonzalo Laje, M.D., Mary T. Guardino, B.A., Mary Anne Pressman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to evaluate whether patients who had shown complete freedom from full-blown panic attacks on psychotropic medication for three years could be safely withdrawn from medication.

SUMMARY:

Objective: We evaluated the course of 30 patients who recovered from their panic attacks and remained stable on medication for three years subsequently withdrawn from the medication and compared them with a group of 152 patients who remained stable for three years and continued on medication.

Method: The patients were treated naturalistically over a 10-year course. Thirty patients who after 12 weeks of initial pharmacotherapy (antidepressants or anxiolytics + antidepressants) recovered with a

complete cessation of full-blown panic attacks were followed over a succeeding 36-month period on the medication to which they had responded. At this point based on the mutual consent of the patient and physician, the patients were gradually discontinued from medication. They were then followed until one of three outcomes—termination well, dropout, or relapse (a breakthrough full-blown panic attack). All patients at baseline and at three-month intervals, were rated with the Hamilton Anxiety Scale, Panic Inventory, Montgomery-Asberg Depression Scale, and CG1 rating for anticipatory anxiety, phobic avoidance, functional impairment, and overall severity of illness. Patients withdrawn from medication chose to do so along with the consent of the treating psychiatrist. The group was matched against a group of 152 patients who remained well for three years and elected to continue on medication. Thus, this was a nonrandom design.

Results: The group withdrawn from medication actually were more stable than the group that remained on medication in that the former group had lower anticipatory anxiety, phobic avoidance, and functional impairment compared with the group that continued on medication. Overall, the probability of remaining free of a subsequent panic attack for the two groups for the continued group vs. discontinued group was 84% vs. 67% at one year, 79% vs. 32% at two years, and 74% vs 17% at three years. The percent relapsing was 40/152 (26.3%) for the continued group vs. 22/30 (73.3%) for the discontinued group

Conclusion: Despite a prior three-year stability, discontinuation of medication led to significant relapse for patients discontinued from medication vs. patients on continued on medication.

REFERENCES:

1. Mavissakalian MR, Perel JM: Clinical experiments and maintenance and discontinuation of imipramine therapy in panic disorder with agorophobia. Arch Gen Psychiatry 1992; 49:318–323.
2. Noyes R, Garvey MJ, Cook BL, Perry PJ: Benzodiazepine withdrawal: a review of the evidence. J Clin Psychiatry 1988; 40:382–389.

No. 31
DISCONTINUATION OF MEDICATIONS IN PANIC PATIENTS

Eric D. Peselow, M.D., *Department of Psychiatry, New York University School of Medicine, 550 First Avenue, Brooklyn, NY 10016;* Mary Anne Pressman, M.D., Jamie A. Luff, M.D., Mary Paizis, M.D., Gonzalo Laje, M.D., Mary T. Guardino, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to assess the probability of remaining free of full-blown panic attacks in patients who were taken off medication to which they had responded in order to assess if panic patients could safely be discontinued from medication.

SUMMARY:

Objective: The use of long-term medication for panic disorder remains unstudied. It was the objective of this study to evaluate the relapse rate for panic disorder after medication discontinuation in patients who had acutely responded.

Method: To date, 98 patients who after 12 weeks of initial pharmacotherapy (antidepressants or anxiolytics + antidepressants) recovered with a complete cessation of full-blown panic attacks were followed over the succeeding one to 83 months (average 17 months) on the medication to which they had responded. At this point based on the mutual consent of the patient and physician the patients were gradually discontinued from medication. They were then followed until one of three outcomes—termination well, dropout or relapse, with relapse with a breakthrough full-blown attack. All patients at baseline and at three-month intervals were rated with the Hamilton Anxiety Scale, Panic Inventory, Montgomery-Asberg Depression Scale, and CGI rating for anticipatory anxiety, phobic avoidance, functional impairment, and overall severity of illness.

Results: 82 of 98 patients (84%) discontinued from medication relapsed with a full-blown attack over the follow-up period. Phobic avoidance and initial degree and severity of anticipatory anxiety negatively correlated with length of time free of a full-blown attack. Patients who received CBT treatment in addition to pharmacotherapy had better outcomes. Patients who required anxiolytics + antidepressants during prophylaxis fared less well. The probability of remaining free of a recurrence of panic disorder was as follows: 50% at one year, 34% at two years, and 20% at three years.

Conclusion: There was significant relapse of panic disorder following medication discontinuation There was no funding for this study.

REFERENCES:

1. Mavissakalian MR, Perel JM: Clinical experiments and maintenance and discontinuation of imipramine therapy in panic disorder with agorophobia. Arch Gen Psychiatry 1992; 49:318–323.
2. Rickels K, Schweizer E, Weiss S, Zavodnick S: Maintenance drug treatment for panic disorder. short- and long-term outcome after drug taper. Arch Gen Psychiatry 1993; 50:61–68.

SCIENTIFIC AND CLINICAL REPORT SESSION 11—ISSUES IN DEPRESSION

No. 32
BRAIN BIOENERGETICS AND THYROID HORMONE TREATMENT IN MDD

Dan V. Iosifescu, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114;* Nicholas R. Bolo, Ph.D., John E. Jensen, Ph.D., Andrew A. Nierenberg, M.D., Julie L. Ryan, B.A., Perry F. Renshaw, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the correlation between the brain bioenergetic metabolism and the outcome of thyroid hormone augmentation of SSRI antidepressants in subjects with major depressive disorder (MDD).

SUMMARY:

Objective: Cerebral bioenergetic hypometabolism has been reported in subjects with major depressive disorder (MDD). We have measured changes in brain bioenergetics during augmentation treatment with thyroid hormone (T3) in MDD.

Method: 18 subjects meeting DSM-IV criteria for MDD, mean age = 43.7 + 10.6 years, (10 females, 55.5%) who had previously failed a course of treatment of at least eight weeks with an SSRI antidepressant (40 mg/day of fluoxetine or equivalent) enrolled in a four-week augmentation treatment with triiodothyronine (T3) 50 mcg/day. We administered the 17-item Hamilton Rating Scale for Depression (Ham-D) four times during the treatment. Phosphorus magnetic resonance spectroscopy (P31 MRS) spectra were obtained at baseline and at the end of the study from a 20 mm thick axial brain slice prescribed through the orbitofrontal and occipital cortices.

Results: Six subjects (33%) were treatment responders (Ham-D reduction ≥ 50%) and five subjects (27.7%) achieved clinical remission (final Ham-D ≤ 7). During thyroid hormone treatment total adenosine triphosphate (ATP) increased 13.9% in treatment responders and decreased 1.9% in treatment nonresponders (Mann Whitney

U Test p<0.04). Alpha ATP increased 20.2% in treatment responders vs. 1.2% in treatment nonresponders (p<0.02). Phosphocreatine (PCr), which has a buffer role for ATP levels, decreasecl 12.7% in treatment responders and 0.6% in nonresponders (p<0.05). There were statistically significant (p<0.05) linear correlations between changes in total ATP, alpha-ATP, and PCr and the degree of clinical improvement (% change in Ham-D scores).

Conclusion: The antidepressant effect of thyroid hormone augmentation of SSRIs is correlated with significant increases in brain bioenergetics. This may be a brain mechanism involved in the recovery from depressive episodes.

REFERENCES:

1. Iosifescu DV, Renshaw PF: 31P-magnetic resonance spectroscopy and thyroid hormones in major depressive disorder: towards a bioenergetic mechanism in depression? Harvard Review of Psychiatry 2003, 11:1–13.
2. Renshaw PF, Parow AM, Hirashima F, et al: Multinuclear magnetic resonance spectroscopy studies of brain purines in major depression. Am J Psychiatry. 2001; 158:2048–55.

No. 33
DEPRESSED OUTPATIENTS FROM PRIMARY CARE VERSUS SPECIALTY CARE SETTINGS

Bradley N. Gaynes, M.D., *Department of Psychiatry, University of North Carolina at Chapel Hill, CB #7160, School of Medicine, Chapel Hill, NC 27599-7160;* A. John Rush, M.D., Madhukar H. Trivedi, M.D., Donald Spencer, M.D., Timothy J. Petersen, Ph.D., Michael Klinkman, M.D., Robert N. Golden, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand how these two groups differ in terms of sociodemographic features, course of depressive illness, and clinical presentation of depression.

SUMMARY:

Objective: The Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study (*www.star-d.org*) provides the first direct, multisite comparison of depressed outpatients enrolled from primary care (PC) and specialty care (SC) settings using identical eligibility criteria.

Methods: We enrolled depressed patients from 41 clinic sites (19 PC, 22 SC). Inclusive eligibility criteria required DSM-IV diagnosis of nonpsychotic major depression; no treatment resistance during the current episode; and HAM-D ≥ 14. We report on baseline data from the first 1500 patients.

Results: Patients presented with equivalent degrees of depressive severity. SC patients reported nearly twice the likelihood of a history of attempted suicide; other suicidal risk measures showed less substantial differences. PC patients reported a significantly greater degree of medical comorbidity. There were statistically significant, but clinically insignificant, differences in the likelihood of endorsing depressed mood or anhedonia. PC patients were more likely to report middle and terminal insomnia and physical complaints; otherwise, the depressive symptoms were similar.

Conclusions: Overall, depressive symptom severity was not different, and symptomatic presentations did not differ substantially. These findings indicate that major depression is more similar than different among SC and PC patients, and similar clinical and research methods to identify and manage depression can be applied.

Funding: This project has been funded in whole or in part with federal funds from the National Institute of Mental Health, National Institutes of Health, under contract N01MH90003; and under 1-K23-MH01951-01A1 (Dr. Gaynes).

REFERENCES:

1. Fava M, et al: Background and rationale for the sequenced treatment alternatives to relieve depression (STAR*D) study. Psychiatr Clin North Am., 2003; 26:457–94.
2. Rush A, et al: Sequenced Treatment Alternatives to Relieve Depression (STAR*D): Rationale and Design. Controlled Clinical Trials, 2003, in press.

No. 34
LIMITS TO THE TREATMENT OF MAJOR DEPRESSION

Gabor I. Keitner, M.D., *Department of Psychiatry, Rhode Island Hospital, 593 Eddy Street, Providence, RI 02903*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to evaluate assumptions and expectations about goals for the treatmcnt of major depression.

SUMMARY:

Method: A literature search (PUBMED) was undertaken with the keywords natural history, treatment outcome, and predictors of response in major depression. This was supplemented by a manual search of references in relevant articles.

Results: Current emphasis for the treatment of depression focuses on pharmacotherapy. Often the goal is to treat depression to the point of remission and to extend pharmacotherapy through the continuation and maintenance phases of the illness. Although there is good evidence that patients with residual symptoms and premature discontinuation of medications are at higher risk for relapse and recurrence, unfortunately most studies suggest a modest remission rate. A pooled analysis, for instance, of 33 clinical trials, involving 7,611 patients, selected for likely good response, showed a 41% remission rate with venlafaxine and 35% with SSRI therapy. This discrepancy between expectations and reality may lead to polypharmacy (most of it unsupported by empirical evidence), a greater side-effect burden for patients, along with a sense of hopelessness and a significant economic burdcn for society. Psychosocial treatments have similar ceiling rates for remission. Studies combining pharmacotherapy with psychotherapy also found comparable rates of remission.

Conclusions: The current emphasis on pharmacotherapy and treating to remission may be causing harm to many patients. Without giving up on the effort to maximize treatment response, with pharmacotherapy and psychosocial treatments, it may be time to focus research efforts on the significant proportion of patients (more than 40%–70%) who do not respond to standard treatments in order to improve these treatments and/or to help patients and their families better cope with and adapt to their illness.

REFERENCES:

1. Casaclenda N, Perry JC, Looper K: Remission in major depressive disorder: a comparison of pharmacotherapy, psychotherapy, and control conditions. Am J Psychiatry 2002; 159:1354–60.
2. Thase ME, Entsuah AR, Rudolf RL: Remission rates during treatment with venlafaxine or selective serotonin reuptake inhibitors, BR J Psychiatry 2001; 27:281–90.

SCIENTIFIC AND CLINICAL REPORT SESSION 12—ADHD

No. 35
ADHD COMORBIDITY IN PRESCHOOL CHILDREN

Atilla Turgay, M.D., *Department of Psychiatry, Scarborough Hospital, 3030 Birchmount Road, Toronto, ON M5G 2C4, Canada;* Rubaba Ansari, M.A., David Ng, M.D., Michael Schwartz, Ph.D., Aruz Mesci

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to differentiate the symptoms of ADHD in preschool children and consider effective treatment for common comorbid disorders of ADHD at this age group.

SUMMARY:

Objective: To examine the ADHD and comorbidity profiles in a sample of 356 patients (aged 2–5 years).

Method: This study was conducted in an ADHD clinic of a university teaching hospital. Patients were diagnosed according to DSM-IV criteria, DuPaul ADHD Rating Scale, and Offord-Boyle Parent and Teacher Rating Scales and were assessed by a multidisciplinary team. In this study, 299 (83.99%) males and 57 (16.01%) females (total N=356) were examined.

Findings: There was a significantly different male:female ratio in this age range (5.2:1, $p<0.01$) as compared with older populations. Most patients (90.17%) suffered from two or more disorders. Oppositional defiant disorder, conduct disorder, pervasive developmental disorders (PDDs), and anxiety disorders were the most common comorbidities (60.67%, 21.91%, 20.79%, 4.21%, respectively). A greater number of males were observed across all diagnoses (ratios ranged from 2.8:1 to 7.8:1), with two exceptions: females were more likely to have comorbid PDDs or anxiety disorders than males (24.56% vs. 20.07%, 7.02% vs. 3.68%, respectively).

Conclusions: The under-identification of female patients in this age range should be further studied. ADHD patients should be carefully screened for comorbidities, even in the preschool age groups, as more complex clinical profiles may require different treatment approaches.

Funding Source: Scarborough Hospital ADHD Clinic, Training and Research Institute.

REFERENCES:

1. Lalonde J, Turgay A, Hudson JI: Attention-deficit hyperactivity disorder subtypes and comorbid disruptive behavior disorders in a child and adolescent mental health clinic. Can J Psychiatry 1998; 43:623–628.
2. The MTA Cooperative Group: A 14-month randomized clinical and trial of treatment strategies for attention-deficit/hyperactivity disorder: multimodal treatment study of children with ADHD. Arch Gen. Psychiatry 1999; 56:1073–1086.

No. 36
ATOMOXETINE FOR COMORBID ADHD AND AFFECTIVE SYMPTOMS

Jeffrey H. Newcorn, M.D., *Psychiatry, Mount Sinai School of Medicine, 1 Gustave L. Levy Place, New York, NY 10029*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the attendee should have an increased awareness of the safety and efficacy of atomoxetine monotherapy compared with combined atomoxetine/fluoxetine therapy in a population of patients with ADHD and concurrent symptoms of depression or anxiety.

SUMMARY:

Objective: Depression and anxiety are commonly comorbid with ADHD. We assessed the safety and efficacy of atomoxetine monotherapy compared with combined atomoxetine/fluoxetine therapy in a population of patients with ADHD and concurrent symptoms of depression or anxiety.

Methods: Children and adolescents with comorbid ADHD and symptoms of depression or anxiety were randomized to treatment with atomoxetine + placebo (A; N=46) or atomoxetine + fluoxetine (A/F; n=127) under double-blind conditions for eight weeks.

Results: At endpoint, reductions in ADHD, depressive, and anxious symptoms were marked for both treatment groups. Some differences for depressive symptoms between treatment groups approached significance, but magnitudes of the differences were small and likely of limited clinical importance. No serious safety concerns were observed. Decreased appetite was the most common adverse event and was more prominent in the A/F group.

Conclusions: In pediatric patients with ADHD who present with depression or anxiety, atomoxetine monotherapy appears to be effective for symptoms of ADHD, as well as for the depressive and anxiety symptoms. Combined therapy with fluoxetine and atomoxetine appeared to be safe and well tolerated. Incremental gain in symptom reduction related to adding fluoxetine was limited, but could be of value with persistent symptoms after atomoxetine monotherapy.

REFERENCES:

1. Biederman J, Newcorn J, Sprich S: Comorbidity of attention deficit hyperactivity disorder with conduct, depressive, anxiety, and other disorders. Am J Psychiatry 1991; 148:564–577.
2. MTA Cooperative Group: A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. Arch Gen Psychiatry 1999; 56:1073–1086.

No. 37
ABUSE LIABILITY ASSESSMENT OF ATOMOXETINE IN A DRUG-ABUSING POPULATION

Donald R. Jasinsky, M.D., *Chemical Dependence, Johns Hopkins, 4940 Eastern Ave, 2nd Floor West, Baltimore, MD 21224;* Douglas E. Faries, Ph.D., Albert J. Allen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the attendee should have an awareness of the evidence presented that atomoxetine has little or no abuse liability, no greater than placebo or desipramine.

SUMMARY:

Objective: Abuse of stimulants used to treat ADHD is a recognized problem. Atomoxetine is a non-amphetamine approved to treat ADHD. This study examines the liability of atomoxetine to produce abuse.

Methods: Following consent and screening, 40 inpatient, experienced, stimulant-preferring drug abusers received double-blind, single doses of eight treatments (placebo, 90mg methylphenidate, 60mg phentermine, 100 and 200mg desipramine, and 45, 90, and 180mg atomoxetine) in random order in a balanced Latin square. The Drug Rating Questionnaire-Subject (DRQS), and subscales of the Addiction Research Center Inventory (ARCI) were collected for 24 hours after each dose. Six-hour AUCs were compared using ANOVA.

Results: Methylphenidate and phentermine produced amphetamine-like effects and euphoria, with significant scores on the DRQS liking scale, the MBG Scale (euphoria), and the Amphetamine and Benzedrine Group Scales (amphetamine-like effects). Neither desipramine nor atomoxetine produced amphetamine-like subjective effects or euphoria.

Conclusions: Atomoxetine is psychoactive, but not a euphoriant, and does not produce amphetamine-like effects. Thus, it is not liable to be abused like amphetamines. Atomoxetine has no greater abuse liability than desipramine or placebo.

REFERENCES:

1. Griffiths RR, Bigelow GE, Ator NA: Principles of initial experimental drug abuse liability assessment in humans. Drug and Alcohol Dependence 2003; 70:S41–54.

SCIENTIFIC AND CLINICAL REPORT SESSION 13—UNDERSTANDING THE EFFECTS OF TERRORISM

No. 38
EFFECTS OF 9/11 AND CHRONIC STRESS ON FEMALE DRINKING AND ANXIETY

Judith A. Richman, Ph.D., *Department of Psychiatry, University of IL at Chicago, 1601 West Taylor Street, MC912, Chicago, IL 60612;* Joseph A. Flaherty, M.D., Joseph S. Wislar, M.S., Michael Fendrich, Ph.D., Kathleen M. Rospenda, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize psychosocial risk factors for elevated drinking and anxiety in women experiencing fateful traumatic events and develop relevant programs for intervention and prevention of resulting distress and drinking.

SUMMARY:

The objective of this report from our NIAAA-funded study is to depict the psychiatric effects of experiencing a macrostressor (the events of 9/11/01) and chronic work stressors as they impact on distress and drinking. This report from our longitudinal workplace cohort study addresses the joint effects of 9/11 and three negative workplace experiences: sexual harassment, generalized workplace abuse, and low decision latitude. A sample of 1,730 employees initially recruited from an urban university completed mail questionnaires in the fall of 1996, 1997, and 2001 (wave 3 occurring before and after 9/11). Questionnaires included measures of sexual harassment (SEQ), generalized workplace abuse (GWA), decision latitude (Karasek measure), depressive symptomatology (CESD), anxiety (Profile of Mood States), quantity and frequency of drinking in the past month, and escapist drinking motives.

Multiple linear regressions demonstrated a main effect of experiencing 9/11 on elevated drinking in women but not men. In addition, for women, 9/11 coupled with either low decision latitude, sexual harassment, or generalized abuse led to the highest scores on quantity of drinking, escapist drinking motives, and anxiety, controlling for baseline status. Future interventions related to fateful traumatic events, including terrorist attacks, should target women already experiencing chronic stress.

REFERENCES:

1. Schuster M, et. al: A national survey of stress reactions after the September 11, 2001 terrorist attacks. New England Journal of Medicine 2001; 345:1507–1512.
2. Richman JA, Rospenda KM, Flaherty JA, et al: Sexual harassment and generalized workplace abuse among university employees: prevalence and mental health correlates, American Journal of Public Health 1999; 89:358–363.

No. 39
PSYCHOSOCIAL PREDICTORS OF LONG-TERM RESILIENCE FOLLOWING THE 9/11 ATTACKS

David Spiegel, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 2325, Stanford, CA 94305-5718;* Lisa D. Butler, Ph.D., Cheryl Koopman, Ph.D., Jay Azarow, Ph.D., Juliette C. Desjardins, M.D., Xin-Hua Chen, B.A., Helena C. Kraemer, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand predictors of risk and resilience in response to the 9/11 attacks.

SUMMARY:

Objective: To examine whether demographic, event exposure, emotional, cognitive, social support, and coping variables measured shortly after the attacks predicted resilience outcomes six–8.5 months later.

Design and Setting: 7,238 adults participated in an Internet-based panel survey administered two to 12 weeks post-9/11. Fifty-three percent also participated in a six-month follow-up. Prior to analysis, data were randomly divided into approximately equal exploratory and confirmatory data sets. Final hypotheses were developed using the exploratory data; hypothesis testing was conducted with the confirmatory data. Participants with complete data on all predictor (baseline) and outcome (follow-up) measures ($n = 1657$) are included in this report.

Participants: The sample was primarily female (71%), middle-aged (median age = 41), European/white (87.5%), and college educated. Ninety-three percent were U.S. citizens.

Main Outcome Measures: Psychological well-being and global distress were examined as indices of psychological resilience.

Results: Higher education, fewer negative changes in worldview, larger social support networks, lower perceived social constraints, and less self-blame at baseline predicted both *higher* well-being and *lower distress* at six-month follow-up. *Higher* well-being was also associated with female gender, less emotional suppression, and more use of planning and emotional support as coping strategies. *Lower* global distress was also associated with less use of denial, substances of abuse, and instrumental support as coping strategies.

Conclusions: Consistent with previous studies, demographic factors, media exposure, social support, and coping assessed in the aftermath of 9/11/01 predicted vulnerability and resilience outcomes six months later. However, three additional factors—negative changes in worldview, emotional suppression, and perceived constraints on social communication—each predicted lower resilience.

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1. Butler LD, Seagraves DA, et al: How to launch a national Internet-based panel study quickly: lessons from studying how Americans are coping with the tragedy of September 11, 2001. CNS Spectrums 2002; 7:597–603.
2. Spiegel D, Butler LD: Acute stress in response to the terrorist attacks on September 11, 2001. Canadian Psychiatric Association Bulletin 2002; 34:15–18.

No. 40
THE TERRORIST AS A NONPATIENT SUBJECT OF PSYCHIATRIC INVESTIGATION

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) understand how the role of psychiatry applied to public events differs from its role in the clinical situation, (2) understand how private determinants of behavior manifest in public events, (3) understand the construct of the person as public figure, (4) recognize a number of factors in the psychology of terrorists.

SUMMARY:

The events of September 11, 2001 have made it imperative to understand the individual psychology of terrorists and how this interacts with the social, political, and criminological aspects. Psychiatry

has a role to play in this important enterprise, but the role differs from that of psychiatry in a clinical situation. Working out useful methods for the study of public figures deserves a high priority. This paper follows the approach used by the author in studying how private determinants of behavior manifest in public events. Psychiatric conclusions about a public figure will be descriptions of the construct of that public figure in his/her role as public figure. Even though they may seem similar to descriptions of a patient, they cannot be equated. It is necessary to develop new terminology to maintain the distinction. The descriptions of this construct carry no implications for other areas of that person's life and make no argument for any clinical psychiatric intervention. They are not diagnoses and do not even imply that the person is mentally ill, mentally healthy, etc. Based upon the author's experience as consultant to the Warren Commission and the Eisenhower Commission, these descriptions and conclusions can be helpful in understanding public figures such as assassins, and political leaders and their followers. This paper presents examples to demonstrate the usefulness of this approach in understanding terrorists and their followers.

REFERENCES:

1. Rothstein DA: The assassin and the assassinated—as non-patient subjects of psychiatric investigation. In Dynamics of Violence, edited by Fawcett J, Chicago, American Medical Association, 1971, pp 145–155.
2. Rothstein DA: Lethal identity: violence and identity formation. In Trauma and Adolescence, Monograph Series of the International Society for Adolescent Psychiatry, Vol 1, Madison, CT, International Universities Press, 1999, 225–250.

SCIENTIFIC AND CLINICAL REPORT SESSION 14—PSYCHOPHARMACOLOGY

No. 41
ANTIPSYCHOTIC TREATMENT AND SEXUAL ADVERSE EVENTS: THE ROLE OF PROLACTIN

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to realize that: sexual dysfunctions occur frequently when treating with antipsychotics, and antipsychotics differ in the influence on sexual performance.

SUMMARY:

Objective: Although patients rarely spontaneously report treatment-related sexual adverse events (AEs), structured questionnaires indicate that 20% to 60% of patients receiving antipsychotic agents experience these problems. Certain antipsychotics increase the risk of sexual AEs and hyperprolactinemia. Antipsychotics, sexual AEs, and hyperprolactinemia will be discussed.

Method: Review of published literature and recent research.

Results: The mechanisms by which antipsychotics may affect sexual function include blockade of dopamine-2 and alpha-1 adrenergic receptors and elevation of serum prolactin levels. Results from recently completed randomized trials and cross-sectional studies in patients treated with antipsychotics indicate that sexual adverse events are reported by 20% to 60% of the patients and probably do not subside during prolonged treatment. Prolonged hyperprolactinemia may be associated with consequences including menstrual disorders, an elevated risk of cardiovascular disorders, and reduced bone mineral density. Antipsychotics that produce the greatest increases in prolactin levels appear to induce the highest incidence of sexual AEs. Sexual dysfunction and hyperprolactinemia are less likely in patients treated with clozapine, olanzapine, and quetiapine.

Conclusions: Antipsychotics differ in their propensity to cause sexual AEs. The potential of these drugs to cause sexual AEs should be a consideration when choosing therapy.

Funding Source: Support contributed by AstraZencca Pharmaceuticals LP.

REFERENCES:

1. Cutler AJ: Sexual dysfunction and antipsychotic treatment. Psychoneuroendocrinol 2003; 28(suppl 1):69–82.
2. Kneglering H: What are the effects of antipsychotics on sexual dysfunction and endocrine functioning? Psychoneuroendocrinol 2003; 28(suppl 1):109–123.

No. 42
THREE-BEAD EXTENDED-RELEASE CARBAMAZEPINE CAPSULE (SPD417) CONTINUATION: MAINTENANCE THERAPY IN BIPOLAR DISORDER

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss efficacy and safety of 3-bead carbamazepine extended-release capsules (SPD417) in the prevention of relapse and recurrence over six months in patients with bipolar disorders with manic or mixed episodes.

SUMMARY:

Objective: To evaluate the long-term efficacy and tolerability of open-label 3-bead carbamazepine extended-release capsules (SPD417) as continuation and short-term maintenance therapy in bipolar disorder patients with manic and mixed episodes.

Method: 92 patients (most-recent episode: 67% mixed, 33% manic) who had participated in a previous three-week, double-blind, placebo-controlled study received open SPD417 (mean final dose of 959 mg/d and serum concentration of 6.8 μg/mL) for six months. The primary efficacy variable was time to relapse. Secondary efficacy variables included the Young Mania Rating Scale (YMRS) and Clinical Global Impression Scale (CGI).

Results: Of 77 patients in the intent-to-treat sample, 11 (14.3%) relapsed during the study. The estimated mean time to relapse (Kaplan-Meier model) was 141.8 ± 5.6 days. Patients previously treated with placebo showed significant improvements in YMRS and CGI scores, and patients previously treated with SPD417 maintained improvements. There were no serious adverse events (AEs) or change in mean weight (−0.4% at endpoint, +0.7% in completers). The most common AEs were headache, dizziness, and rash.

Conclusion: SPD417 appears effective in bipolar disorder patients for up to six months of continuation treatment. AEs were generally mild to moderate and typical of those associated with carbamazepine.

Funding: Supported Shire Pharmaceutical Development Inc.

REFERENCES:

1. American Psychiatric Association: Practice guideline for the treatment of bipolar disorder (revision). Am J Psychiatry. 2002; 159(suppl 4):1–50.
2. Denicoff KD, Smith-Jackson EE, Disney ER, et al: Comparative prophylactic efficacy of lithium, carbamazepine, and the combination in bipolar disorder. J Clin Psychiatry. 1997; 58:470–478.

No. 43
PARKINSONISM IN A NURSING HOME: UNDERRECOGNITION

Hubert H. Fernandez, M.D., *Department of NeuroSciences, Brown University, 111 Brewster Street, Pawtucket, RI 02860;* Joseph Friedman, M.D., Martha Trieschmann, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to characterize the prevalence of parkinsonism in a nursing home population, contrast the true prevalence with the frequency of recognition, and identify antipsychotic drugs as a risk factor for parkinsonism.

SUMMARY:

Objective: Parkinsonism is a common condition in the elderly, particularly the elderly with dementia, but our experience suggests that the condition is generally underdiagnosed in this population. During a quality assessment at a local nursing home's gait program, we evaluated residents for parkinsonism and compared our findings with those noted in the patients' charts.

Methods: Patients were assessed using three cardinal features of Parkinson's disease. Charts were then reviewed to determine if patients with parkinsonian signs were taking medications that might induce the condition and if the physician or other staff members had written any notes alluding to the condition. We looked separately at those receiving antipsychotics because of the increased risk of parkinsonism with these agents.

Results: Among 100 residents, 26 had "probable" parkinsonism and 30 had "possible" parkinsonism. Symptoms of parkinsonism were detected in 23 of 27 residents taking antipsychotics versus 43 of 73 not taking these drugs ($P<0.02$). Only one resident with drug-induced parkinsonism and three with previously diagnosed Parkinson's disease had chart notes indicating prior recognition of the condition.

Conclusions: Parkinsonism is common in nursing home residents, especially those taking antipsychotics, but the condition is often unrecognized.

Funding Source: Travel support contributed by AstraZeneca Pharmaceuticals LP.

REFERENCES:

1. Friedman JH, Fernandez HH: A typical antipsychotics in Parkinson-sensitive populations. J Geriatr Psychiatry Neurol 2002; 15:156–170.
2. Hassin-Baer S, Sirota P, Korczyn AD, et al: Clinical characteristics of neuroleptic-induced parkinsonism. J Neural Transm 2001; 108:1299–1308.

SCIENTIFIC AND CLINICAL REPORT SESSION 15—ISSUES IN PSYCHIATRIC RESEARCH AND PSYCHOPHARMACOLOGY

No. 44
CONCURRENT USE OF MULTIPLE ANTIPSYCHOTICS IN PSYCHIATRIC INPATIENTS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to 1) discuss the potential risks and benefits of using more than one antipsychotic, 2) recognize variables associated with this prescribing practice, 3) describe recent trends in the use of antipsychotics.

SUMMARY:

Objective: To determine the proportion of inpatients treated with more than one antipsychotic concurrently and the demographic and clinical variables associated with this practice.

Methods: Consecutively admitted inpatients receiving concurrent antipsychotics were compared with those treated with a single antipsychotic. Variables included demographics, diagnosis, LOS, and readmissions. Statistical analyses included chi square, two-tailed t-tests, and forward stepwise logistic regression.

Results: Of 1,750 patients prescribed antipsychotics, 311 (17.8%) received more than one concurrently; for 59.8% (N=186) of these this regimen continued through discharge. The two most common types of combinations were an atypical plus a typical antipsychotic (N=181; 58.2%) and two atypicals (N=120, 28.6%). There were 45 different drug combinations. Concurrent antipsychotics were most frequently prescribed for schizophrenia (47.6% of all with schizophrenia) or schizoaffective disorder (35.9%). There were no differences in age or gender, but the concurrent group had a longer LOS and more readmissions during the 12 months of the study vs. patients on one antipsychotic. The most commonly documented rationale for this prescribing practice was "as an augmentation strategy."

Conclusions: This practice appears to be a response to "treatment resistance" and is primarily seen in patients with schizophrenia/schizoaffective disorder. Age, gender, and race did not appear to play a role in treatment decisions.

REFERENCES:

1. Waddington JL, Youssef HA, Kinsella A: Mortality in schizophrenia. antipsychotics polypharmacy and absence of adjunctive anticholinergics over the course of a 10-year prospective study. Br J Psychiatry 1998; 173:325–329.
2. Miller AL, Craig CS: Combination antipsychotics: pros, cons, and questions. Schizophr Bull 2002; 28:105–109.

No. 45
HOW DO PSYCHIATRIC PATIENTS PERCEIVE RESEARCH PARTICIPATION?

Cherise Rosen, M.A., University *of IL at Chicago, 1601 West Taylor Street, Chicago, IL 60612;* Linda S. Grossman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to be familiar with academic debates about standardizing competency assessments in psychiatric research, to recognize the importance of patients' perceptions when making decisions about their research eligibility.

SUMMARY:

Objective: Psychiatric research faces a dilemma important to all branches of medicine: the balance between paternalism and patient autonomy. In light of national trends to standardize competency assessments for psychiatric research participation, we studied patients' subjective experience of the value they derived from participating, especially since in some cases these studies offer novel treatments.

Method: We studied 145 psychiatric inpatients admitted to a research unit, using the Patient Satisfaction Questionaire, which assesses patients' perceptions of research participation. We compared the 97 who completed research protocols with the 48 who did not

complete the research and also asked all patients about their willingness to participate in future studies.

Results: Patients who completed the research protocol were significantly more satisfied globally (P<.03) and more likely to express belief that treatment had been effective (P<.0001). Factors contributing to patients' willingness to participate in future research included favorable perceptions of: a) psychoeducation (P<.001), b) safety (P<.01), and c) comfort level with research procedures (P<.05).

Conclusions: Overall, our data suggest that patients find psychiatric research to be beneficial. This study emphasizes the importance of including patients' opinions in the academic discussion of risk vs. benefits of independent competency assessments in psychiatric research. Limiting patients' access to research participation also limits their access to treatments otherwise unavailable.

Funding Source: Departmental

REFERENCES:

1. Appelbaum PS, Grisso T, Frank E, et al: Competence of depressed patients to consent to research. American Journal of Psychiatry; 1999; 156:1380–1384.
2. Capron AM: Ethical and human-rights issues in research on mental disorders that may affect decision making. New England Journal of Medicine; 1999; 348:1430–1434.

No. 46
POLYPHARMACY AND ITS RAMIFICATIONS IN A CHRONIC PSYCHIATRIC HOSPITAL

Jambur V. Ananth, M.D., *Department of Psychiatry, Harbor—UCLA Medical Center, 1000 West Carson Street, Building F-9 Box 495, Torrance, CA 90509-2910;* Sarath Gunatilake, M.D., Sharat Parameswaran, B.S., Chris E. Marshall, B.S., Steven Brown, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate the extent of polypharmacy to understand the dangers and benefits of polypharmacy and to treat patients with rational therapy.

SUMMARY:

Objective: Polypharmacy is not proven to be more beneficial than monotherapy, and produces side effects. We investigated the extent of polypharmacy and its impact in a chronic inpatient facility.

Method: The prescriptions of 853 patients were analyzed. The total number of drugs prescribed for each patient was noted.

Results: Some patients received from one to 15 drugs daily; 51% of the patients received two to four drugs; 3.76% received 10 or more drugs. Females and dementia patients received more drugs. Surprisingly, antiparkinsonian agents are used frequently; 55% of patients received one, 189 patients received two; 12 patients received three; and four patients received four antipsychotic drugs. Also, 293 patients were taking a conventional and one or more atypical antipsychotic drugs; 382 patients received mood stabilizers; 191 received a combination of a mood stabilizer and an antidepressant drug; 56 patients were taking more than one mood stabilizer and an antipsychotic drug; 492 patients received a mood stabilizer and an antipsychotic drug; and 134 patients received a mood stabilizer and an antipsychotic drug. The detailed analysis various combinations was assessed.

Conclusions: Educating physicians about the dangers of polypharmacy and well-designed studies to assess and isolate good and bad combinations are necessary.

REFERENCES:

1. Freudenreich O, Goff DC: Antipsychotic combination therapy in schizophrenia: a review of efficacy and risks of current combinations. Acta Psychiatrica Scand 2002; 106:323–330.
2. Tapp A, Wood AE, Secrest L, et al: Combination antipsychotic therapy in clinical practice. Psychiatric Services 2003; 54: 55–59.

SCIENTIFIC AND CLINICAL REPORT SESSION 16—CHILD AND ADOLESCENT PSYCHIATRY

No. 47
EXTERNALIZING BEHAVIORS IN PREADOLESCENT CHILDREN: A NATIONAL PANEL STUDY

David J. Pevalin, Ph.D., *University of Essex, Department of Health and Human Sciences, Colchester C04 3SQ, United Kingdom;* John Cairney, Ph.D., Terrance J. Wade, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify factors associated with changes in externalizing behaviors and the educational consequences of such changes in a large, nationally representative panel study of preadolescent children.

SUMMARY:

Objective: Children with high levels of disruptive behaviors place a heavy burden on their families and communities and are at risk for poor educational outcomes. This study examines the course of externalizing behaviors in preadolescent children within the context of family factors and educational consequences.

Method: A sample of ~4,000 children aged 4 to 7 years in 1994 is drawn from the Canadian National Longitudinal Survey of Children and Youth and followed over the first three waves (1994 to 1998). Levels of externalizing behavior are determined through a cluster analysis of misconduct, aggression, and prosocial behavior measures.

Results: Findings indicate that about 10% of children are in the highest cluster at anytime, with 35% in the middle cluster, and 55% in the lowest cluster. Children in the highest cluster in any given year had deficits in schooling measures at all ages. Increases in externalizing behaviors over time are associated with decreases in scholastic performance.

Conclusions: Poor school performance is clearly linked to problematic externalizing behaviors. The substantial movement of children into and out of the cluster indicating problematic behavior suggests a window of opportunity for intervention in preadolescence. Without early intervention these children will likely have multiple disadvantages in adolescence and adulthood.

Funding: This study was funded by the Social Sciences and Humanities Research Council of Canada. Grant no. 539-2002-0005 to T.J. Wade, D.J. Pevalin, and J. Cairney.

REFERENCES:

1. Nagin DS, Tremblay RE: Parental and early childhood predictors of persistent physical aggression in boys from kindergarten to high school. Archives of General Psychiatry 2000; 58:389–394.
2. Boyce WT, Essex MJ, Woodward HR, et al: The confluence of mental, physical, social, and academic difficulties in middle childhood. I: Exploring the "headwaters" of early life morbidities. Journal of the American Academy of Child and Adolescent Psychiatry 2002; 41:580–587.

No. 48
GENDER AND THE PREDICTION OF DRUG AND ALCOHOL ABUSE IN ADOLESCENT INPATIENTS

Daniel F. Becker, M.D., *Mills-Peninsula Medical Center, 1783 El Camino Real, Burlingame, CA 94010;* Carlos M. Grilo, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize some of the psychosocial predictors of drug and alcohol abuse in adolescent inpatients and how these predictors differ according to gender.

SUMMARY:

Objective: To examine psychological and environmental predictors of substance abuse in hospitalized adolescents and the extent to which these associations may be affected by gender.

Method: 462 psychiatric inpatients (194 males, 268 females), ages 12–18, completed a battery of psychometrically sound, self-report measures of psychological functioning, environmental stressors, drug abuse, and alcohol abuse. After examining correlations between the psychosocial predictor variables and drug or alcohol abuse, separate multiple regression analyses were conducted to determine the joint and independent predictors of drug abuse and alcohol abuse. Finally, these analyses were repeated for males and females separately.

Results: Differences were observed in the correlates of drug abuse and alcohol abuse, as well as between genders. In predicting drug abuse, multiple regression analysis revealed that eight variables accounted for 26% of the variance ($F = 20.3$, $p < .001$); age, impulsiveness, delinquent predisposition, family discord, and history of child abuse made significant independent contributions. For alcohol abuse, the same predictor variables accounted for 20% of the variance ($F = 14.4$, $p < .001$), with significant independent contributions being made by age, impulsiveness, hopelessness, self-esteem, delinquent predisposition, and history of child abuse. Further analyses revealed several gender differences.

Conclusions: We found distinct patterns of psychosocial predictor variables for drug and alcohol abuse, and for males and females. These results may reflect differing risk factors for drug abuse and alcohol abuse in male and female adolescent psychiatric patients—and they may also have implications for prevention and treatment programs.

REFERENCES:

1. Brook JS, Brook DW, De La Rosa M, et al: Pathways to marijuana use among adolescents. J Am Acad Child Adolesc Psychiatry 1998; 37:759–766.
2. Clark DB, Pollack N, Bukstein OG, et al: Gender and comorbid psychopathology in adolescents with alcohol dependence. J Am Acad Child Adolesc Psychiatry 1997; 36:1195–1203.

No. 49
PREVALENCE AND OUTCOMES OF CHILDHOOD ADVERSITY IN AN AUSTRALIAN POPULATION

Stephen J. Rosenman, M.D., *Centre for Mental Health Research, Australian National University, Canberra ACT 0200, Australia;* Bryan Rodgers, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should understand the population experience of childhood adversity and its effects on psychological symptoms in young, middle, and older-aged adulthood. In particular, the consequences of sexual abuse are explored.

SUMMARY:

Objective: To assess prevalence and consequences of childhood adversity experienced by a community adult population.

Method: The Path study in Canberra studied 7,415 adults in three age groups (20–24, 40–44, 60–64yrs). Questions were asked about recollected childhood abuses, cruelties, and deprivations within families. We examine the prevalence of 18 adversities and their interrelationships. Consequent affective symptoms and their moderators are reported.

Results: 60% of the population experienced at least one adversity. Those now aged 40–44 and women reported more adversity of all types. Four factors of adversity grouped paternal psychopathology with sexual abuse, maternal psychopathology with divorce and poverty, affectionlessness with neglect, authoritarianism with physical and mental cruelty. There is a clear relationship of adversity and recent life events and with difficulties in current relationships. These factors explain a significant proportion of the variance of affective symptoms.

Conclusion: Childhood adversity has been common and co-occurrences of adversity conform with intuition. Affective symptoms in adulthood follow childhood adversity but their effect is mediated in part by the difficulties in relationships and a greater load of adverse life events. These data form the basis for study of the present and longitudinal effects of childhood adversity.

REFERENCES:

1. Mullen PE, Martin JL, Anderson JC, et al: The long-term impact of the physical, emotional and sexual abuse of children: a community study. Child Abuse and Neglect 1996; 20:7–21.
2. Kessler RC, Davis CG, Kendler KS: Childhood adversity and adult psychiatric disorder in the U.S. National Comorbidity survey. Psychological Medicine 1997; 27:1101–1119.

SCIENTIFIC AND CLINICAL REPORT SESSION 17—SOCIAL AND COMMUNITY PSYCHIATRY

No. 50
EVALUATION OF AN HIV INTERVENTION FOR PSYCHIATRIC CARE PROVIDERS IN SOUTH AFRICA

Pamela Y. Collins, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Room 1713, New York, NY, 10032;* Kezziah Mestry, LL.B., Graham Lindegger, Ph.D., Thobile Nzama, Francine Cournos, M.D., Milton L. Wainberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize strategies for introducing public health interventions into mental health facilities in low-income settings, and recognize the benefits of collaboration between mental health care providers and researchers in developing country settings.

SUMMARY:

Objective: Two recent studies revealed HIV prevalence rates of 9% and 29% among psychiatric inpatients in South Africa. Persons with psychiatric illness need adequate HIV education and care; yet lack of knowledge among mental health care providers (MHCPs) can be a barrier: This study aimed to develop and conduct a contextually relevant HIV education program for MHCPs at three institutions in South Africa.

Method: The research team worked collaboratively with a core group of 16 MHCPs (nurses, psychologists, occupational therapists, social workers) to assess HIV training needs in three psychiatric institutions and to develop an on-site training intervention focused on identified issues. The training intervention was administered to three groups of MHCPs (Total N=42) during three 1.5-day work-

shops. MHCPs completed pre- and post-intervention assessments that measured HIV/AIDS knowledge and attitudes.

Results: Data analysis revealed a significant increase in reported levels of comfort with HIV care (p=.001), perceived knowledge of HIV (p<.001), and factual knowledge (p<.001).

Conclusion: MHCP involvement permitted the development of an effective HIV education program for the local context. This collaborative effort provides insights into the introduction of public health interventions into clinical settings.

Funding Source: NIMH Supplement to R01 MH58917

REFERENCES:

1. Collins PY: Dual taboos: sexuality and women with severe mental illness in South Africa: perceptions of mental health care providers. AIDS & Behavior 2001; 5:151–161.
2. Reddy P, et al: Research capacity building and collaboration between South African and American partners: the adaptation of an intervention model for HIV/AIDS prevention in corrections research. AIDS Education & Prevention 2002; 14 (Suppl B): 92–101.

No. 51
DEVELOPING CAPACITY WITHIN CBOS FOR HEALTH EDUCATION AND OUTREACH

Mary Jane Massie, M.D., *Department of Psychiatry, MSKCC Memorial Hospital, 1275 York Avenue, New York, NY 10021-6007;* David Lounsbury, Ph.D., Bruce Rapkin, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to have a better understanding of the role of community-based organizations in meeting public health and mental health challenges and will recognize opportunities to apply the ACCESS model to their own communities within the context of their own professional expertise.

SUMMARY:

This report will describe how a team of psychiatrists and community psychologists at a major cancer center formed ACCESS, an innovative breast cancer outreach and education project, which worked with community-based organizations (CBOs), including mental health settings, to promote breast cancer screening for medically underserved women. Over a five-year period, ACCESS initiated partnerships with a diverse sample of more than 60 organizations in a major urban area. The project used a participatory approach to assessing characteristics of CBOs and their clients' breast health behaviors, knowledge, and attitudes. Results show how CBOs are important mediating structures to help communities respond to public health problems. An analysis of client data compared women with similar characteristics, and these organizational data can be generated and used to design appropriately tailored programs. Findings underscore that women within a particular agency are more likely than chance to demonstrate similar health beliefs and behaviors. Moreover, offering agencies an opportunity to jointly plan and conduct a client-needs assessment proved to be a major reason for forming a partnership with the ACCESS Project. This approach can be used to address other types of health service needs, for example mental health, that an agency may choose to address.

Funding Source: National Cancer Institute

REFERENCES:

1. Minkler M, Wallerstein N: Community-Based Participatory Research for Health. San Francisco, CA, Jossey-Bass., 2003.
2. Oetting ER, Donnermeyer JF, Plested BA, et al: Assessing community readiness for prevention. International Journal of the Addictions 1995; 30:659–683.

No. 52
INTER-EUROPEAN COUNTRIES COMPARISON ON TREATMENT USE FOR MENTAL HEALTH DISORDERS

Viviane Kovess, M.D., *MGEN Public Health Foundation, 3 Square Max Hymans, Paris 75015, France;* Jordi Alonso, M.D., Mathias C. Angermeyer, Tery Brugha

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to have a better knowledge about the diversity of health system and how diverse provider propose diverse treatment for the most frequent disorders.

SUMMARY:

Objectives: European countries have different health care systems concerning psychiatric disorders care: this report will compare care received in six EU countries in cases of depressive, anxiety and substance disorders.

Method: The study was conducted in: Belgium, France, Germany, Italy, the Netherlands and Spain. Individuals aged 18+ years not institutionalized were eligible for an in-home computer-assisted interview. 21,185 participated and reported on use of formal health services for 'emotions or mental health', type of professional consulted, and treatment received in the previous year such as medication or some session of psychological counseling or therapy.

Results: In some countries the general practitioner is the main provider (France, Belgium), in other countries a mental health provider is the main provider (Spain, Italy), and in some countries both types of providers are the more frequent (Netherlands). Comparisons will be presented for mood, anxiety, and mixed disorders on the relative percentage of drug and psychotherapy either alone or together and percentage of non-treated disorders. Logistic regression by countries shows that demographic variables operate diversely

Conclusions: Care received for mental health is quite diverse across these countries, and these differences may be linked to diversity of availability and organisation.

Funding: EU Commission (QLG5-1999-0142), GSK.

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SCIENTIFIC AND CLINICAL REPORT SESSION 18—VIOLENCE, TRAUMA, AND VICTIMIZATION

No. 53
EVALUATION OF A THERAPEUTIC INTERAGENCY PRESCHOOL FOR TRAUMATIZED CHILDREN

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: discuss a successful county-based, integrated preschool inter-

vention for severely traumatized children combining child protection, mental health, and Head Start services.

SUMMARY:

Objective: The Therapeutic Interagency Preschool (TIP), a mental health and Head Start program, works with young victims of severe abuse to stablize/improve their social-emotional development. It integrates existing fragmented county-based services and funding, children's services, mental health services, and Head Start in a cost-neutral fashion. The effect of TIP on child outcomes was assessed in a three-year evaluation.

Method: Data were gathered on baseline exposure to trauma for 196 children. One-year follow-up data exist for 82 children. Outcome measures included social-emotional development, parent-child interaction, and family relationships.

Results: Only 50% of the children are with their biological parents. Traumas included sexual abuse (24%), physical abuse (40%), emotional/verbal abuse (33%), neglect (51%), and witnessing domestic violence (62%). The majority experienced at least two traumas. One-year results showed small, nonsignificant overall reductions in dissociation but significant reductions among children experiencing sexual ($p < .05$) or physical abuse ($p < .05$). Significant improvements were identified across behavioral measures, including self-control ($p < .01$), responsibility ($p < .001$), cooperation ($p < .05$), and assertion ($p < .05$). Significant reductions were found in internalizing behavior ($p < .001$), parental distress ($p < .001$), and family relationships ($p < .05$).

Conclusions: TIP demonstrated clear success in improving the social, emotional, and cognitive competencies and the environment of severely maltreated preschoolers. Moreover, where TIP has been implemented, it has successfully secured sustained support and generated demand for new TIP sites. Its success can be attributed to the seamless reorganization and integration, as well as the intensification of existing services, without the need for new skills or increased funding.

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No. 54
MENTAL HEALTH IN POSTWAR AFGHANISTAN

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the prevalence of war-related mental illness in Afghanistan.

SUMMARY:

Objectives: More than two decades of war and conflict have led to widespread human suffering and massive displacement of people in Afghanistan. In 2002 the Centers for Disease Control and Prevention carried out a nationwide mental health survey in Afghanistan in collaboration with the Ministry of Public Health of Afghanistan and others. The purpose of the survey was to provide national estimates of war-related mental health status for the population of Afghanistan 15 years of age or older.

Methods: The study design was a multistage cluster survey; 50 district-level clusters were selected on the basis of probability proportional to size methods. One village was randomly selected in each cluster, and 15 households were randomly selected in each village. The questionnaire included demographics, questions addressing culture-specific symptoms of mental illness and coping mechanisms, selected questions from the 36-item Short-Form Health Survey, the Hopkins Symptom Checklist-25, and the Harvard Trauma Questionnaire.

Results: The most common trauma events experienced were lack of food and water (56.1%) and ill health without access to medical care (54.9%). Most people experienced multiple psychological traumatic events. The prevalence of depression was 66.9% and of anxiety, 72.4%. The total prevalence rate for PTSD was 37.8%.

Conclusions: Prevalence rates for depression and anxiety were high, compared to other populations affected by war. Results of this survey will be used for the implementation of mental health programs in Afghanistan.

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No. 55
A THREE-DIMENSIONAL MODEL OF VIOLENCE IN SCHIZOPHRENIA

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the heterogeneous manifestation and varying course of violence in patients with schizophrenia and schizoaffective disorder and relate these manifestations of violence to different psychiatric symptoms and neurological impairments.

SUMMARY:

Objective: To characterize further the heterogeneity of violence in schizophrenia on the basis of its varying course and setting.

Method: Violent inpatients with schizophrenia or schizoaffective disorder (N=129) were followed for four weeks; physical assaults were recorded, and the patients' history of violence in the community was obtained. Symptoms were assessed with the Brief Psychiatric Rating Scale (BPRS) upon study entry and after four weeks. Neurological impairment was assessed with the Quantified Neurological Scale (QNS).

Results: Patients could be divided into three groups on the basis of inpatient violence course and presence/absence of community violence (CV): 1) transiently violent patients (with/without CV; N = 61), who presented with more severe BPRS baseline excitation than the other two groups ($F=4.9$, $df=2, 122$, $p < .05$); 2) persistently violent patients with CV (N = 29), who had high BPRS endpoint hostility scores ($F=4.1$, $df=1, 67$, $p < 0.5$), compared to persistently violent patients with no CV but low neurological impairment; and 3) persistently violent patients with no CV (N = 39), who had severe neurological impairment (QNS total $F=6.7$, $df=1, 67$, $p < .01$), compared to persistently violent patients with CV. On canonical correlation analysis, violent parameters were significantly associated with clinical symptoms ($p < .05$). Three distinct dimensions of violence were identified and were associated with acute excitement, hostility, and neurocognitive impairments, respectively.

Conclusions: A three-dimensional model explained the heterogeneous manifestations and varying longitudinal course of violence in patients with schizophrenia and schizoaffective disorder.

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2. Krakowski M, Czobor P, Chou J: Course of violence in schizophrenic patients: relationship to clinical symptoms. Schizophr Bull 1999; 25:505–517.

WEDNESDAY, MAY 5, 2004

SCIENTIFIC AND CLINICAL REPORT SESSION 19—ALCOHOL ABUSE

No. 56
THE EFFECTS OF STATE INCOME INEQUALITY AND ALCOHOL TAX ON ALCOHOL DEPENDENCE

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the effects of two state-level contexual variables, income inequality and beer tax, on symptoms and diagnosis of alcohol dependence in a national U.S. sample and discuss the policy implications of these findings.

SUMMARY:

Objective: The effect of two U.S. state-level variables, income inequality and beer tax, on alcohol dependence was studied in a U.S. national sample.

Method: Individual-level data came from the National Longitudinal Alcohol Epidemiologic Survey, a cross-sectional U.S. sample, and state-level income data came from the 1990 census. The Gini coefficient indicated state income inequality. Outcome measures included presence of one or more symptoms of alcohol dependence and current DSM-IV alcohol dependence. Logistic regression was applied to data for men and women separately.

Results: After controlling for individual- and state-level variables, the analysis showed that the odds of alcohol dependence were not positively associated with income inequality. Higher beer tax was significantly associated with lower prevalence of alcohol dependence. Compared to the odds of having any dependence symptoms when the tax was < $0.01/drink, the odds of having any dependence symptoms were reduced for men when the tax was > $0.03/drink (OR = 0.72, 95% CI = 0.58 – 0.89) and for women when it was $0.02 – $0.03/drink (OR = 0.72, 95% CI = 0.54 – 0.96) and > $0.03/drink (OR = 0.61, 95% C = 0.47 – 0.79). Results were similar for a dependence diagnosis.

Conclusions: Evidence suggests a protective effect of increased beer taxation against alcohol dependence symptoms and a dependence diagnosis, adding to knowledge about the effects of alcohol policy on alcohol use disorders.

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No. 57
EFFECT OF AGE ON LONG-TERM OUTCOMES OF INPATIENT ALCOHOLISM TREATMENT

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the major favorable impact of older age on the long-term outcomes of men in inpatient alcoholism treatment.

SUMMARY:

Objective: This 12-year naturalistic study examined the outcomes of a method of subtyping alcoholics on the basis of chronological age at entry into an inpatient treatment program.

Method: In the mid-1980s a group of 360 inpatients treated at veterans' hospitals were entered into a long-term prospective study. All satisfied DSM-III diagnostic criteria for alcohol dependence. Their average age at intake was 41 years; 74% were white. They were reassessed one and 12 years later. Four empirically supported chronological age subgroups were formed: Group 1, age 19 – 30 years, N = 76 (21%); Group 2, age 31 – 40 years, N = 111 (31%); Group 3, age 41 – 50 years, N = 82 (23%); and Group 4, age ≥ 51 years, N = 91 (25%). All but three of the subjects were located or identified as dead at the 12-year follow-up; only two of the remaining subjects refused to participate (98.6% follow-up).

Results: Twenty-seven percent (N = 96) of the subjects died by the 12-year follow-up; the death rate among younger subjects exceeded expected death rates to a greater extent than the death rate among older subjects, although proportionally more of the older subjects had died. At entry into the study, younger subjects reported higher rates of alcoholism and other psychiatric disorders among first-degree relatives, an earlier onset of alcoholism, and a more virulent course. Over the 12-year follow-up, older subjects showed the greatest improvement in alcoholism severity, including higher abstinence rates over the 12-year follow-up period. Levels of psychosocial functioning were highest and levels of emotional distress were lowest in the older subgroup.

Conclusions: Chronological age is a major influence in predicting the long-term outcomes of inpatients with alcoholism.

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No. 58
TOPIRAMATE TREATMENT OF ALCOHOL DEPENDENCE: EFFECTS ON PSYCHOSOCIAL FUNCTIONING AND ITS RELATIONSHIP WITH HEAVY DRINKING

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Ph.D., Fatema Z. Akhtar, M.S., John D. Roache, Ph.D., Norman Rosenthal, M.D., Charles L. Bowden, M.D., Carlo C. DiClemente, Ph.D., Martin A. Javors, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the use of topiramate in treatment of alcohol dependence.

SUMMARY:

Objective: Topiramate, a sulfamate fructo-pyranose derivative, may antagonize alcohol reward associated with abuse liability by inhibiting mesocorticolimbic dopamine release, presumably by facilitating gamma-amino-butyric acid activity and suppression of glutamate function. Consistent with this hypothesis, up to 300 mg/day of topiramate, compared with placebo, significantly reduced heavy drinking among alcohol-dependent individuals. Nevertheless, does topiramate's efficacy at improving drinking outcomes result in an appreciable improvement in psychosocial well-being or quality of life?

Methods: In a randomized 12-week clinical trial, 150 individuals received topiramate (up to 300 mg/day) or placebo for the treatment of alcohol dependence. Their quality of life and psychosocial functioning in addition to their drinking behavior were assessed.

Results: Topiramate was superior to placebo at improving the odds of overall well-being (odds ratio = 2.17, 95% CI = 1.16 – 2.60, p = .008) and overall life satisfaction (odds ratio = 2.28, 95% CI = 1.21 – 4.29, p = .01). Reductions in heavy drinking were significantly correlated with improvements in quality of life and psychosocial functioning.

Conclusions: Topiramate-induced improvement in drinking outcome is sufficient to also enhance quality of life and psychosocial functioning among alcohol-dependent individuals. The data demonstrate topiramate's utility in the treatment of alcohol dependence.

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SCIENTIFIC AND CLINICAL REPORT SESSION 20—CROSS-CULTURAL ISSUES

No. 59
PREVALENCE OF MATERNAL DEPRESSION IN HONDURAS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to estimate the prevalence of major depression among Honduran mothers and demonstrate the feasibility of using the Spanish PHQ9 to assess depression in Central America.

SUMMARY:

Objectives: 1) To estimate the prevalence of major depression among Honduran mothers and 2) to assess the feasibility of using the Spanish Patient Health Questionnaire (PHQ9) to assess major depression in communities and clinics in Honduras.

Method: In October 2001 the study team interviewed mothers of children under age 10 years in one rural and one urban Honduras site, using the Spanish translation of the depression module of the PHQ9 administered as a structured interview, as well as a demographics questionnaire.

Results: The sample (N = 414) had a mean age of 30.6 years, a mean of 3.6 children, and a mean of 4.9 years in school. Seventy-three subjects (17.6%) met the criteria for current major depression, and 130 (31%) scored 10 or more on the PHQ9, consistent with moderate depression. The Spanish PHQ9 was easy to administer as an interview in both urban and rural samples. For a subgroup of 34 subjects who completed both the PHQ9 and the SCID, the PHQ9 showed a sensitivity of 77% and a specificity of 100%. The urban and rural sites reported similar frequencies and severities of depression.

Conclusions: The prevalence of current major depression (17.6%) among Honduran mothers of young children is high and comparable to rates among poor mothers in the United States. In this population the Spanish PHQ9 provided a feasible and reliable way to estimate this high prevalence of major depression. This finding points to the need for larger epidemiologic studies of maternal depression in Honduras and for clinical trials to assess the effectiveness of treatment.

Funding: Pfizer, Inc.

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No. 60
SCREENING FOR DEPRESSION AMONG CHINESE AMERICANS IN PRIMARY CARE USING TWO ITEMS

Albert Yeung, M.D., *Department of Psychiatry, Massachusetts General Hospital, 50 Standord Street, Suite 401, Boston, MA 02114;* Jessica L. Murakami, B.A., Maurizio Fava, M.D., Wendy M. Guyker, B.S., Melissa E. Abraham, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the usefulness and limitations of using screening instruments for case identification in a primary care setting, understand methods of validating screening instruments, and discuss a model of integrating primary care and psychiatric services by having primary care physicians ask about key psychological symptoms.

SUMMARY:

Objective: To investigate the validity of using two items from the Chinese version of the Beck Depression Inventory (CBDI) to screen for major depressive disorder among Chinese Americans in a primary care setting.

Method: Chinese American patients in the primary care clinic of a community health center were screened for depression with the CBDI by using a cutoff score of 16 or greater to detect potential cases. A psychiatrist assessed patients who screened positive with the Structured Clinical Interview for DSM-IV (SCID-P) to determine if they met the criteria for major depressive disorder (MDD). Two items were selected from the 21-item CBDI based on their capability to separate MDD and non-MDD patients, relevance to the DSM-IV concept of MDD, and whether they were considered sensitive items that may cause uneasiness among Asian Americans in a primary care setting. The validity of using the two-item questionnaire as a

screening tool for depression was evaluated by using the SCID interview results as the standard for comparison.

Results: Six hundred and eighty primary care patients were screened with the CBDI. Of these, 76 scored 16 or higher, and 40 of them were found to meet the criteria for MDD based on the SCID interview. The mean scores of each of the 21 CBDI items were compared between the MDD and the non-MDD patients. The differences between the mean scores for sadness (#1), guilt (#3), loss of interest/pleasure (#4), irritability (#11), insomnia (#16), and fatigue (#17) were large between these two groups of patients. The presence of the two BDI items, sadness and loss of interest, both core symptoms of MDD, was found to identify MDD patients with reasonable sensitivity (0.66), excellent specificity (0.91), and good positive predictive power (0.71) and negative predictive power (0.89).

Conclusion: The two-item questionnaire (the presence of both sadness and loss of interest) may be a simple and valid method to screen for depression among Asian Americans in a primary care setting. Further testing of this brief method may show that these two items can be used as a quick, routine verbal screening method by primary care clinicians.

Funding: Supported by Fellowship Grant 5T32MH19126-10 from the American Psychiatric Association Program for Minority Research Training in Psychiatry.

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No. 61
SUICIDAL THINKING IN COLOMBIAN YOUTH WITH A HISTORY OF ATTEMPTED SUICIDE

Ruby C. Castilla-Puentes, M.D., *WW Epidemiology Research and Development, GlaxoSmithKline, 5 Moore Drive, Research and Development, Triangle Park, NC 27709;* Wilma I. Castilla-Puentes, M.D., Sandra R. Castilla-Puentes, M.D., Leo Russo, Ph.D., Ivan S. Gomez, M.D., Gilma P. de Contreras, M.S.W., Miguel Habeych, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the impact of previous suicide attempts in youths with suicidal ideation and to determine if depression, anxiety, and PTSD increase youths' risk of suicidal thoughts.

SUMMARY:

Objective: To examine the risk of suicidal plans and ideation, depression, and other factors (high anxiety, PTSD, somatic complaints, substance abuse) among rural Colombian youth with a lifetime history of attempted suicide.

Method: A self-administered questionnaire was given to a total of 300 school-aged children/adolescents from a stratified, random sample of schools in a rural area in Belen, Boyacá, Colombia. Usable questionnaires were obtained from 293 respondents (97.6%), consisting of 184 girls and 109 boys with a mean age of 12.3 years (range 8 – 18 years). Data were obtained on a wide range of constructs, including recent and lifetime suicide attempts, recent and lifetime suicide plans, recent ideation, and symptoms of DSM-IV PTSD, anxiety, depression, somatic complaints, and substance abuse. Associations between psychosocial factors and history of attempts were evaluated by using univariate and multivariate logistic models.

Results: Data on crude prevalence showed that the prevalence of thoughts about death, wishing to be dead, thoughts of suicide, and suicide plans was significantly higher among youths with a history of suicide attempts. Suicidal thinking was related to more somatic complaints, more substance abuse, and to more anxiety, in addition to depression and a history of attempts. Factors associated with current suicidal thinking were depression (odds ratio [OR] = 5.34), history of attempts (OR = 3.50), and recent life stress (OR = 2.62). Compared with youths with none of the factors examined, those with five or more were at extreme risk (OR = 20.64).

Conclusion: The strong association between history of suicide attempts, current ideation, and depression indicates that past suicide attempts occur in the context of other signs of psychosocial dysfunction. Given the lack of epidemiological data on the natural history of suicidal behaviors among youths, more epidemiological studies of the antecedents and consequences of the range of suicidal behaviors among children and adolescents are needed. Given the high risk of subsequent suicidal behaviors by Colombian youths that have attempted but not completed suicide, this constitutes a high-risk population on which future research should focus.

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SCIENTIFIC AND CLINICAL REPORT SESSION 21—SUICIDE

No. 62
SUICIDALITY AND SECOND-GENERATION ANTIPSYCHOTICS IN PATIENTS WITH SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to assess risk of suicidality in schizophrenia patients and evaluate the "antisuicide" effects of the various second-generation antipsychotics.

SUMMARY:

Objective: In the last decade evaluation of antisuicide effects of pharmacological treatment in schizophrenia was undertaken. The aim of the present study was to assess the effects of exposure to second-generation antipsychotics (SGA) on suicidality in schizophrenia patients. This is a retrospective, 5-year, case-controlled study.

Methods: Records of schizophrenia or schizoaffective disorder patients (ICD-10) hospitalized between 1998 and 2002 were reviewed. Patients who had attempted suicide before admission were the index group. The control group consisted of the next admission of a patient matched for diagnosis, gender, and age who did not attempt suicide.

Results: Records of 756 patients (of 4,486 admissions for said period) were analyzed (56.6% male, mean age = 39.1 ± 13.5 years). Among 378 patients (index group) who attempted suicide, 9.8% were exposed to SGA, while 27.8% were exposed in the control

group (p = .0001). The protective effect (odds ratio) of SGA was 3.55 (95% CI = 2.4 – 5.3). Risperidone was more frequently prescribed in the control group (57.6%) and had a stronger protective effect than olanzapine (3.1 vs 1.8).

Conclusions: Schizophrenia patients treated with both risperidone and olanzapine may gain protection from suicidality. This antisuicide effect seems to differ between SGAs and should be further investigated.

Funding: Supported by a restricted educational grant from J & C, Israel.

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No. 63
MELANCHOLIA AND SUICIDE ATTEMPT PROBABILITY AND LETHALITY

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the relationship between melancholia and suicide attempts.

SUMMARY:

Objective: Suicidal behavior is most often a complication of depression, but less is known about the suicidal behavior associated with different subtypes of depression. This study compared the probability and lethality of suicide attempts associated with melancholic versus nonmelancholic depression.

Method: A sample of 377 persons with a lifetime history of a major depressive episode was assessed on clinical measures and lifetime history of suicidal behavior. Follow-up assessments were done for up to two years in 263 of the subjects. Subjects with the melancholic subtype of depression were compared with nonmelancholic depressed subjects across demographic, clinical, and suicide-related variables.

Results: Controlling for index episode depression severity and other covariates, the analysis showed that melancholia was associated with more lethal past suicide attempts and with a greater probability of suicide attempt during prospective follow-up.

Conclusions: Melancholia is a risk factor for greater past suicide attempt lethality and higher future suicide attempt probability. The mechanism mediating this risk warrants further research.

Funding: PHS grants MH46745, MH48514, and MH62185 (Conte Neuroscience Center).

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2. Jackson SW: Melancholia and Depression: From Hippocratic Times to Modern Times. New Haven, Yale University Press, 1986.

No. 64
NONVIOLENT SUICIDES IN WOMEN ARE INCREASED DURING AND AFTER HIGH EXPOSURE TO TREE POLLEN

Teodor T. Postolache, M.D., *Department of Psychiatry, University of Maryland, 701 West Pratt Street, Suite 388, Baltimore, MD 21201;* Mark A. Goldstein, B.A., Richard Herrell, Ph.D., Srirangam S. Shreeram, M.D., Courtney M. Thrower, M.A., John W. Stiller, M.D., Hirsh Komarow, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: 1) be aware of the seasonal variation in suicidal rates, one of the most-highly replicated epidemiological finding in psychiatry; 2) recognize potential environmental contributors to the peaks in suicide; and 3) consider specific instances when release of cytokines may contribute to depression, specifically during seasonal allergy.

SUMMARY:

Objective: Suicide rates have been consistently shown to peak in spring and early fall. Given high pollen exposure during discrete intervals within these seasons, the pollen exposure-induced release of cytokines, and cytokine-induced depression, the authors hypothesized that suicide rates would be higher during and after intervals of high pollen exposure.

Methods: Data for tree and ragweed pollen were obtained from the American Academy of Allergy, Asthma, & Immunology for the continental USA for 1995 – 1998. Peak pollen intervals and corresponding pre- and post-exposure intervals were identified for each location. Suicide data were obtained from the National Center for Health Statistics. Sites included in the study (based on available pollen exposure intervals) made available 92,705,505 person-years, with 9,528 suicides recorded (rate = 10.3 per 100,000 person-years, 95% confidence interval [CI] = 10.1 – 10.5). Suicides were categorized by sex and age (younger than 65 years, and 65 years and older), and as violent/nonviolent. Suicide rates and standard errors were estimated by using Poisson regression models.

Results: No significant differences were found during the ragweed season. During the tree pollen season, while no significant difference emerged in men, in women significant increases in the relative rates of nonviolent suicides were found in the high exposure interval (younger women had a twofold increase) and post-exposure interval (older women had a 4.6-fold increase), compared with pre-exposure intervals.

Conclusion: The findings are consistent with the association between pollen exposure and depressed mood in sensitive individuals and with a higher prevalence of allergies in women. Biological, psychological, and iatrogenic factors (to be discussed) may contribute to these results, which need to be replicated longitudinally.

Funding: Supported by the D.C. Department of Mental Health.

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SCIENTIFIC AND CLINICAL REPORT SESSION 22—BIPOLAR DISORDER

No. 65
CHARACTERISTICS OF PATIENTS TREATED WITH GABAPENTIN REFERRED TO A BIPOLAR SPECIALTY CLINIC

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that even after the publication of data suggesting that gabapentin is ineffective for bipolar disorder, the drug continues to be prescribed for that illness.

SUMMARY:

Objective: Gabapentin remains widely prescribed to patients with bipolar disorder despite randomized clinical trials suggesting lack of efficacy. The reasons that patients with bipolar disorder are still prescribed gabapentin are unclear. The authors hypothesized that patients taking gabapentin were prescribed this anticonvulsant because they had more comorbid anxiety disorders.

Methods: The charts of 30 patients prescribed gabapentin before clinic entry were compared to those of 30 age- and sex-matched patients not prescribed gabapentin before clinic entry. All subjects were evaluated after the publication of data suggesting that gabapentin is ineffective for bipolar disorder. Baseline evaluation included demographics, concurrent medications, current depressive and manic symptoms, lifetime depressive and manic/hypomanic episodes, prior suicide attempts and violence, age of onset, and comorbid anxiety, substance use, and personality disorders.

Results: The groups differed significantly on the number of medications, with the gabapentin group taking more medications. ($p = .01$). In t test and chi-square analyses, no significant differences between groups were found for any other variables.

Conclusions: The hypothesis that patients prescribed gabapentin had a higher rate of comorbid anxiety disorders was not supported. Gabapentin appears to be used as a mood stabilizer despite the lack of evidence supporting this use of the drug. The findings suggest a lag between research and clinical practice.

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No. 66
OLANZAPINE/FLUOXETINE COMBINATION: RAPID ONSET WITH LOW RISK OF MANIA

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to compare the onset of effect and mania risk for olanzapine/fluoxetine combination (OFC), olanzapine, and placebo in the treatment of bipolar depression.

SUMMARY:

Objective: An ideal treatment for bipolar depression should have both rapid onset of antidepressant effect and low risk of mania. The authors examined onset of effect and emergence of mania for olanzapine/fluoxetine combination (OFC) in a study comparing OFC, olanzapine, and placebo (N = 833).

Methods: The Montgomery-Asberg Depression Rating Scale (MADRS) was used to measure depressive symptoms, and the Young Mania Rating Scale (YMRS) was used to measure manic symptoms. Multiple post hoc analyses examined onset of effect. Treatment-emergent mania was defined as baseline YMRS < 15 and ≥ 5 at any subsequent visit.

Results: Traditional analysis revealed significantly greater improvement in MADRS scores at week 1 for OFC versus placebo and for olanzapine versus placebo. The OFC group had a significantly greater percentage of early persistent responders than the olanzapine or placebo groups. Survival analysis revealed a significantly shorter time to sustained response for OFC versus placebo, for OFC versus olanzapine, and for olanzapine versus placebo. Area-under-the-curve analysis showed a significantly greater percentage of total possible improvement for OFC versus olanzapine and for OFC versus placebo. The incidence of treatment-emergent mania was low and similar among treatment groups (OFC, 6.4%; olanzapine, 5.7%; placebo, 6.7%; $p = .86$).

Conclusion: Overall, OFC and olanzapine demonstrated rapid antidepressant action without increased risk of mania. The magnitude of antidepressant effect was greater for OFC.

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No. 67
PSYCHOTIC FEATURES IN MDD ARE ASSOCIATED WITH MANIA

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that psychotic symptoms in depressed patients are a major risk factor for the development of mania.

SUMMARY:

Objective: This study examined the association between psychotic symptoms and mania in a large group of psychiatry clinic outpatients who fulfilled the DSM-III criteria for one or more major depressive episodes.

Method: Of the 1,458 consecutive admissions to an outpatient clinic over a 5-year period, 1,002 fulfilled the DSM-III criteria for major depression (67% were female; 33% were male). The average age was 38 years, 80% were white, and 27% had never married. Of the 1,002 patients with major depression, 275 (27%) also satisfied the inclusive diagnostic criteria for mania. The 1,002 depressed patients were divided into three groups: Group 1, depression with no psychotic symptoms (N = 774; 77%); Group 2, depression with minimal psychotic symptoms (N = 60; 6%); and Group 3, depression with major, long-term psychotic symptoms (N = 168; 17%).

Results: The presence of mania with depression was strongly associated with any report of psychotic symptoms. The presence of mild or major psychotic symptoms more than doubled the risk of mania. This relationship held true for both male and female patients, as well as for patients with no prior history of substance abuse (N = 725).

Conclusions: The presence of *any* psychotic symptoms in a patient with major depression should alert practitioners to the possibility of bipolar illness.

REFERENCES:

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SCIENTIFIC AND CLINICAL REPORT SESSION 23—BIOLOGICAL PSYCHIATRY

No. 68
FMRI OF SPATIAL WORKING MEMORY IN SCHIZOTYPAL PERSONALITY DISORDER

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the differences in the pattern of regional activation of the brain between schizotypal personality disorder patients and healthy volunteers as they perform a visuospatial working memory task.

SUMMARY:

Objective: Schizotypal personality disorder (SPD), a condition sharing genetic, neurophysiological, cognitive, and neuroanatomic features with schizophrenia, affords an opportunity to study cognitive processes in the schizophrenia spectrum unaffected by possible confounds of ongoing psychotic symptoms and prior exposure to neuroleptic medications. The authors used functional magnetic resonance imaging to compare the regional brain activation of SPD patients and healthy control subjects as they performed a visuospatial working memory task.

Method: BOLD images were obtained as six SPD patients and seven healthy control subjects performed a working memory task in which they were asked to retain the location of three dots over a period of 30 seconds. The exact Talairach and Tournoux coordinates of brain areas previously reported to show activation with spatial memory tasks were assessed.

Results: Regions in the left ventral and middle prefrontal area, frontal pole, premotor, and parietal cortex showed significantly less activation for the spatial memory retention period in the patients with SPD than in the control subjects. Regions in the right middle prefrontal and prestriate cortex showed significantly greater activation in patients with SPD.

Conclusion: Patients with SPD allocate cerebral resources differently than healthy control subjects in carrying out a visuospatial working memory task.

REFERENCES:

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No. 69
HYPOFRONTALITY IN PATIENTS WITH SCHIZOPHRENIA AND BIPOLAR DISORDER: AN FMRI STUDY

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to 1) recognize that the cognitive deficits of psychiatric patients as assessed by using clinical and neuropsychological examination could be correlated with neuroanatomical deficits, and 2) the usefulness of functional MRI as a potential tool for assessing cerebral activation in psychiatric patients.

SUMMARY:

Objective: To evaluate the cerebral activation during a Stroop test in patients with schizophrenia and bipolar disorder, compared with healthy subjects, by using functional magnetic resonance imaging (fMRI). This test was used to obtain supplementary information for better understanding the hypofrontality described in these patients.

Methods: During one fMRI session the Stroop test was presented in five incongruent blocks (task) and five congruent blocks (control) to six clinically stabilized patients with schizophrenia, six patients with bipolar disorder, and six healthy subjects. SPM99 has shown significant activation correlated to a Stroop interference effect when conditions (task and control) and groups were compared.

Results: Overall, with respect to the control subjects, both patient groups showed frontal hypoactivation. In schizophrenia patients *versus* bipolar disorder patients, the hypoactivation was located within the dorsolateral prefrontal, anterior cingulate, and medial frontal cortices, while in bipolar disorder patients *versus* schizophrenia patients, the hypoactivation was situated within the right middle-frontal cortex, inferior parietal lobule, right insula, and left middle temporal gyrus. These results are discussed within the framework of the neuropsychological deficit of these disorders.

Conclusions: Although clinical evidence of hypofrontality in both disorders exists, the results indicate that different mechanisms are altered in schizophrenia, compared with bipolar disorder. These preliminary findings suggest either a different pathophysiology or different cognitive strategies used by these patients for performing cognitive tasks.

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No. 70
LOW LEVELS OF ANTIBODIES TO CARDIOLIPIN IN FIRST-EPISODE AND CHRONIC SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that antibodies to cardiolipin are lower in schizophrenic patients, and especially in first-episode patients.

SUMMARY:

Objective: To measure anticardiolipin antibodies (aCL) in major psychiatric diseases.

Methods: In experiment 1, 96 subjects were evaluated: 20 first-episode schizophrenia patients [SCZ1], 20 chronic schizophrenia patients in acute exacerbation [SCZ2], 19 bipolar disorder patients, 20 schizoeffective disorder patients, and 17 healthy age-matched control subjects. In experiment 2, 97 subjects were studied: 20 first-episode schizophrenia patients [SCZ1], 60 chronic schizophrenia patients in acute exacerbation [SCZ2], and 17 healthy matched control subjects. Diagnosis was according to DSM-IV guidelines. Serum samples were tested for aCL in parallel by enzyme-linked immunosorbant assay in the presence of bovine serum. Five positive control samples with high levels of aCL were run in parallel. Background binding to wells uncoated with cardiolipin (CL) was also measured.

Results: In experiment 1, aCL levels were similar in the control, bipolar disorder, and schizoeffective disorder groups. In contrast, aCL levels in the SCZ1 and SCZ2 groups were significantly lower than that in the control group ($p = .000002$ and $p = .00002$, respectively). In experiment 2, significantly lower levels of aCL antibodies were found in all schizophrenia patients ($p = .0002$ for all schizophrenia patients versus control subjects). Background levels in both experiments were higher in the schizophrenia groups than in the control group.

Conclusions: Serum aCL levels are lower in schizophrenia patients, and especially in first-episode patients, compared to control subjects. One possible explanation for the lower levels of aCL in schizophrenia patients is the consumption of these antibodies in an acute phase and exacerbation of the disease. The higher background levels in schizophrenia patients may indicate a high level of antibodies to some serum component in schizophrenia, which is still unclear and needs further elucidation.

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SCIENTIFIC AND CLINICAL REPORT SESSION 24—PSYCHOPHARMACOLOGY RESEARCH IN DEPRESSION

No. 71
PREVALENCE OF MTHFR C677T AND MEHIONINE SYNTHASE A2756G POLYMORPHISMS IN MAJOR DEPRESSION AND IMPACT ON RESPONSE TO FLUOXETINE TREATMENT

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the significance of the polymorphisms of the MTHFR and methionine synthase genes in patients with major depression and understand the potential impact of these polymorphisms on antidepressant treatment.

SUMMARY:

Objective: Recent investigations have suggested a relationship between mood disorders and the C677T mutation in the methylene tetrahydrofolate reductase (MTHFR) enzyme, perhaps by means of impaired folate metabolism. The C677T homozygote mutation is present in 10% – 12% of the general population. The authors examined the prevalence of this mutation in depressed individuals and its effect on treatment response. The effect of the A2756G mutation of methionine synthase (MS), an enzyme also involved in folate metabolism, was also examined.

Methods: A total of 224 subjects (52% of whom were female) ages 18 – 65 years with major depressive disorder (MDD) from various depression studies were screened for the C677T mutation in MTHFR and the A2756G mutation in MS. MDD diagnoses were obtained with the SCID-I/P. Twenty-seven subjects participated in a clinical trial in which they received open-label fluoxetine in a dose of 20 – 60 mg/day for 12 weeks. Response rates and their association with C677T and A2756G status were examined.

Results: In 194 MDD patients for whom genotyping data were available, the overall C677T prevalence was 41% for C/C wild type "normals," 47% for C/T heterozygotes, and 11% for T/T homozygote mutants. The prevalence of A2756G was 66% for wild type normals (–/–), 29% for heterozygotes (+/–), and 4% for homozygote mutants (+/+). Response data and genetic data were available for 22 of the 27 patients who received fluoxetine treatment. Response rates were 40% (N = 4/10) for C677T C/C normals and 33% (N = 4/12) for C/T heterozygotes and T/T homozygotes. Response rates for A2756G were 44% (N = 7/16) for wild type "normals" (–/–) and 33% (N = 2/6) for heterozygotes (+/–). No patients in the fluoxetine arm exhibited the (+/+) homozygote mutation.

Conclusion: The prevalence of the C677T T/T homozygote in MDD patients appears comparable to that in the general population, but the heterozygous C/T form was more prevalent than expected in this sample. Individuals with the C677T mutation may be slightly less likely to respond to antidepressants than individuals without the mutation, although these preliminary findings need to be replicated in a larger sample.

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No. 72
ORAL S-ADENSOYL METHIONINE (SAME) FOR ANTIDEPRESSANT AUGMENTATION: AN OPEN-LABEL TRIAL

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the potential role of oral SAMe when used in conjunction with selective serotonin reuptake inhibitors or venlafaxine in the treatment of major depressive disorder.

SUMMARY:

Objective: To evaluate the safety, tolerability, and efficacy 800-1600 mg/day of oral SAMe for augmentation of conventional antidepressants among adults with major depressive disorder (MDD) with partial or nonresponse to a standard course of SSRI or venlafaxine.

Methods: Thirty adult outpatients (22 female patients, mean age = 48.4 ± 13.0 years, mean baseline Hamilton Depression Rating Scale [HAM-D-17] score = 17.7 ± 14.2) with retrospectively established treatment resistance to adequate dose/duration of an SSRI or venlafaxine received open-label adjunctive treatment with oral SAMe starting at 800 mg/day for two weeks and increased to 1600 mg/day, depending on response and tolerability, for an additional four-week period. Response was defined as a 50% or greater decrease from baseline to endpoint in the HAM-D-17 score. Remission was defined as an endpoint HAM-D-17 score ≤7.

Results: Intent-to-treat analysis indicated a significant decrease in depression severity from baseline to endpoint as measured by the HAM-D-17 ($p < 0.0001$) and the BDI ($p = 0.0002$). At endpoint, there were 15 (50.0%) responders and 13 (43.3%) remitters. Benign safety and tolerability data included a decrease in pre- to post-treatment homocysteine levels (from 8.2 ± 2.5 to 7.8 ± 2.3 μmol/liter, $p = 0.003$).

Conclusions: The combination of a stable oral form of SAMe with an SSRI or venlafaxine may offer an additional treatment strategy among outpatients with treatment-resistant MDD.

Funding: Supported by Pharmavite.

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2. Hardy M, Coulter I, Favreau J, Venturupalli S, Chiappelli F, Rossi F, Jurigvig L, Roth E, Suttorp M, Shanman R, Newberry S, Ramirez L, Shekelle P, Morton SC: S-Adenosyl-L-Methionine for Treatment of Depression, Osteoarthritis, and Liver Disease. AHRQ Publication No. 02-E04. Rockville, Md, Agency for Healthcare Research and Quality, 2002.

No. 73
SOMATIC SYMPTOMS AS PREDICTORS OF TIME TO ONSET OF RESPONSE TO FLUOXETINE IN MDD

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the relationship between somatic symptoms of depression and time to onset of antidepressant response with fluoxetine in major depression.

SUMMARY:

Objective: The relationship between somatic symptoms and the time to onset of clinical response to fluoxetine in patients with major depressive disorder (MDD) was examined.

Methods: Eighty-seven outpatients (mean age = 41.4 ± 10.2 years; 59.8% women) with MDD who had sustained acute response to fluoxetine completed the Symptom Questionnaire (SQ) at baseline. Onset of response was defined as a 30% decrease in the total score for the 17-item Hamilton Depression Rating Scale (HAM-D-17) that led to a 50% decrease by week 8. With the use of two separate multiple regressions, controlling for the severity of depression at baseline, the relationship between the number of somatic symptoms as assessed by the somatic symptom subscale of the Symptom Questionnaire (SQ-SS) and the 1) time to onset of clinical response and 2) time to clinical response was assessed.

Results: A greater number of somatic symptoms at baseline predicted a greater time to onset of clinical response to fluoxetine ($p = .02$). The relationship between SQ-SS scores and time to response was not found to be statistically significant ($p > .05$).

Conclusion: Somatic symptoms of depression were found to be associated with a delayed onset of antidepressant response to fluoxetine in MDD.

REFERENCES:

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SCIENTIFIC AND CLINICAL REPORT SESSION 25—OUTCOMES IN PSYCHOSIS

No. 74
IC-SOHO: INTERCONTINENTAL SCHIZOPHRENIA OUTPATIENT HEALTH OUTCOMES STUDY

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to have an enhanced understanding of the long-term clinical, social, quality-of-life, and economic outcomes observed in patients receiving antipsychotics for schizophrenia in real clinical practice settings across a large and diverse sample.

SUMMARY:

Objective: IC-SOHO was designed and implemented to provide information on the use and outcome of antipsychotic treatments for schizophrenia from a large, diverse population as assessed in naturalistic settings.

Method: Outpatients with schizophrenia, who initiated or changed a new antipsychotic, entered this three-year, noninterventional, prospective observational study. A range of simple, but valid, measures and questionnaires were used to evaluate clinical, social, and quality-of-life (QoL) outcomes. Initial (six-month) findings are described; further one-year results will be presented.

Results: This study spans 27 countries within Africa, Asia, Central and Eastern Europe, Latin America, and the Middle East. At baseline, 7,658 patients entered IC-SOHO. At six months, efficacy improvements were observed with all treatments; however, olanzapine resulted in significantly greater improvements in overall, positive, negative, depressive, and cognitive symptoms, compared with quetiapine, risperidone, or haloperidol ($p < .001$). Extrapyramidal symptoms and tardive dyskinesia decreased, compared to baseline, with olanzapine, quetiapine, and risperidone, but increased with haloperidol. Further efficacy, tolerability, and QoL findings will be presented.

Conclusions: The results support the previously reported positive effect of atypical antipsychotics in patients with schizophrenia. Long-

term real-life observations about treatment of this disease in regions where such information has previously not been available are also provided.

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2. Haro JM, Edgell ET, Jones PB, Alonso J, Gavarl S, Gregor KJ, Wright P, Knapp M: The European Schizophrenia Outpatient Health Outcomes (SOHO) study: rationale, methods and recruitment. Acta Psychiatr Scand 2003; 107:222–232.

No. 75
MALE PATIENTS WITH SCHIZOPHRENIA HAVE IMPAIRMENT IN THE PROCESSING OF SPATIAL INFORMATION FROM DISSOCIATED SPATIAL REFERENCE FRAMES

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to 1) recognize that patients with schizophrenia have impairments in their ability to organize their spatial behavior when processing spatial information from two dissociated spatial reference frames and 2) recognize that this impairment is analogous to the impairments seen in rats with partial unilateral hippocampal lesions.

SUMMARY:

Objective: A validated computer-based navigation task was used to test whether the ability of male schizophrenia patients to organize responses to spatial stimuli in two spatial frames deteriorated when the spatial frames of reference were dissociated.

Methods: Thirteen stable male schizophrenia patients between the ages of 18 and 50 years were included in the study. The computer task involved viewing a 10-sided polygonal "arena" projected onto a wall. The subject had to hit a target shown at the beginning of each trial, which was then hidden. The target was anchored to the arena, which may be stable or rotating. Two interference landmarks could be either absent or anchored to either the stationary or the rotating frame. The arena-target and the interference landmarks could be in the same or in a dissociated frame of reference.

Results: As predicted, patients had a deterioration in performance when the arena-targets were rotating while the interference objects were stable, i.e., dissociation ($p = .01$). Poorer performance was associated with younger age of illness onset ($p = .04$) and greater number of hospitalizations ($p = 0.05$).

Conclusions: A disturbance of the ability to organize spatial stimuli from two dissociated spatial frames of reference is a cognitive deficit in schizophrenia patients that has not been previously reported.

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2. Bures J, Fenton AA: Neurophysiology of spatial cognition. News Physiol Sci 2000; 15:233–240.

No. 76
PREDICTORS OF OUTCOME IN 52 CASES OF PSYCHOTIC NONAFFECTIVE DISORDERS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should 1) have an understanding of the early course of psychotic nonaffective illness for patients presenting for their first lifetime hospitalization, 2) be able to distinguish among different types of recovery, and 3) be able to recognize some of the factors associated with recovery among psychotic nonaffective disorder patients.

SUMMARY:

Objective: Understanding the natural course of psychotic nonaffective disorders from onset and first hospitalization to recovery remains a clinical imperative for researchers and providers of clinical care.

Methods: Patients with DSM-IV psychotic nonaffective disorder (93 entered, 1989 – 1996) were followed-up for at least two years to assess timing and predictors of syndromal and functional recovery.

Results: Fifty-two patients received or maintained a diagnosis of psychotic nonaffective disorder by two years. There were three (5.8%) patients with brief psychotic disorder, 12 (23.1%) with delusional disorder, 16 (30.8%) with psychosis not otherwise specified, and 21 (40.4%) with schizophrenia. Time to 50% *syndromal* recovery assessed for psychotic nonaffective disorder patients was 8 ± 3.6 weeks, with a range from four to 46 weeks. Factors associated with *syndromal* recovery include onset age ≥ 30 years, milder baseline psychosis symptoms (BPRS item thought disorder score ≤ 1), fewer social problems (SANS item intimacy absent), fewer problems with attention (SANS item attention during mental status testing absent), and being married. Eight of 26 patients (33.8%) achieved *functional* recovery at 24 months. Factors associated with *functional* recovery included milder baseline symptoms measured by BPRS items suspiciousness, guilt, and dysphoric mood; the HAM-D-31 guilt item; and the SAPS voices conversing item.

Conclusion: Younger, married, and less severely ill patients have a better prognosis for recovery after a first lifetime hospitalization for psychotic nonaffective illness.

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SCIENTIFIC AND CLINICAL REPORT SESSION 26—SUBSTANCE ABUSE

No. 77
RISK FACTORS FOR DSM-IV CANNABIS ABUSE AND DEPENDENCE

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the relationship between early onset of alcohol or marijuana use and subsequent marijuana dependence or abuse, and the potential for using patients' marijuana and alcohol use histories in addressing and preventing marijuana disorders in conjunction with treatment of other diagnoses.

SUMMARY:

Objective: Little is known about risk factors for DSM-IV marijuana abuse and dependence in the general population. The authors investigated DSM-IV cannabis dependence or abuse among marijuana-using subjects (N = 401) in a longitudinal study of adult community residents initially screened for heavier than average drinking (10-year follow-up rate, 85.3%).

Method: Subjects were evaluated at baseline and follow-up with the AUDADIS, a highly reliable and valid diagnostic interview. Analysis included Kruskal-Wallis and Wilcoxon tests.

Results: Among the sample, 8.0% met the criteria for DSM-IV marijuana dependence and 38.7% met the criteria for abuse. The most common dependence symptom was "desire/unsuccessful efforts to cut down/control use" (N = 103, 25.7%). The most common DSM-IV abuse criterion was "physically hazardous use" (N = 161, 40.1%), mainly driving after smoking marijuana. Variables significantly associated with DSM-IV marijuana abuse and dependence included onset of drinking before age 15 ($p = .009$), cannabis use before age 18 ($p = .02$), lifetime DSM-IV alcohol abuse and dependence diagnoses ($p = .006$), and symptoms of childhood conduct disorder ($p < .0001$) and adult antisocial personality disorder ($p = .0002$).

Conclusions: Results suggest that early cannabis or alcohol use and childhood conduct problems increase the likelihood of future problems with cannabis and that a general proclivity to dependence or abuse may exist across substances.

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No. 78
CANNABIS USE REDUCES THE LIKELIHOOD OF SUSTAINED REMISSION FROM OTHER DRUGS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify the potentially large extent of cannabis use among patients treated for dependence on other drugs and recognize the risk incurred by use of cannabis for poor outcome of the treatment of dependence on other drugs.

SUMMARY:

Objective: Little information exists on whether postdischarge cannabis use affects the treatment outcome of dependence on other drugs. The relationship of cannabis use to sustained remission from alcohol, cocaine, and/or heroin dependence and subsequent relapse was examined.

Method: Adult inpatients (N = 250) from a psychiatric/substance setting who were dependent on alcohol, cocaine, and/or heroin participated in baseline and follow-up PRISM diagnostic interviews for an average of 91 weeks of follow-up (response rate, 91%). Sustained remission was defined as 26 or more weeks without use of the relevant drug(s), and Cox proportional hazards models was used to analyze the data.

Results: More than one-half (57.6%) of the patients used cannabis after discharge. In analyses controlling for demographics and other variables, including major depression, cannabis use after discharge increased the hazard of first use of other substances (hazard ratio = 4.8, 95% CI = 3.1 – 7.6), reduced the likelihood of achieving stable remission from other substances (hazard ratio = .18, 95% CI = .05 – 76), and increased the risk of subsequent relapse to alcohol (hazard ratio = 4.77, 95% CI = 1.44 – 15.72), with a similar trend for cocaine.

Conclusions: These data suggest that the negative clinical implications of widespread continued cannabis use should be taken seriously when treating dependence on other substances and in planning aftercare.

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No. 79
SUBSTANCE-INDUCED RISK FOR DEPRESSION IN A SUBSTANCE-DEPENDENT POPULATION

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to 1) identify risk factors for depression among a patient population with a recent history of dependence on alcohol, cocaine, and/or heroin and 2) appreciate the further clinical implications of major depressive disorder in this population.

SUMMARY:

Objective: Substance use increases the risk of psychiatric disorders, including major depressive disorder (MDD). Prospective studies have focused on links between adolescent substance use and development of adult psychiatric disorders. However, a more immediately relevant clinical question is the risk incurred by substance abuse in a given week for a depressive syndrome the following week. The authors studied this question in 217 inpatients with a recent history of heroin, cocaine, and/or alcohol dependence who were followed prospectively postdischarge for a year.

Method: Substance use and mood disorders were assessed at baseline and follow-up by using the PRISM. A transition probability of MDD occurrence in a week was modeled as a function of control variables from baseline and substance use from the previous week.

Results: The combined substance variable strongly predicted MDD occurrence the following week ($p < .0001$, OR = 1.90, 95% CI = 1.40 – 2.59). When use of each substance was analyzed separately, alcohol and heroin, respectively, both significantly increased the odds of MDD occurrence the following week ($p < .0001$, OR = 3.30, 95% CI = 2.22 – 4.90) ($p = .01$, OR = 2.34, 95% CI = 1.22 – 4.49).

Conclusions: Heavy drinking and/or heroin use among patients treated for substance dependence should serve as a signal to clinicians

of an increased risk for MDD, which subsequently increases the risk for other problems.

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1. Brook DW, Brook JS, Zhang C, Cohen P, Whiteman M: Drug use and the risk of major depressive disorder, alcohol dependence, and substance use disorders. Arch Gen Psychiatry 2002; 59:1039–1044.
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SCIENTIFIC AND CLINICAL REPORT SESSION 27—ISSUES IN PSYCHIATRIC EPIDEMIOLOGY

No. 80
ETHNICITY, DIAGNOSIS, AND HEALTH CARE UTILIZATION IN INCARCERATED WOMEN

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the relationship of ethnicity to psychiatric diagnoses and health care utilization among incarcerated women.

SUMMARY:

Objective: To examine ethnic differences in psychiatric diagnoses and health service utilization, and preferences in incarcerated women.

Method: Demographic and health service utilization data were collected for 85 women incarcerated at York Correctional Institute, the sole prison for women in Connecticut. The Semi-Structured Assessment for the Genetics of Alcoholism-II (SSAGA-II) and SCID II were used to assess diagnoses. A questionnaire was administered to assess preferences for race of health care provider.

Results: Women in this study had a mean age of 33.0 years (SD = 10.4 years). Forty-four percent of the women were Caucasian, 29% African American, 21% Hispanic, and 6% other. Lifetime major depression (38.8%), PTSD (41.8%), alcohol dependence (41.4%), cocaine dependence (52.0%), opioid dependence (35.7%), and antisocial personality disorder (39.8%) were prevalent. Ethnicity was not significantly related to psychiatric diagnoses, emergency room visits, psychiatric hospitalizations, medical hospitalizations, or outpatient psychiatric treatment before incarceration. All but one of the women said that they had no ethnic preference for health care provider.

Conclusion: Ethnicity does not appear to be significantly related to psychiatric diagnoses, health service utilization prior to incarceration, and preferences regarding health care provider in this sample of incarcerated women. Further research is needed on ethnicity and the utilization of health services among incarcerated women.

Funding: National Institutes of Health Building Interdisciplinary Research Centers in Women's Health (BIRCWH) and the University of Connecticut Health Center Center for Interdisciplinary Research in Women's Health (CIRWH).

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2. Wu LT, Kouzis AC, Leaf PJ: Influence of comorbid alcohol and psychiatric disorders on utilization of mental health services in the National Comorbidity Survey. Am J Psychiatry 1999; 156:1230–1236.

No. 81
PSYCHOTROPIC DRUG UTILIZATION IN SIX EUROPEAN COUNTRIES

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the patterns of utilization of psychotropic drugs in Europe and recognize variables associated with utilization of psychotropic drugs in the general population.

SUMMARY:

Objective: To assess psychotropic drug utilization in the general population of six European countries.

Method: Data were derived from the European Study of Epidemiology of Mental Disorders (ESEMeD/MHEDEA 2000), a cross-sectional psychiatric epidemiological study in a representative sample of 21,185 adults age 18 years or older from six European countries (Belgium, France, Germany, Italy, the Netherlands, and Spain). Individuals were asked about any psychotropic drug use in the past 12 months, even if they used the drug(s) just once. A color booklet containing high-quality pictures of psychotropic drugs commonly used to treat mental disorders was provided to help respondents recall drug use.

Results: Psychotropic drug utilization was generally low in individuals with any 12-month mental disorder (31.9%). The extent of psychotropic drug utilization varied according to the specific DSM-IV diagnosis. Among individuals with a 12-month diagnosis of pure major depression, only 20.6% had received any antidepressants within the same period; the exclusive use of antidepressants was even lower (8.8%), while more individuals took only anxiolytics (19.9%).

Conclusion: These data question the appropriateness of current pharmacological treatments, particularly for major depression, in which undertreatment is coupled with a high frequency of use of nonspecific medications, such as anxiolytics.

Funding: From the European Union Commission (QLG5-1999-0142) and an unrestricted grant from GSK.

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No. 82
ONSET OF DSM-IV ALCOHOL ABUSE AND DEPENDENCE: A 10-YEAR PROSPECTIVE STUDY

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to 1) demonstrate knowledge of risk factors for developing DSM-IV alcohol dependence among heavy drinkers with no previous

alcohol diagnosis, and of how these factors differ from DSM-IV alcohol abuse risk factors and 2) demonstrate familiarity with the fundamental differences between these two alcohol use disorders.

SUMMARY:

Objective: Few prospective studies have addressed new onset of DSM-IV alcohol abuse and dependence in adults, how various risk factors work together, or whether the predictors of abuse and dependence differ. The authors examined inherited, psychosocial, and drinking history predictors of new-onset DSM-IV alcohol abuse and dependence in a 10-year prospective study of 514 men and women. At baseline, these individuals were heavier-than-average drinkers without a history of alcohol dependence.

Method: The AUDADIS was used to diagnose DSM-IV dependence or abuse during the 10-year follow-up.

Results: In bivariate analysis, many factors appeared related to new onset of alcohol dependence. However, in a stepwise analysis, only a family history of alcoholism, a low level of response to alcohol (e.g., the ability to drink large quantities of alcohol without feeling its effects), younger age, and baseline frequency of at-risk drinking (five or more drinks/occasion) remained significant predictors ($p < .03$). Significant predictors of new-onset abuse included only male gender, smoking, and heavy drinking ($p < .03$). Almost all cases of alcohol abuse received the diagnosis only for driving after drinking too much.

Conclusions: Predictors of dependence and abuse differ. Attention to this difference may assist in preventing the onset of dependence, a serious disorder, among individuals at risk.

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1. Hasin DS, Schuckit MA, Martin CS, Grant BF, Bucholz KK, Helzer JE: The validity of DSM-IV alcohol dependence: what do we know and what do we need to know? Alcohol Clin Exp Res 2003; 27:244–252.
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THURSDAY, MAY 6, 2004

SCIENTIFIC AND CLINICAL REPORT SESSION 28—EATING DISORDERS

No. 83
WEIGHT AND RELAPSE TO COCAINE AND ALCOHOL USE IN PATIENTS WITH EATING DISORDERS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the importance of weight control in patients with comorbid diagnoses of eating disorders and alcohol and cocaine dependence.

SUMMARY:

Objective: Cocaine and alcohol suppress appetite. Cocaine and alcohol misuse has been reported in women with eating disorders, but investigations have not examined whether these substances interact with weight to inhibit relapse prevention.

Methods: The charts of eight female outpatients with DSM-IV diagnoses of cocaine dependence, alcohol dependence, and eating disorder were retrospectively reviewed.

Results: Over 12 to 16 weeks, all patients reported that weight gain was an important provocation for relapse. Five patients experienced an increase in weight of 2 kg or more. Three of these patients relapsed to either cocaine and/or alcohol use and reported that the weight gain was a major factor in their relapse. Two of these patients were started on topiramate, titrated to 200 mg/day, and lost 500 g. They perceived avoidance of weight gain to be important to maintaining sobriety.

Conclusion: Weight control may be important in relapse prevention in patients with a diagnosis of eating disorder and alcohol and cocaine dependence.

Funding: Supported by grant # K24-DA00427 to Dr. Gastfriend from the National Institute on Drug Abuse.

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No. 84
DSM-IV COMORBIDITY IN BINGE-EATING DISORDER

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the patterns and associations of axis I psychiatric and axis II personality disorders in patients with binge-eating disorder.

SUMMARY:

Objective: To examine comorbidity of DSM-IV axis I psychiatric and axis II personality disorders in patients with binge-eating disorder (BED).

Method: A consecutive series of 221 BED patients were reliably administered semistructured diagnostic interviews to assess axis I disorders (SCID-I/P), axis II disorders (DIPD-IV), and the features of eating disorders (Eating Disorder Examination Interview).

Results: Major depressive disorder (MDD) was the most frequently assigned axis I disorder (51% of patients met lifetime criteria), followed by anxiety (40%) and alcohol use (24%) disorders. Roughly 28% of patients met the criteria for an axis II disorder; avoidant (19%) and obsessive-compulsive (13%) personality disorders were most frequent. In terms of axis I/II co-occurrence, chi-square analyses revealed that avoidant and obsessive-compulsive personality disorders were associated with significantly higher rates of mood and anxiety disorders, and avoidant personality disorder with significantly higher rates of substance use disorders. The distribution of axis I/II disorders did not differ by obesity status. MANOVAs revealed that co-occurrence of axis I/II disorders were generally unrelated to variability in eating disorder psychopathology.

Conclusion: BED patients frequently have co-occurring axis I, axis II, or a combination of axis I/II disorders. Eating disorder symptoms and obesity, however, do not appear to be influenced significantly by the presence of additional axis I/II co-morbidity.

Funding: National Institutes of Health and the Donaghue Research Foundation.

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No. 85
MALES AT RISK: HAWAIIAN AND FILIPINO ADOLESCENTS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize gender differences between Filipino and Hawaiian youth, recognize that these groups may not match majority culture norms, and consider cultural and genetic etiologies of depression and problematic eating behavior.

SUMMARY:

Objective: Risk factors for depression and problematic eating behavior have not been studied in adolescents of the Asian-Pacific region.

Method: Hawaiian and Filipino seventh grade male (N = 41) and female (N = 44) students enrolled in health classes provided height/weight and completed the EAT-26, Figure Drawings (body dissatisfaction), and SLSS (self dissatisfaction).

Results: Four 2 × 2 ANOVA analyses were conducted. Male subjects reported higher EAT-26 scores (mean = 18.00) than female subjects (mean = 11.02) ($F = 4.90$, $df = 1, 73$, $p < .05$) and higher levels of body dissatisfaction (mean = 1.40) than female subjects (mean = .80) ($F = 9.04$, $df = 1, 80$, $p < .01$). There were no interactions or ethnic differences on these two measures, and no gender or ethnic differences on BMI. Filipinos reported higher self-dissatisfaction scores (mean = 12.86) than Hawaiians (mean = 11.09), and no interaction or gender difference was found. Separate correlation analyses were conducted to determine which variables related to gender differences on the EAT-26 scores. Self-dissatisfaction correlated with EAT-26 scores among male subjects ($r = .44$, $p < .01$) and female subjects ($r = .50$, $p < .001$). Body dissatisfaction related to EAT-26 scores among female subjects ($r = .32$, $p < .05$) but not male subjects.

Conclusion: Unexpectedly, male students appeared more dissatisfied with body/self and more at risk for depression and problematic eating behavior than female subjects in this young adolescent Hawaiian and Filipino sample.

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SCIENTIFIC AND CLINICAL REPORT SESSION 29—ADDICTION PSYCHIATRY

No. 86
PRISM-IV: RELIABLE DIAGNOSIS IN ALCOHOL AND DRUG ABUSERS

Sharon Samet, M.S.W., *Columbia University, 105 Riverside Drive #123, New York, NY 10032;* Edward V. Nunes, M.D., Jakob Meydan, Psy.D., Karen Matseoane, B.A., Deborah S. Hasin, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to 1) demonstrate knowledge of issues in differentiating between DSM-IV independent (primary) and substance-induced psychiatric diagnoses in drug users or heavy drinkers and 2) demonstrate familiarity with approaches that overcome some of the complexities and improve reliability.

SUMMARY:

Objective: The diagnosis of mental disorders in heavy drinkers or drug users has long been a problem because of the need to distinguish between psychiatric symptoms and the expected effects of alcohol/drug intoxication or withdrawal, which can appear similar. The PRISM-IV, a semistructured diagnostic interview designed especially for use in substance abusers, implements DSM-IV guidelines to differentiate independent ("primary") from substance-induced disorders. The interview includes specific questions on the relationship of substance use to psychiatric disorders. The authors assessed the reliability of psychiatric diagnoses from the PRISM-IV.

Method: A test-retest study of the PRISM-IV was conducted in a group of 285 substance-abusing patients recruited from New York City mental health and substance abuse treatment settings. Kappa was used as the reliability coefficient.

Results: As expected, reliability was excellent for DSM-IV dependence on different substances. Reliability was good to excellent (kappa of .60 or higher) for mood, psychotic, and personality disorders (borderline and antisocial personality disorders). Reliability was lower for anxiety disorders. Administration time was shorter than for previous versions of the PRISM. Current developments include computerization of the interview.

Conclusions: The PRISM-IV offers a method for reliable psychiatric diagnosis when patients are expected to be heavy drinkers or drug users.

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No. 87
COGNITIVE FUNCTIONING: PREDICTORS OF OUTCOME IN COCAINE-DEPENDENT PATIENTS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to 1) recognize the prevalence of cognitive deficits in cocaine-dependent patients and their effect on treatment outcome and 2) identify the possible need for treatment modification in cognitive behavior treatment for substance abusers.

SUMMARY:

Objective: Premature dropout from substance abuse treatment predicts poor outcome and is a critical issue in clinical trials of medications, where early dropout precludes an adequate dose. To identify remediable factors involved in dropout, the authors investigated the association between cognitive impairments and treatment retention in cocaine-dependent patients. Lower cognitive functioning was hypothesized to be associated with premature treatment dropout, defined as < 12 weeks in treatment.

Method: Fifty-six depressed and nondepressed cocaine-dependent patients who participated in an outpatient controlled clinical trial of cognitive behavior therapy plus medication consented for this study. They were assessed for diagnosis with the SCID for DSM-IV, and the MicroCog computerized battery was used to assess cognitive performance at treatment entry.

Results: In an analysis controlling for demographic and comorbidity variables, logistic regression models indicated that lower scores on attention, spatial ability, and general cognitive functioning significantly increased the odds of dropout ($p < .05$). Better general cognitive functioning positively correlated with increased weeks in treatment (Spearman correlation = .26, $p < .05$).

Conclusions: This study suggests that levels of cognitive functioning at treatment entry predict retention in cocaine-dependent patients participating in an outpatient cognitive behavior therapy. These findings have important implications for treatment modifications for cognitively impaired substance abusers.

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1. Aharonovich E, Nunes E, Hasin D: Cognitive impairment, retention and abstinence among cocaine abusers in cognitive-behavioral treatment. Drug Alcohol Depend 2003; 71:207–211.
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No. 88
COCAINE EXPECTANCY QUESTIONNAIRE: PSYCHOMETRIC AND UNDERLYING MODEL

Marie C. Martin, Ph.D., *Burlingame, Institute of Living, 400 Washington Street, Hartford, CT 06106;* Bruce J. Rounsaville, M.D., Adam J. Jaffe, Ph.D., Charles H. Wilber, M.Ed.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate familiarity with the Cocaine Expectancy Questionnaire (CEQ) and understand how to use the CEQ in clinical settings and treatment-related research.

SUMMARY:

Objective: To examine the psychometric properties and underlying model of the Cocaine Expectancy Questionnaire (CEQ) in a treatment sample of cocaine-dependent individuals.

Methods: A total of 132 cocaine-dependent participants were randomly assigned to one of three 12-week outpatient interventions: substance expectancy therapy, relapse prevention, and standard addiction counseling. The CEQ (a 70-item survey developed previously by this research team to assess cocaine-related expectations) was completed at baseline, midpoint, and termination and at six- and 12-month follow-up (N = 569).

Results: While strength of cocaine expectations changes in therapy over time, preliminary analyses with a limited sample size suggests that the CEQ factor structure may remain fairly stable. New factor analytic results conducted across assessment points (N = 569) support a seven-factor CEQ model. The analyses identified both positive and negative factors ranging from (1) grandiosity/euphoria and (5) enhancement of cognitive abilities to (2) anxiety and depression and (4) paranoia. When applied to the current cocaine-dependent treatment sample, the new seven-factor CEQ model had good psychometric properties (e.g., item-level statistics and reliabilities) that compared favorably to the earlier 12-factor solution.

Conclusions: A more parsimonious (seven-factor) CEQ model is proposed for outpatient cocaine abusers.

REFERENCES:

1. Jaffe AJ, Kilbey MM: The Cocaine Expectancy Questionnaire: construction and predictive utility. Psychol Assess 1994; 6:18–26.
2. Jaffe AJ: Cognitive factors associated with cocaine abuse, in Clinician's Guide to Cocaine Addiction: Theory, Research, and Treatment. Edited by Kosten T, Kleber H. New York, Guilford Press, 1992, pp 128–150.

SCIENTIFIC AND CLINICAL REPORT SESSION 30—ISSUES IN ADDICTIONS

No. 89
PSYCHOSOCIAL THERAPIES FOR COCAINE DEPENDENCE: A CONTROLLED STUDY

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate familiarity with Substance Expectancy Therapy (SET) and understand how treatment outcomes for Substance Expectations Therapy compare to relapse prevention and addiction counseling for the treatment of cocaine addiction.

SUMMARY:

Objective: To examine treatment retention and reduction in cocaine use for cocaine abusers treated with one of three different treatments.

Methods: A total of 157 cocaine abusers were randomly assigned to one of three 12-week, manualized interventions: substance expectation theory (SET) (a new cognitive behavior therapy for substance abuse), relapse prevention (RP), or addiction counseling (AC). Treatment retention and cocaine use during treatment were the major dependent variables explored.

Results: SET demonstrated significantly greater treatment retention than RP and/or AC (across outcome variables). Specifically, SET participants showed significantly less early dropout (i.e., one to three sessions) (7.69%) relative to RP (28.85%) and AC (16.98%) ($p < .05$) and significantly greater treatment completion (71%) relative to RP (44.23%) and AC (66.04%) ($p < .05$). Survival analyses suggested that individuals receiving SET had greater study participation and treatment retention for longer periods of time than RP participants ($p < .05$). All three treatments were equally effective in reducing cocaine use (e.g., mean = 90% abstinent across treatments) with one exception. During the last month of treatment, participants in SET used significantly smaller amounts of cocaine (mean = .02 grams/day) than AC participants (mean = .07 grams/day) ($p < .05$).

Conclusions: SET is a promising new psychotherapeutic treatment for cocaine abuse and merits further study.

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No. 90
PATIENT TREATMENT MATCHING WITH AMBULATORY COCAINE ABUSERS

Charles H. Wilber, M.Ed., *Burlingame, Institute of Living, 400 Washington Street, Hartford, CT 06106;* Adam J. Jaffe, Ph.D., Joshua J. Brandt, Psy.D., Marie C. Martin, Ph.D., Richard A. Rodriguez, B.S., Bruce J. Rounsaville, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to 1) recognize specific patient characteristics that may be helpful to consider in assigning clients to substance abuse interventions and 2) understand the methods involved in patient treatment matching studies.

SUMMARY:

Objective: To explore the hypothesis that patients could be matched to one of three different treatments on the basis of specific pretreatment characteristics.

Method: A total of 157 cocaine dependent participants were randomly assigned to receive one of three 12-week, manualized interventions: substance expectations therapy (SET) (a new therapy designed to improve treatment outcomes), relapse prevention therapy (RP), and standard addiction counseling (AC). Hypotheses were developed by using four treatment matching variables: craving, motivation, sociopathy, and cognitive measures of learning and memory.

Results: Linear regression analyses suggested 1) participants experiencing higher levels of craving may derive the greatest benefit from SET versus RP or AC; 2) participants with high levels of sociopathy did best in RP and AC, while participants with low levels of sociopathy did best in SET; and 3) highly motivated participants did equally well in all three treatments, but poorly motivated participants receiving SET and AC did better than those receiving RP.

Conclusions: The current results suggest that craving, sociopathy, and level of motivation may be important client characteristics to consider when assigning clients to substance abuse interventions.

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1. Jaffe AJ, Chang GM, Schottenfeld RS, Meyer RE, Rounsaville BJ, O'Malley SS: Naltrexone, coping skills and supportive therapy with alcoholics: an analysis of patient treatment matching. J Consult Clin Psychol 1996; 64:1044–1053.
2. Project MATCH Research Group: Matching alcoholism treatments to client heterogeneity: treatment main effects and matching effects on drinking during treatment. J Stud Alcohol 1998; 59:631–639.

No. 91
VIRTUAL REALITY CUE-REACTIVITY: CONTROLLED TRIAL FOR NICOTINE DEPENDENCE

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the use of virtual reality in clinical research.

SUMMARY:

Objectives: A virtual reality cue exposure (VRCE) environment for nicotine addiction (NA) was constructed to expand traditional cue exposure methods. VRCE offers researchers realistic, controlled social interactions and smoking cues by combining computer-generated and video images. This is the first controlled, clinical research of VRCE for NA.

Methods: Twenty healthy male and female nicotine-dependent (<21 cigarettes/day) subjects, without anticraving medication entered the study. All experienced neutral and smoking-related stimuli counterbalanced to control for time of exposure. A Coulbourn Instruments system measured heart rate, skin conductance level, and respiration during exposure. If the VRCE is effective, participants would demonstrate increased physiological reactivity and subjective craving.

Results: Comparisons of physiological and craving measures indicated that craving ratings were higher for VR smoking cues/stimuli, compared to VR neutral cues/stimuli. Similar findings for other clinical variables are presented.

Conclusions: VRCE resulted in increased physiological and subjective responses in nicotine-dependent smokers. Specifically, craving for cigarettes increased with VR smoking cues. VRCE is a significant methodological advance allowing tight control of research on craving in cigarette smokers.

Funding: Supported by NIDA grant #1-R41-DA016085-01.

SCIENTIFIC AND CLINICAL REPORT SESSION 31—SLEEP AND SEASONALITY

No. 92
MODAFINIL IMPROVES PATIENT FUNCTIONING IN SHIFT WORK SLEEP DISORDER

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the tolerability of modafinil and its effects on patient functioning and daytime sleep in patients with shift work sleep disorder who have excessive sleepiness.

SUMMARY:

Objective: Shift work sleep disorder (SWSD) is characterized by excessive sleepiness and/or symptoms of insomnia associated with nighttime work, the negative consequences of which contribute to impaired functional status. The authors evaluated the effects of the wake-promoting agent modafinil on patient functioning and tolerability in SWSD patients with excessive sleepiness.

Method: A total of 487 patients entered two 12-week, randomized, double-blind, placebo-controlled studies. Patients received placebo or modafinil (200 mg/day in study 1; 200 or 300 mg/day in study 2) before each night shift. Patient functioning was assessed by using the Functional Outcomes of Sleep Questionnaire (FOSQ). Patient diaries were used to evaluate sleepiness, its consequences during night shifts and daytime sleep, and caffeine use.

Results: Relative to placebo, modafinil at doses of 200 or 300 mg/day (treatment groups combined) and 300 mg/day significantly improved patient functioning (FOSQ total score and domain scores for activity, vigilance, and productivity; $p < .01$) at final visit. Modafinil significantly reduced sleepiness, as measured subjectively, during night shifts and the commute home ($p = .01$). Modafinil did not affect daytime sleep or caffeine use. Modafinil was well tolerated. Most common adverse events were headache, nausea, and nervousness. Modafinil had no clinically meaningful effect on laboratory or vital sign parameters.

Conclusions: Modafinil significantly improved subjective wakefulness and patient functioning and did not adversely affect daytime sleep in patients with SWSD.

Funding: Supported by Cephalon, Inc.

REFERENCES:

1. American Sleep Disorders Association, Diagnostic Classification Steering Committee: The International Classification of Sleep Disorders: Diagnostic and Coding Manual. Rochester, Minn, American Sleep Disorders Association, 1997.
2. Hughes RJ, Van Dongen H, Dinges DF, Rogers N, Wright KP Jr, Edgar DF, Czeisler CA: Modafinil improves alertness and performance during simulated night work (abstract). Sleep 2001; 24:A200.

No. 93
MODAFINIL TREATMENT OF CHRONIC SHIFT WORK SLEEP DISORDER

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe shift work sleep disorder and the results of a randomized trial on the therapeutic utility of modafinil for this chronic condition.

SUMMARY:

Objective: Shift work sleep disorder (SWSD) is a circadian rhythm sleep-wake disorder that is associated with night and rotating work schedules and characterized by excessive sleepiness during nighttime work and insomnia during daytime sleep periods. The authors evaluated the efficacy and safety of modafinil in patients with SWSD.

Method: This 12-week, randomized, double-blind study included 209 patients who 1) had a diagnosis of chronic SWSD, 2) worked $\geq$ 5 night shifts/month, 3) had a mean nighttime Multiple Sleep Latency Test (MSLT) of $\leq$ 6 minutes, and 4) had a baseline daytime sleep efficiency $\leq$ 87.5%. Modafinil (200 mg/once daily) or placebo was taken 60 to 30 minutes before each night shift. Efficacy measures included the mean MSLT latency, the Karolinska Sleepiness Scale (KSS), and the Clinical Global Impression of Change (CGI-C).

Results: Modafinil significantly improved wakefulness. Mean MSLT latency was greater for modafinil (mean = 1.7, SD = 3.8) than for placebo (mean = .34, SD = 2.8) ($p = .002$). Modafinil also reduced subjective sleepiness as measured by the KSS ($p < .001$), compared with placebo. A greater percentage of patients receiving modafinil (74% versus 36%) improved on the CGI-C ($p < .001$) at 12 weeks. The most common adverse events with modafinil were headache and nausea.

Conclusions: Modafinil was well tolerated and efficacious, as indicated by all dependent measures. Modafinil may be helpful for SWSD patients experiencing excessive sleepiness at work. These results are consistent with modafinil's effects in other disorders of sleep and wakefulness.

Funding: Supported by Cephalon, Inc.

REFERENCES:

1. American Sleep Disorders Association, Diagnostic Classification Steering Committee: The International Classification of Sleep Disorders: Diagnostic and Coding Manual. Rochester, Minn, American Sleep Disorders Association, 1997.
2. Hughes RJ, Van Dongen H, Dinges DF, Rogers N, Wright KP Jr, Edgar DF, Czeisler CA: Modafinil improves alertness and performance during simulated night work (abstract). Sleep 2001; 24:A200.

No. 94
A COMPARISON OF SEASONALITY OF MOOD AND BEHAVIOR IN AFRICAN AND AFRICAN-AMERICAN STUDENTS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will recognize the concept of adaptation/habituation to changes in season and will be sensitized to the issue of prevalence of seasonal affective disorder in African and African American subjects.

SUMMARY:

Objective: In comparing seasonality of mood in African and African American students, two opposite hypotheses are being considered: adaptation versus sensitization to seasonal environmental changes.

Method: A convenience sample of 846 students (246 African and 599 African American students) studying in Washington, D.C. completed the Seasonal Pattern Assessment Questionnaire (SPAQ), which was used to calculate a global seasonality score (GSS) and to estimate the prevalence of winter- and summer-type seasonal affective disorder (SAD). The effects of ethnicity, gender, and age and their interactions on the GSS score were evaluated by using ANCOVA.

Results: Degree of seasonality was related to a complex interaction between having general awareness of SAD, ethnicity, and gender. African American female subjects and African male subjects were more seasonal than the others. A greater percentage of African students reported experiencing a problem with seasonal changes ($p < .001$), relative to African American students. African students had a significantly greater prevalence of summer-type SAD, relative to African American students.

Conclusions: An increased rate of problems with change in season in African students is consistent with the adaptation hypothesis, while an increased rate of summer SAD in African students is consistent with the sensitization hypothesis.

Funding: Supported by the D.C. Department of Mental Health.

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1. Magnusson A: An overview of epidemiological studies on seasonal affective disorder. Acta Psychiatr Scand 2000; 101:176–184.
2. Han L, Wang K, Du Z, Cheng Y, Simons JS, Rosenthal NE: Seasonal variations in mood and behavior among Chinese medical students. Am J Psychiatry 2000; 157:133–135.

SCIENTIFIC AND CLINICAL REPORT SESSION 32—ISSUES IN BPD

No. 95
THE FREQUENCY OF DSM-IV PERSONALITY DISORDERS IN PSYCHIATRIC OUTPATIENTS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the frequency of personality disorders in psychiatric outpatients.

SUMMARY:

Objective: The largest clinical epidemiological surveys of personality disorders have been based on unstructured clinical evaluations. However, several recent studies have questioned the accuracy and thoroughness of clinical diagnostic interviews; consequently, clinical epidemiological studies, like community-based studies, should be based on standardized evaluations. The Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project is one of the largest clinical epidemiological studies using semistructured interviews to assess a wide range of psychiatric disorders in general clinical outpatient practice. The authors examine the frequency of DSM-IV personality disorders in the sample and the comorbidity among these disorders.

Methods: A total of 859 psychiatric outpatients were interviewed with the Structured Interview for DSM-IV Personality (SIDP-IV) upon presentation for treatment.

Results: Slightly less than one-third of the patients received a diagnosis of one of the 10 official DSM-IV personality disorders (31.4%, N = 270). When the patients with personality disorder not otherwise specified were included, the rate of any personality disorder increased to almost half of the sample (45.5%, N = 391). The majority of patients meeting criteria for one of the specific personality disorders received more than one personality disorder diagnosis. Avoidant, borderline, and obsessive-compulsive personality disorders were the most frequent specific diagnoses.

Conclusions: Personality disorders, as a group, are among the most frequent disorders treated by psychiatrists. They should be evaluated in all psychiatric patients because their presence can influence the course and treatment of the axis 1 disorder that patients typically identify as their chief complaint.

REFERENCES:

1. Kass F, Skoldol AE, Charles E, Spitzer RL, Williams JBW: Scaled ratings of DSM-III personality disorders. Am J Psychiatry 1985; 142:627–630.
2. Mattia J, Zimmerman M: Epidemiology of personality disorders, in Handbook of Personality Disorders. Edited by Livesley J. New York, Guilford Press, 2001, pp 107–123.

No. 96
INHIBITORY FUNCTIONING IN BPD: AN FMRI STUDY

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the neurobiological underpinnings of borderline personality disorder.

SUMMARY:

Objective: Behavioral dysregulation, a main characteristic of borderline personality disorder, occurs in states of high emotional arousal. From a neurofunctional perspective, cortical and limbic systems closely interact for the benefit of behavioral regulation, i.e. cortical areas inhibit the limbic system to ensure goal-directed behavior in the context of emotional distractors.

Method: Fourteen patients and 14 age-matched control subjects participated in an fMRI study based on a "negative priming" paradigm. In the priming condition, the unlabeled word has to be ignored, while in the immediately following (probe) trial the same word has to be selected, forcing a reversal from inhibition to disinhibition. Emotional interaction with the inhibition/disinhibition process is produced by negative words compared to neutral words.

Results: Behavioral data showed a reduction of response time in the probe condition in the patients with borderline personality disorder. Neuroimaging data indicated enhanced activation in ventrolateral areas of the prefrontal cortex in the prime condition, an area that has been shown to mediate the inhibition of emotional distractors. In addition, greater activation was found in the pregenual part of the anterior circulate cortex.

Conclusion: Behavioral data suggest a failure to inhibit emotional distractors, although neuroimaging findings suggest that patients with borderline personality disorder make a hard effort. The results provide additional evidence for the concept of deficient cortical top-down control on limbic areas in borderline personality disorder.

Funding: Supported by DFG Grant HE 2666/5-1.

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1. Herpertz SC, Kunert HJ, Schwenger UB, Sass H: Affective responsivity in borderline personality disorder: a psychophysiological approach. Am J Psychiatry 1999; 156:1550–1558.
2. Herpertz SC, Dietrich TM, Wenning B, Erberich SG, Krings T, Thron A, Sass H: Evidence of abnormal amygdala functioning in borderline personality disorder: a functional MRI study. Biol Psychiatry 2001; 504:292–298.

No. 97
LIFE CHANGES, SOCIAL ADJUSTMENT, AND ATTEMPTED SUICIDE IN BPD AND MDD

Thomas M. Kelly, Ph.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh, PA 15213;* Paul H. Soloff, M.D., John J. Mann, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize how recent life events and social adjustment affect suicidal behavior among patients with borderline personality disorder and major depressive disorder.

SUMMARY:

Objective: Patients with borderline personality disorder (BPD) attempt suicide more often than patients with major depression (MDD). Based on previous findings, the authors tested whether BPD patients experienced more recent life changes and less social adjustment than patients with MDD and whether social adjustment interacts with diagnostic status to increase the risk for attempted suicide among BPD patients.

Method: A total of 187 patients (66 with MDD only, 61 with BPD only, and 60 with BPD plus MDD) were assessed by using structured interviews and standardized measures. BPD and MDD

patients were compared on demographic and clinical variables, recent life changes, and social adjustment. Discriminating variables were entered into a multivariate logistic regression model to define predictors of attempted suicide.

Results: Univariate analyses found that BPD patients had higher scores on recent life events and lower scores on overall social adjustment than MDD patients. In the multivariate analysis, BPD predicted attempted suicide, and overall social adjustment was found to moderate the effect of diagnostic status on suicidal outcomes. BPD patients with low social adjustment scores were almost three times more likely to make a suicide attempt than MDD patients.

Conclusions: Increased social adjustment may decrease the effects of life events on BPD patients, thereby diminishing the risk of suicidal behavior.

Funding: Supported by NIMH grant MH048463.

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1. Kelly TM, Soloff PH, Lynch KG, Haas GL, Mann JJ: Recent life events, social adjustment, and suicide attempts in patients with major depression and borderline personality disorder. J Personal Disord 2000; 14:316–326.
2. Weissman MM, Bothwell S: Assessment of social adjustment by patient self-report. Arch Gen Psychiatry 1976; 33:1111–1115.

SCIENTIFIC AND CLINICAL REPORT SESSION 33—CONSULTATION-LIAISON PSYCHIATRY

No. 98
DEPRESSION AND NONLINEAR HEART RATE DYNAMICS IN OLDER CORONARY PATIENTS

Salvador M. Guinjoan, M.D., *Departmento de Salud Mental, Hospital De Clinicas, Cordoba 2351, Buenos Aires 1121, Argentina;* Daniel E. Vigo, M.D., Rodolfo D. Fahrer, M.D., M. Soledad Laorondeguevara, B.S.C., Daniel Cardinali, M.D., Leonardo Nicola Siri, Ph.D., Eduardo Sampo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to formulate hypotheses on potential prognostic implications of alterations of nonlinear heart rate dynamics related to depression in older patients with acute coronary syndromes.

SUMMARY:

Objective: To ascertain if depression is associated with alterations of nonlinear dynamics of heart rate in older adults with acute coronary syndromes.

Method: Ten-minute RR interval recordings were obtained from 52 patients age ≥ 60 years with acute coronary syndromes (52% were women). On these recordings the following measurements of nonlinear heart rate variability were obtained: standard deviation of the instantaneous beat to beat variability (SD1), scaling exponent alpha 1 ($\alpha 1$), and approximate entropy (ApEn). The presence of depression per DSM-IV criteria was evaluated, and its severity was measured with the 21-item Hamilton Depression Rating Scale.

Results: Nineteen patients were depressed on admission to the hospital. In depressed patients, $\alpha 1$ was higher (1.23 ± 0.21 vs. 1.03 ± 0.30, $p < .05$), whereas SD1 (10.4 ± 3.7 vs. 14.4 ± 7.3, $p < .05$) and ApEn (0.98 ± 0.22 vs. 1.16 ± 0.15, $p < .001$) were lower. In addition, $\alpha 1$ increased ($r = 0.31$, $p < .05$), whereas SD1 ($r = -0.46$, $p < .01$) and ApEn ($r = -0.28$, $p < .05$) decreased with worsening depressive symptoms.

Conclusions: Depression relates to an increased correlation and decreased complexity of the interbeat interval time series in older adults with recent acute coronary syndromes.

REFERENCES:

1. Goldberger A: Non-linear dynamics for clinicians: chaos theory, fractals, and complexity at the bedside. Lancet 1996; 347: 1312–1314.
2. Ladrón de Guevara M, Schauffele S, Nicola-Siri L, Fahrer RD, Ortiz Frágola E, Martinez Martínez JA, Cardinali DP, Guinjoan SM: Worsening of depressive symptoms 6 months after an acute coronary event in older adults is associated with impairment of cardiac autonomic function. J Affect Dis, in press.

No. 99
THE ROLE OF DEXMEDETOMIDINE IN REDUCING DELIRIUM IN CARDIOTOMY PATIENTS

Jose R. Maldonado, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 2317, Stanford, CA 94305;* Ashley Wysong, M.S., Thaddeus S. Block, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to understand the unique characteristics of the novel anesthetic, dexmedetomidine; how it may help reduce the incidence of delirium in postoperative cardiac patients; and the broader implications of novel anesthetic use related to consultation-liaison psychiatry.

SUMMARY:

Objectives: To determine if postoperative sedation is associated with the development of ICU delirium. Specifically, to understand the unique characteristics of dexmedetomidine and how it may reduce the incidence of postoperative delirium in cardiac surgery patients.

Methods: Ninety patients undergoing elective cardiac surgery were included in this prospective, randomized trial. All participants underwent a battery of neuropsychiatric tests before to surgery and received similar general anesthesia consisting of a combination of inhalation agents, intravenous sedatives, and opioids. Patients were randomly assigned to three postoperative sedation protocols: dexmedetomidine, propofol, or fentanyl/midazolam, started intraoperatively at sternal closure. Patients were followed for the development of delirium and neurocognitive deficits.

Results: Preliminary results for the first 60 patients showed an incidence of delirium of 5% (1/21) for patients receiving dexmedetomidine, 52% (12/23) for propofol, and 50% (8/16) for fentanyl/midazolam. Additionally, dexmedetomidine patients spent less time in the ICU and had a shorter overall stay in the hospital, compared to the other two groups.

Conclusions: Postoperative sedation with dexmedetomidine may be associated with a lower incidence of postoperative delirium, compared with the use of more conventional forms of postoperative sedation. Although these findings are preliminary, several important trends exist that warrant further investigation.

REFERENCES:

1. Scholz J, Tonner PH: $\alpha 2$-adrenoreceptor agonists in anaesthesia: a new paradigm. Current Opinion in Anaesthesiology 2000; 13:437–442.
2. Shinn JA, Maldonado JR: Performance improvement: increasing recognition and treatment of postoperative delirium. Prog Cardiovasc Nurs 2000; 3:114–115.

No. 100
PSYCHIATRY TRAINING IN PRIMARY CARE: FACTORS FOR A SATISFACTORY PROGRAM

Hoyle Leigh, M.D., *Department of Psychiatry, University of California, 445 South Cedar Avenue, Fresno, CA 93702;* Deborah C. Stewart, M.D., Ronna Mallios, M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the factors in psychiatric training (e.g., training venues, formats, and faculty) associated with program directors' satisfaction for medicine, family practice, obstetrics, and pediatrics programs and formulate specialty-specific optimal psychiatric training.

SUMMARY:

Objective: The need for psychiatric training for primary care physicians has been well recognized. However, no standards for such training exist, and to date, there is great variability in such training. The authors previously reported that a majority of program directors of primary care residencies considered the psychiatry training inadequate and were dissatisfied with it. This study explored the factors in training venues, faculty, and format that are associated with primary care training directors' satisfaction or dissatisfaction with current psychiatric training for primary care residents.

Methods: A 16-item questionnaire surveying the amount, specific areas (such as interviewing, psychopharmacology, depression), faculty, and satisfaction with current teaching was distributed to 1,365 U.S. program directors.

Results: The response rate was 58%. Sixty-five percent of family practice training directors were satisfied with psychiatry teaching, compared to 35% for internal medicine, 31% for obstetrics, and 23% for pediatrics. Satisfaction across specialties was significantly associated with the amount of training, diversity in training formats and faculty, and the degree of contribution to teaching by psychiatry departments. For certain programs, hiring mental health professionals directly seem to contribute to satisfaction. There were intriguing differences among specialties in the teaching of specific techniques and areas of psychiatry that contributed to satisfaction (e.g., psychopharmacology, delirium, eating disorders for obstetrics).

Conclusion: There are general and specialty-specific factors that affect satisfaction with psychiatric training. Enhancement of psychiatric curriculum for primary care training should encompass both general and specialty-specific elements.

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1. Hodges B, Inch C, Silver I: Improving the psychiatric knowledge, skills, and attitudes of primary care physicians, 1950–2000: a review. Am J Psychiatry 2001; 158:1579–1586.
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SCIENTIFIC AND CLINICAL REPORT SESSION 34—OCD

No. 101
SELF-ADMINISTERED VERSUS THERAPIST-ADMINISTERED COGNITIVE BEHAVIOR THERAPY FOR MEDICATION NONRESPONDERS WITH OCD

David Tolin, Ph.D., *Anxiety Disorders Center, Institute of Living, 200 Retreat Avenue, Hartford, CT 06106;* Scott Hannan, Ph.D., Gretchen Diefenbach, Ph.D., Nicholas Maltby, Ph.D., Patrick Worhunsky, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to describe components of intensive residential treatment (IRT) for severe obsessive-compulsive disorder (OCD) and to discuss its effectiveness with regard to OCD and depression severity, as well as psychosocial functioning.

SUMMARY:

Objective: The purpose of this study was to determine the effectiveness of an innovative intensive residential treatment (IRT) program for severe refractory obsessive-compulsive- disorder (OCD). No formalized outcome studies of this OCD treatment modality have been completed to date.

Method: All subjects admitted to the Massachusetts General Hospital OCD Institute between its 1998 inception and June 2003 were included in the study. Psychometric outcome measures of OCD severity (Y-BOCS), depression severity (BDI), and psychosocial well-being (SOS, WSA) were used. Admission scores were compared with scores at two weeks, monthly, and at discharge by using t tests and a last-observation-carried-forward approach.

Results: The study population consisted of 505 individuals (57.6% of whom were male) with a mean age of 32.8 years (SD = 12.0) and a median length of stay of 40 days (SD = 74.8). Y-BOCS severity scores decreased significantly between admission and subsequent time points at two weeks (–5.9, 20.7%, $p < .001$) and at one (–6.2, 21.4%, $p < .001$), two (–6.4, 21.7%, $p < .001$), and three (–6.5, 20.7%, $p = .04$) months. At discharge there was a significant decrease in OCD (–8.3, 30.3%, $p < .001$) and depression (–6.2, 25.3%, $p < .001$) severity scores and an improvement in psychosocial outcomes (WSA: 24.0%, $p < .001$; SOS: 64.5%, $p < .001$).

Conclusions: IRT appears to be an effective and promising treatment modality for severe, refractory OCD. The 30.3% decrease in mean Y-BOCS score, from the severe (26.3) to moderate (18.4) range, reflects both clinically and statistically significant improvement of OCD.

Funding: Harvard Women and Neuroscience Fellowship and a grant from the Obsessive-Compulsive Foundation.

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2. Goodman W, Price L: Assessment for severity and change in obsessive-compulsive disorder. Psych Clin N Am 1992; 15: 861–869.

No. 102
EFFECTIVENESS OF INTENSIVE RESIDENTIAL TREATMENT OF SEVERE, REFRACTORY OCD

S. Evelyn Stewart, M.D., *Department of Psychiatry, Harvard University, 1558 Massachusetts Ave, Apt. 26, Cambridge, MA 02138;* Colleen Farrell, B.A., Denise Egan-Stack, M.A., Michael A. Jenike, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the comparative efficacy of self-administered versus therapist-administered cognitive behavior therapy for obsessive-compulsive disorder.

SUMMARY:

Objective: To compare the efficacy of self-administered and therapist-administered cognitive behavior therapy (CBT) for obsessive-

compulsive disorder (OCD) patients whose symptoms had failed to respond to medication.

Method: In this ongoing project, OCD patients (current N = 14) whose symptoms have failed to respond to an adequate dose of at least one serotonin reuptake inhibitor are assigned at random to self-administered or therapist-administered CBT. An independent evaluator, blind to treatment condition, assesses symptom severity and functional impairment at pretreatment, posttreatment, and at 1-, 3-, and 6-month follow-ups.

Results: Patients in both conditions showed significant reductions in OCD severity as measured by the Yale-Brown Obsessive-Compulsive Scale. However, when a conservative criterion for good outcome was used, 80% of the patients in the therapist-administered group met the criterion, whereas none of the self-administered treatment patients met the criterion.

Conclusions: Self-administered treatment may reduce OCD symptoms when therapist-administered treatment is not available or feasible; however, therapist-administered treatment is clearly preferable whenever possible.

Funding: Grant from the Patrick and Catherine Weldon Donaghue Medical Research Foundation.

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No. 103
HYPERACTIVE ERROR PROCESSING IN OCD

Nicholas Maltby, Ph.D., *Anxiety Disorders Center, Institute of Living, 200 Retreat Avenue, Hartford, CT 06106;* Patrick Worhunsky, B.S., Kent Kiehl, Ph.D., David Tolin, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss how dysfunctions in error processing relate to the symptom presentation of obsessive-compulsive disorder.

SUMMARY:

Objective: Excessive error signals generated by the caudal anterior cingulate have been proposed as one process that may underlie the symptom presentation of obsessive-compulsive disorder (OCD). The objective of the present study was to explore dysfunctions in error processing using fMRI.

Method: Ten patients with OCD and 10 matched control subjects completed a go/nogo task during fMRI. The task was modified to increase response conflict. Specifically, the high proportion of targets to nontargets (70%/30%) created a strong prepotent response bias toward target stimuli. In addition, the similarity between target stimuli (the letter "X") and nontarget stimuli (the letter "K"), coupled with a short and variable interstimulus interval (1000 – 3000 msec), created response conflict to target stimuli.

Results: Compared to healthy control subjects, patients with OCD exhibited increased caudal anterior cingulate activation during errors of commission and correct hits. Patients with OCD also exhibited increased activation in the lateral prefrontal cortex, an area thought to moderate error processing by filtering responses to limit responses to those appropriate to the context of the task.

Conclusions: These results support the hypothesis that error processing is dysfunctional in OCD. In addition, they provide further evidence that the caudal anterior cingulate is involved in conflict monitoring.

Supported by a grant from Hartford Hospital.

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SCIENTIFIC AND CLINICAL REPORT SESSION 35—ADULT ADHD

No. 104
COGNITIVE-BEHAVIORAL THERAPY FOR RESIDUAL ADHD IN ADULTS

Steven A. Safren, Ph.D., *Department of Psychiatry, Mass General Hospital, 15 Parkman St., WACC 815, Boston, MA 02118;* Michael W. Otto, Ph.D., Timothy E. Wilens, M.D., Susan Sprich, Ph.D., Joseph Biederman, M.D., Carol Winette, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the rationale for, outcome of, and components of cognitive behavior therapy for residual attention-deficit/hyperactivity disorder in adults.

SUMMARY:

Objective: To examine the efficacy, patient acceptability, and feasibility of a novel 12 – 15 session cognitive behavior treatment (CBT) for adults with attention-deficit/hyperactivity disorder (ADHD) who have been stabilized on medications but still show clinically significant symptoms.

Method: Thirty-one patients with adult ADHD and stable psychopharmacotherapy were randomly assigned to receive to either CBT plus continued psychopharmacology or continued psychopharmacology alone. Intent-to-treat analyses were used.

Results: At the outcome assessment, those who were randomly assigned to CBT had lower levels of ADHD symptoms and overall severity as rated by both self-report and by an independent evaluator (IE) who was blind to treatment condition (p's < .01). Those who received CBT also had significantly lower IE-rated and self-reported anxiety and lower IE-rated depression (p's < .05) and lower self-reported depression that approached significance (p = .06). When the analysis controlled for depression or depression changes, CBT showed superiority over continued psychopharmacology alone, with greater decreases in core ADHD symptoms. Categorical analyses revealed that there were significantly more treatment responders among patients who received CBT than among those who did not (p < .02).

Conclusion: CBT for adults with ADHD who have been stabilized on medications but show significant residual symptoms is a feasible, acceptable, and potentially efficacious next-step treatment approach for this prevalent, distressing, and impairing psychiatric disorder.

Funding: National Institute of Mental Health grant MH 60940.

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No. 105
A CONTROLLED STUDY OF FUNCTIONAL IMPAIRMENTS IN 500 ADHD ADULTS

Stephen V. Faraone, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, Boston, MA 02114;* Joseph Biederman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize and apprcciate the functional impairments commonly seen in adults with attention-deficit/hyperactivity disorder.

SUMMARY:

Objective: Although prior studies have revealed much about the functional impairments of adult attention-deficit/hyperactivity disorder (ADHD), this work has relied on relatively small samples of either children followed up from childhood or adults referred to mental health clinics. Due to differences in referral patterns hetween mental health and general medical clinics, findings from onc setting may not generalize to the other.

Method: To address this limitation, a telephone survey was conducted with a sample of 500 ADHD adults recruited from both mental health and general medical clinics and 501 gender- and age-matched non-ADHD adults. All interviews were conducted April–May of 2003 by RoperASW.

Results: Survey results reveal that adults with ADHD are more likely to have no high school diploma (17% versus 7% of control subjects), less likely to have a college degree (18% versus 26%), and less likely to be currently employed (52% versus 72%), with significantly more job changes over 10 years (5.4 versus 3.4 jobs). They also are more likely to have been arrested (37% versus 18%) and divorced (28% versus 15%) and to report dissatisfaction with achievements in life (22% versus 9%).

Conclusion: Compared to control subjects, ADHD adults show impairments in multiple domains of functioning consistent with those previously reported.

Funding: Supported by Shire US Inc.

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2. Biederman J, Faraone SV, Spencer T, Wilens T, Norman D, Lapey KA, Mick E. Lehman BK, Doyle A: Patterns of psychiatric comorbidity, cognition, and psychosocial functioning in adults with attention deficit hyperactivity disorder. Am J Psychiatry 1993; 150:1792–1798.

No. 106
LONG-TERM SAFETY AND EFFICACY OF MIXED AMPHETAMINE SALTS EXTENDED-RELEASE FOR ADULT ADHD

Joseph Biederman, M.D., *Department of Pediatric Psychiatry, Massachusetts General Hospital, 15 Parkman Street, ACC—725, Boston, MA 02114;* Thomas J. Spencer, M.D., Allan K. Chrisman, M.D., Timothy E. Wilens, M.D., Simon J. Tulloch, M.D., Richard H. Weisler, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the long-term safety and efficacy of mixed amphetamine salts (MAS XP) for the treatment of adults with attention-deficit/hyperactivity disorder.

SUMMARY:

Objective: This ongoing 24-month, open-label cxtension study assessed the long-term safety, efficacy, and quality of life associated with use of an extended-release formulation of mixed amphetamine salts (MAS XR in doses of 20, 40, or 60 mg once daily) in 223 adults (age ≥ 18 years) with attention-deficit/hyperactivity disorder (ADHD).

Methods: Patients met the DSM-IV criteria for ADHD and had a history of ADHD before age 7; all patients rolled over from a 4-week, randomized, double-blind, placebo-controlled, forced-dose titration study of once-daily MAS XR, during which the dose was titrated to optimum cffect and minimum adverse effects. The intent-to-treat (ITT) population included 221 adults (mean age = 39.8 years). Vital signs and data on adverse events were collected monthly; ECG and laboratory measures were collected at months three, six, 12, 18, and 24. Primary efficacy was assessed monthly by using the 18-item ADHD Rating Scale (ADHD-RS) for adults.

Results: Patients who previously received placebo had the largest improvement in ADHD-RS scores after six months (mean change: −11.9 from baseline to endpoint; $p < .001$). Patients who received MAS XR with interruption showed significant improvement from baseline to endpoint (mean change: −7.6: $p = .04$), as did those with no interruption (mean change: −6.0: $p < .001$). The most commonly reported adverse events were dry mouth (42% of patients), anorexia (30%), insomnia (25%), and headache (21%). Updated, 12-month results will be presented.

Conclusion: Results of this interim analysis suggest that MAS XR in doses of 20, 40, or 60 mg once daily is well tolerated for the long-term treatment of adult ADHD. All patients showed continued symptomatic improvement with no evidence of tolerance to drug efficacy.

Funding: Supported by Shire Pharmaceutical Development Inc.

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SYMPOSIUM 1—BRAIN STIMULATION: NEW TREATMENTS FOR MOOD DISORDERS

EDUCATIONAL OBJECTIVES:

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

No. 1A
ECT: ROLE IN BRAIN STIMULATION

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

SUMMARY:

Electroconvulsive therapy (ECT) is the oldest and most widely used form of brain stimulation therapy. The fact that ECT has traditionally involved the elicitation of a generalized seizure has obscured the fact that its therapeutic and adverse effects are highly dependent on the current paths of the electrical stimulus and the current density within those paths. New findings will be presented on optimal forms of brain stimulation with ECT, highlight both the role of pulse width in matching the physiology of cell depolarization, and the use of unidirectional current to focus the ECT stimulus and develop a more targeted approach to seizure induction. With these innovations, adverse effects may be sharply reduced, while maintaining efficacy.

No. 1B
MAGNETIC SEIZURE THERAPY: DEVELOPMENT OF A NOVEL CONVULSIVE TREATMENT

Sarah H. Lisanby, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, NYSPI #126, New York, NY 10027-6902*

SUMMARY:

ECT remains an important treatment for severely depressed patients, but its use is limited by its cognitive side effects. Magnetic seizure therapy (MST) was developed as a possible means to lower the side effects of ECT through enhanced control over the site of stimulation and seizure initiation. Recent research suggests that strategies to focus current and seizure initiation in prefrontal cortex may enhance efficacy. Likewise, limiting current and seizure spread in medial temporal lobes might be expected to reduce side effects. However, the application of an electrical stimulus across the scalp results in significant shunting of current through the scalp and skull and offers little control over current spread. Since magnetic fields pass through tissue without impedance, seizure induction using magnetic fields offers the promise of more precise control over induced electrical current and seizure initiation. MST involves the induction of a seizure under general anesthesia using transcranial magnetic stimulation. This presentation will review the development of MST, from device development, to pre-clinical testing, to clinical trials. Preliminary results indicate that seizures induced with MST have a better acute side-effect profile than those induced with ECT. Results of clinical trials on the antidepressant efficacy of MST will be presented.

No. 1C
REPEATED PREFRONTAL REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION AS AN ANTIDEPRESSANT: AN UPDATE

Mark S. George, M.D., *Department of Psychiatry, Medical University of South Carolina, 67 President Street, Room 502 North, Charleston, SC 29425-0720;* Ziad H. Nahas, M.D., Andrew F. Kozel, M.D., Alexander Mishory, M.D., Xingbao Li, M.D., Berry Anderson, R.N.

SUMMARY:

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

No. 1D
THE USE OF VAGUS NERVE STIMULATION (VNS) IN THE LONG-TERM TREATMENT OF MOOD DISORDERS

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

SUMMARY:

Vagus nerve stimulation (VNS) delivered by an implantable, programmable pulse generator is an effective treatment for patients with medically intractable epilepsy. In addition, VNS has shown promising acute and long-term (one year) results in an open pilot study of adult outpatients with treatment-resistant depression (study D01, n=59). A subsequent randomized, controlled, double-blind trial for treatment-resistant depression did not demonstrate statistically significant improvement acutely when compared with the control group (study D02). However, preliminary analysis of the one-year follow-up of the D02 treatment group (those who continued to receive active VNS therapy for one year) found a response rate of 34% and a remission rate of 16% (n=103). The accrual of symptomatic benefit over time with VNS, now demonstrated in two cohorts, is unusual in a treatment-resistant population, and may be of mechanistic and clinical importance.

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SYMPOSIUM 2—TREATMENT OF MALADAPTIVE PERSONALITY TRAITS

EDUCATIONAL OBJECTIVES:

After attending this symposium, the participant should have an understanding of how to treat some specific symptoms of personality disorders. The participant will understand that while personality disorders may not be eliminated, there may be some options for reducing dysfunction.

No. 2A
DRUG TREATMENT OF MALADAPTIVE PERSONALITY TRAITS

James H. Reich, M.D., *Department of Psychiatry, Stanford Medical School, 2255 North Point Street, Unit 102, San Francisco, CA 94123*

SUMMARY:

This presentation will be on drug treatment of personality disorder traits. Recent work on the biology of personality disorders has uncovered biological abnormalities in many personality disorders. These new findings have been followed by new drug treatments to reduce personality disorder symptoms. Drugs that have some role in reducing personality disorder traits include traditional neuroleptics, atypical neuroleptics, tricyclic antidepressants, selective seritonergic response inhibitors, monoamine oxidase inhibitors, mood stabilizers, naltrexone, benzodiazepines, and others. Although not a cure for personality disorders, drug treatments are quite useful in reducing some disabling symptoms. Drug treatment should be used as part of an overall treatment program involving psychotherapy. The presentation will first describe an approach to diagnosing personality traits and how to decide those that might be amenable to treatment. It will then describe a cluster approach to treatment. These clusters are (1) aggressive symptoms, (2) impulsive symptoms and minor mood fluctuations, (3) anxiety symptoms, and (4) Brief psychotic symptoms.

No. 2B
NEUROBIOLOGY, COMORBIDITY, AND DRUG TREATMENT OF CHILDHOOD ABUSED BPD PATIENTS

Thomas Rinne, M.D., *Department of Psychiatry, LUMC, PO Box 9600, NL-2300 RC Leiden, Netherlands;* Wim Van Den Brink, M.D., Jaap G. Goekoop, M.D., Roel H. Ryk, Ph.D., Ronald de Kloet, Ph.D.

SUMMARY:

Many studies of borderline personality disorder (BPD) report a high prevalence of a history of sustained childhood abuse in this population. BPD patients suffer also from stress-related disorders like PTSD, substance abuse, and very often from major depression. Animal models and research with women who felt victim to sustained childhood abuse indicate that early sustained stress renders the hypothalamic pituitary adrenal (HPA) axis hyperresponsive to stress. An increased central drive of the corticotropine releasing hormone (CRH) and its potent co-regulator argenine vasopressin (AVP) in the hypothalamus is the hallmark of HPA-axis hyperresponsivity. Moreover, this alteration is found not only in childhood abuse victims but also in patients suffering from major depressive disorder. Therefore, the increased central CRH/AVP drive may be an important interface between childhood abuse and depression during adulthood. Selective serotonine reuptake inhibitor (SSRI) treatment has been demonstrated to normalize HPA axis hyperresponsivity in BPD subjects with a history of sustained childhood abuse. SSRIs also turn out to improve affect instability in BPD subjects. These neurobiological data from empirical studies form an important cue for the development of a treatment aimed at prevention of depression in the subgroup of BPD patients with a history of chronic childhood abuse. SSRI treatment in combination with psychotherapeutic interventions focused on stress management might be a useful strategy for the prevention of depression in chronically abused BPD subjects.

No. 2C
DEVELOPMENT AND TREATMENT OF FAMILY PATHOLOGY AROUND CLUSTER-B TRAITS

David M. Allen, M.D., *Department of Psychiatry, University of Tennessee, 135 North Pauline Street, Memphis, TN 38105*

SUMMARY:

Current ongoing interactions between adults exhibiting Cluster B personality traits and members of their families of origin may reinforce self-destructive behavior. These interactions are often characterized by coexisting extremes of hostile over- and underinvolvement by parental figures coupled with provocative behavior by the offspring with the traits. Parental behavior may trigger preexisting role relationship schemata in temperamentally vulnerable individuals. Negative family reactions to new behavior patterns may inhibit change. This talk will present data showing that adults with borderline personality disorder report more contradictory and fewer appropriate responses from parental figures than do similar individuals with other psychiatric problems. It will present a model for how disturbed interpersonal patterns develop and lead to self-destructive behavior, and an overview of treatment strategies for adults in individual psychotherapy designed to directly alter dysfunctional interactions. Strategies will be described to plan a metacommunicative strategy designed to help the patient address the problem with his or her family.

No. 2D
COGNITIVE THERAPY FOR MALADAPTIVE PERSONALITY TRAITS

David P. Bernstein, Ph.D., *Department of Psychology, Bronx VAMC/ Fordham University, 130 Kingsbridge Road, Dealy Hall, 3rd Floor, Bronx, NY 10568*

SUMMARY:

Rationale: Research suggests that maladaptive personality traits are associated with poor treatment outcomes across a variety of patient populations. In this presentation, I will discuss an integrative form of cognitive therapy, Schema Therapy, which focuses on the amelioration of maladaptive traits and maladaptive coping mechanisms that are the hallmarks of personality disorders.

Methods: In the Schema Therapy model, early maladaptive schemas (EMSs) are dimensional personality traits that develop in childhood due to temperament and early life experiences, and are pervasive, and chronic. They are conceptualized as self-defeating patterns or themes, such as abandonment, defectiveness, and deprivation, which play out over the course of a lifetime. In this presentation, I will introduce the Schema Therapy model and therapeutic approach, which I will illustrate with a clinical case. I will also discuss preliminary findings of a randomized clinical trial of Schema Therapy.

Conclusions: Schema Therapy is a promising treatment for maladaptive personality traits that may improve outcomes for a variety of challenging patient populations.

No. 2E
AFFECTIVE DEFICITS IN RECURRENT SUICIDAL BEHAVIOR

Paul S. Links, M.D., *Department of Psychiatry, University of Toronto, 30 Bond Street Shuter Wing RM 2011, Toronto, ON M5B 1W8, Canada;* Yvonne Bergmans, M.S.W., A. Barr, Ph.D.

SUMMARY:

Objective: Models of recurrent suicidal behavior (SB) argue for a temporal relationship between cognition and emotion with emotional predating cognitive factors in the causal chain of events. To test whether measures of deficits in affective functioning capture pre-group- post-group changes in individuals with recurrent SB exposed to a 20-week psychosocial/psychoeducational intervention, we utilized the Toronto Alexithymia Scale (TAS-20).

Methods: Participants (N=35) were given a series of questionnaires pre and post-group covering the deficit domains identified by previous research: problems with affect identification and expression, TAS-20; impulsive aggressiveness, Barratt's Impulsivity Scale (BIS) and the Diagnostic Assessment for Personality Disorders (DAPP) self-harm subscale; and cognitive deficits measured by the Beck Hopelessness Scale (BHS) and the Satisfaction with Life Scale (SWLS).

Results: Using Wilcoxon signed rank tests, preliminary results show significant changes in the affective domain (TAS-20, N=35; p=.0029) and a trend toward improvement in the cognitive domain (SWLS N=28; p=0.0339).

Conclusions: The results of this exploratory study show evidence for possible changes in affective deficits after a 20-week group intervention. These preliminary results support the hypothesis that emotional literacy plays a significant part in the etiology and remediation of recurrent suicidal behavior.

No. 2F
NARCISSISTIC TRAITS IN SUBSTANCE ABUSERS: ANY TREATMENT IMPLICATIONS?

Per Vaglum, M.D., *Department of Behavioral Sciences, University of Oslo, Sognsvannsveien 9, P.O. Box 1111 Blindern, Oslo N-0317, Norway*

SUMMARY:

Narcissistic personality traits and disorder (NPD) are relatively common among substance abusers. In an unselected treatment-seeking sample, we recently found NPD in 16% among pure alcoholics, and in 18% among polydrug abusers (Landheim, Bakken & Vaglum 2003). This is 30 times more prevalent than in the general population. NPD traits may increase risk taking. In a previous prospective study of a Phoenix House sample, we found that having a NPD increased the risk of dying five times during the following five years.

What are the clinical and therapeutic implications of these facts? The paper will start with a brief historical review of the psychodynamic view on the relationship between addiction and personality, from Freud to Kohut. This will be followed by a review of the empirical literature concerning the relationship between narcissistic traits and treatment response and outcome among substance abusers.

Finally, the therapeutic implications of the presence of narcissistic disturbances among substance abusers will be discussed.

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SYMPOSIUM 3—FUNCTIONAL BRAIN IMAGING OF ADDICTION
Collaborative Session with the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should better understand the application of non-invasive brain imaging in the study of drug addiction, the underlying neurobiological and neurochemical mechanisms responsible for drug-induced reinforcement, and the ability of environmental and genetic factors to influence brain-behavior mechanisms.

No. 3A
NEUROPSYCHIATRIC IMPLICATIONS OF MAPPING REWARD/AVERSION CIRCUITRY

Hans C. Breiter, M.D., *Department of Radiology, Massachusetts General Hospital, MGH-NMR Center, 149 13th Street, Boston, MA 02129;* Gregory P. Gasic, Ph.D.

SUMMARY:

Since the time of Spinoza, Bentham, and Acquinas, there has been a question of how the experience of reward was similar across category of reinforcer, and how these reinforcers were experienced relative to aversive or painful events. Studies using functional magnetic resonance imaging (fMRI) across multiple categories of rewarding and aversive stimuli now suggest that at the scale of their measurements, there is a generalized circuitry for processing motivationally salient stimuli, comprised of subcortical gray matter and paralimbic cortices. In our lab and others, there is strong evidence that the motivationally salient features of monetary gains and losses, infusions of drugs of abuse, visual processing of beautiful faces, and somatosensory experience of pain, are evaluated by these brain regions, and produce putative signatures for rewarding vs. aversive events. Some of these studies have further begun to dissect the functions of reward and aversion into their subcomponent processes

and integrate them with other motivational processes. These experiments point to a general integrative model for motivated behavior that has implications for understanding neuropsychiatric illness, and may, in fact, point toward a new foundation for psychiatry. These experiments are also driving integrative neuroscience approaches to identify the genes of susceptibility for these illnesses.

No. 3B
ENDOGENOUS OPIOID NEUROTRANSMISSIONS: INTERFACING REWARD AND STRESS REGULATION

Jon-Kar Zubieta, M.D., *Department of Psychiatry, University of Michigan, 205 Zina Pitcher Place, Ann Arbor, MI 48109-0720*

SUMMARY:

The ventral basal ganglia (e.g., nucleus accumbens) and interconnected cortical and subcortical regions are thought to have a primary role in responses to drugs of abuse and in drug reinforcement. Neurotransmitter systems thought to mediate some of these responses include the dopaminergic, and possibly the opioid system. Studies in human subjects with positron emission tomography and receptor selective radiotracers demonstrate the activation of these circuits by non-rewarding, stressful, or noxious stimuli. The activation of endogenous opioid neurotransmission was associated with the suppression of affective and sensory ratings of these experiences, and accounted for some of the sex differences in the responses to these stimuli. Alterations in the metabolism of dopamine conferred by a common genetic polymorphism were also shown to dysregulate the response of the opioid system. These data demonstrate a point of interaction between the direct effect of drugs of abuse (dopamine neurotransmission) and stress regulatory responses (opioid neurotransmission). The understanding of these mechanisms would be of importance to understand the effects of stress on drug craving and relapse in substance-dependent individuals.

No. 3C
CHRONIC EFFECTS OF DRUG USE AND HIV

Linda Chang, M.D., *Medical Department, Brookhaven National Laboratory, 30 Bell Avenue, Upton, NY 11973*

SUMMARY:

Neuroimaging studies demonstrate abnormal brain metabolites (on proton magnetic resonance spectroscopy) and abnormal resting or activated brain function (on functional MRI) with chronic psychostimulant dependence, including cocaine, methamphetamine, and 3,4 methylene-dixoy-methamphetamine (MDMA or ecstasy). Likewise, patients infected with HIV consistently show elevated glial marker myoinositol (indicating a reactive process to brain injury) during early stages of HIV dementia, and decreased neuronal marker N-acetylaspartate (indicating neuronal dysfunction) at later stages of the dementia. Since psychostimulant abuse is a common comorbid condition in those infected with HIV, the combined conditions may lead to synergistic or interactive effects. Preliminary data will be presented to demonstrate additive effects of HIV and methamphetamine on brain injury, and to evaluate possible relationships between these physiological abnormalities and cognitive or behavior dysfunction. Future studies are needed to determine whether treatments, both pharmacological and behavioral, will lead to improvement on these physiological parameters. A major challenge in neuroimaging studies is that many drug users abuse multiple drugs concurrently; therefore, attributing the effects to a particular drug requires extensive screening for and exclusion of confounding variables (e.g. other drug use, concurrent neuropsychiatric disorders, and other medications). Preliminary MRS and BOLD-fMRI studies evaluating the possible effects of polydrug use also will be presented.

No. 3D
NEUROBIOLOGICAL SUBSTRATES OF STIMULANT ACTION AND REWARD

Elliot A. Stein, Ph.D., *Department of Neuroimaging, National Institute on Drug Abuse-IRP, 5500 Nathan Shock Drive, Baltimore, MD 21224*

SUMMARY:

The psychostimulant cocaine is one of the most reinforcing and addictive drugs known. Methylphenidate (MP), a psychostimulant clinically used to treat ADHD, has similar pharmacological properties to cocaine when given intravenously (IV). Both drugs increase synaptic dopamine (DA) by blocking the DA transporter, yet MP is only rarely abused. While the pharmacokinetics and distribution of these drugs in the human brain have been studied using PET, their common sites of action, which may help isolate their independent from their common behavioral properties, has never been studied. The current study exploits the high spatial resolution and sensitivity of fMRI in a within-subjects design incorporating multiple doses of each drug with on-line behavioral measures. Further, the sites mediating drug reinforcement and craving were revealed by using the behavioral measures as regressors to the fMRI data. We show that modeling of the pharmacokinetic profiles of IV cocaine and MP from fMRI data yield similar sites of activation, which partially agree with PET findings. These data show recruitment of parts of the striato-thalamo-orbitofrontal circuitry, by both cocaine and MP, predicating their similarities. Incomplete overlap may reflect the influence that their different pharmacological profiles has on their behavioral consequences.

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SYMPOSIUM 4—TREATMENT OF CHRONIC PAIN IN RECOVERING ADDICTS
Collaborative Session with the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

This symposium will address issues related to appropriate screening and assessment of pain, optimal pain management for individuals with a history of addiction including patients in opioid maintenance treatment, and legal ethical regulatory issues related to prescribing opioids.

No. 4A
PAIN ASSESSMENT AND ISSUES IN SCREENING

Russ Portenoy, M.D., *Department of Pain Medicine, Beth Israel Medical Center, New York, NY 10003*

SUMMARY:

Chronic pain is extremely complex and a comprehensive assessment is essential in creating and sustaining a multimodality treatment strategy that can enhance comfort, improve functioning, and avoid complications. In all cases, the assessment first involves data collection through history taking, record review, examination, and testing. The relevant data include (1) pain characteristics, (2) pain-related impact on function and other quality of life domains, (3) prior evaluations and prior therapies, and (4) relevant medical and psychiatric comorbidities (patient and family). This information should always include elements related to substance use, including past and current history of prescription drug use, prescription drug abuse, and illicit drug use, adverse drug-related consequences, drug abuse treatment, and family history of drug abuse. Based on this assessment, the clinician should be able to develop a better understanding of the pain (etiology, pathophysiology, and syndrome), functional impairments, and comorbidities that may influence pain treatment decisions or require treatment themselves. This understanding, in turn, will highlight the need for further evaluation, clarify the opportunity for primary treatment for the sources of pain (if available), and provide the foundation for selection of a multimodality pain management strategy. If treatment with a potentially abusable drug, such as an opioid, is being considered, this evaluation will provide the information needed to judge the risk of abuse. Although studies have been done to try to clarify the specific elements in the history that may be predictive of abuse, only current and past drug abuse has appeared consistently, and most of the clinical decision making must be based on inferences developed from this more comprehensive assessment.

No. 4B
ASSESSING ABERRANT DRUG-TAKING BEHAVIORS IN MEDICALLY ILL PATIENTS WITH PAIN

Steve Passik, Ph.D., *Department of Medicine, University of Kentucky, 800 Rose Street, CC449, Lexington, KY 40536*

SUMMARY:

Many medically ill populations present with pain of moderate to severe intensity requiring opioid therapy for management. Chronic opioid therapy is the cornerstone of pain therapy for many such patients, though it remains controversial at times and requires careful monitoring of outcomes. Among the important domains of outcome is the assessment and management of aberrant drug-related behaviors. This concept has been articulated to attempt to focus attention on aspects of compliance with drug therapy and to differentiate the phenomenology of the pain treatment setting from that of the addiction treatment setting. This presentation will describe the domains of outcome and their assessment and will provide data from studies of aberrant drug-related behaviors in patients with AIDS, cancer, and non-malignant pain. Clinical implications and future research directions will be discussed. Attempts will be made to help psychiatrists understand the multiple etiologies of aberrant drug taking so that they can employ appropriate management strategies when consulting with pain specialists.

No. 4C
THE DEVELOPMENT AND TREATMENT OF OPIOID-INDUCED HYPERALGESIA

Walter Ling, M.D., *Department of Psychiatry, University of California, Los Angeles, 11075 Santa Monica Boulevard, #200, Los Angeles, CA 90025-3556*

SUMMARY:

A growing body of evidence from animal and human studies suggests that chronic exposure to opioids induces a state of hyperalgesia, which both complicates and compromises the management of pain in patients with long-term opioid experience resulting from treatment of either addictive disease or chronic pain. This comes amid the worldwide cry that pain is under-treated and that therapeutic opioids are under-utilized, on the one hand, while the incidence of licit and illicit opioid abuse is increasing, on the other. Recent investigations by Ling, et al (2003) have explored the development of opioid-induced hyperalgesia (OIH) in methadone and buprenorphine (Suboxone) maintained opiate dependent patients by measuring cold pressor and electrically induced pain. Results of these studies indicate that methadone maintenance increases the level of OIH from baseline while Suboxone neither increases nor decreases OIH over time (Ling, et al, 2003 and Doverty, et al, 2001a). These results are particularly significant in light of the increasing number of chronic pain patients being placed on opiate maintenance treatment for their chronic pain. In addition, opiate maintenance patients appear to be cross-tolerant to the effects of morphine (Doverty, et al, 2001b) and thus treatment of pain in opiate maintained patients suffering from OIH, with additional opiates appears problematic. In the coming years more and more people will be taking opioids chronically, either for pain or for addiction, and management of pain in these patients will be an increasing challenge.

No. 4D
PRESCRIBING PAIN MEDICATIONS FOR RECOVERING ADDICTS WITH CHRONIC PAIN

Richard Brown, M.D., *Department of Family Medicine, University of Wisconsin, 777 South Mills Street, Madison, WI 83715-1896*

SUMMARY:

For patients with addiction and chronic pain, inadequate pain treatment can prompt substance use and impede addiction treatment retention and recovery. Many such patients with moderate to severe pain and poor response to other treatments can be treated safely and effectively with opioid analgesics along with non-opioid analgesics and non-pharmacologic modalities. Medication agreements specify patients' and clinicians' responsibilities and facilitate management. Patients are expected to take medicines as prescribed; obtain potentially addictive medicines from only one clinician and pharmacy; avoid dangerous activities if drowsy; participate in other recommended treatments for pain, addictions, and other psychiatric disorders; and undergo urine drug screening on request. Clinicians monitor patients for analgesia, adverse effects, activity, and adherence. The short-acting opioids most familiar to clinicians are usually best avoided. Certain long-acting opioids are preferred, since they minimize euphoria, addiction, and diversion. Doses are iteratively increased for patients with inadequate relief who do not manifest functional decline, significant adverse effects, or non-adherence. Opioids are discontinued for patients with serious or repeated violations of medication agreements. For most patients, a respectful, empathic approach with clear limit setting allows continuation of opioids, promotes participation in addiction treatment, provides pain relief, and augments function.

No. 4E
PRINCIPLES OF PAIN TREATMENT IN ADDICTIVE DISORDERS

Seddon R. Savage, M.D., *Department of Anethesiology, Manchester VA Center, 135 East Main Street, Bradford, NH 03221*

SUMMARY:

Safe and effective pain management in individuals with substance-use disorders is often challenging. Symptoms of drug or alcohol withdrawal may complicate acute pain assessment and interfere with treatment efficacy. Opioid tolerance may dictate a need for high doses to achieve analgesia. Drug craving may shape pain reporting and clinicians often fear that opioids provided for analgesia will exacerbate substance-use problems or be diverted by patients. Chronic pain and addictive disorders each may adversely affect mood, sleep, function, and overall quality of life, and may reinforce one another. Distress associated with pain may drive use of non-prescribed substances. The use of opioids (potentially rewarding substances) to treat pain (a subjective phenomena) may shape the experience of pain. Pain may be physiologically facilitated by episodes of intoxication and withdrawal, and behaviors driven by addiction may impair compliance with pain treatment. This lecture will provide a rational approach to addressing pain in persons with substance-use disorders. The neurobiology and clinical phenomenology of drug reward, abuse, and addiction, as relevant for pain treatment, will be discussed. The synergy of pain and substance use disorders will be explored. Key principles of acute and chronic pain treatment in persons with substance use disorders will be presented.

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2. Passik SD, Kirsh KL: Commentary: the need to identify predictors of aberrant drug-related behavior and addiction in patients being treated with opioids for pain. Pain Medicine 2003; 4(2):185–188.
3. Ling W, Cunningham-Rathner J, Fradis J, Torrington M, Keating M, White J: Opioid-Induced Hyperalgesia: Effects of Buprenorphine Treatment. Oral Presentation at College on Problems of Drug Dependence, Miami, Florida, 2003.
4. Compton P, Estepa CA: Addiction in Patients with Chronic Pain. Lippincott's Primary Care Practice 2000; 4(3): 254–272.

SYMPOSIUM 5—CHILD SOLDIERS, CHILD AND ADOLESCENT VICTIMS OF WAR AND TERRORISM: BIOPSYCHOSOCIAL TREATMENT FOR REINTEGRATION INTO FAMILY AND SOCIETY
APA Alliance

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand and address the treatment and psychotherpeutic need for reintegration of child soldiers and child and adolescent victims of war and terrorist attacks.

No. 5A
CHILDREN'S RESPONSE TO TERRORISM IN NAIROBI: THE 1998 U.S. EMBASSY BOMBING IN KENYA

Frank G. Njenga, M.D., *Upperhill Medical Center, P.O. Box 73749, Nairobi 00200, Kenya*

SUMMARY:

In the aftermath of the 1998 U.S. embassy bombing in Nairobi, special programs were put in place to respond to the needs of children. The children's program stood out for two reasons. Firstly, the responding teams were unaware of children's needs in disasters, and secondly, because several schools were located close to the epicenter of the blast, and as a consequence many witnessed the unfolding drama. Additionally, several thousand children were attending the national music festival two blocks from the blast. The chaos and confusion that enveloped the city for the first 24 hours affected them: some because they were injured, some were lost in a strange city, and others watched helplessly as their teachers fled in terror. This paper describes the response to this disaster, drawing in its design from African traditions in a project that reached over 11,000 children. A surprising finding during the project was the very high level of preexisting trauma in the city's children. Many had already witnessed fatal road accidents, hijackings, physical fights, muggings, and domestic violence. The bomb blast was another trauma to a group already severely traumatized.

No. 5B
THE VOICES OF GIRL-CHILD SOLDIERS

Yvonne Keairns, Ph.D., *Human Rights Office, Quaker United Nations Office, 777 United Nations Plaza, New York, NY 10017*

SUMMARY:

A world-wide study of female child soldiers shows that many girls joined armed movements to take control of their lives or escape poverty and family problems. Twenty-three former girl soldiers in Angola, Columbia, the Philippines, and Sri Lanka were interviewed for the study. The Voices of Girl Child Soldiers compared girl combatants' experiences across the various regions and found certain patterns emerging, including

- Living in poverty was important.
- Propaganda provided by the movement was important in recruitment.
- It is incorrect to assume that all girls used as soldiers are sexually abused.
- The mother-daughter relationship was significant for the girls prior to becoming a soldier, during soldiering, and following escape or capture.
- Many of the girls felt the armed movement provided them with valuable skills.
- Girls from all conflict areas saw education or training as fundamental to their future after being a child soldier.

No. 5C
TERROR AND TERRORISM: COMMUNITY RESPONSES AND NEEDS

Robert J. Ursano, M.D., *USUHS, 3900 Clevaland Street, Kensington, MD 20895-3804;* Carol Fullerton, Ph.D.

SUMMARY:

The effects of terrorism include resiliency, as well as distress, behavioral changes, and psychiatric illness. Effective interventions must consider the individual, the family. The psychiatric interventions are based on the principles of preventive medicine and include community consultation and outreach programs with the goals of identifying high-risk groups, promoting community recovery, and minimizing social disruption. Psychiatric illness after terrorism includes, but is not limited to, PTSD; major depression, substance abuse, generalized anxiety disorder, and adjustment disorder have also been diagnoses. The effects on children have been less often studied, but the literature from the adult studies suggests that psychological responses can be severe and enduring for those most exposed and those who lose family and social supports. In addition, psychological reactions to physical injury and illness as well as psychological resiliency are important post-trauma responses.

No. 5D
CHILD SOLDIERS REINTEGRATION: A HOLISTIC COMMUNITY-BASED APPROACH

Michael Wessells, Ph.D., *Department of Psychology, Randolph-Macon College, Ashland, VA 23005*

SUMMARY:

Western psychiatric approaches, many of which have reflected a medical model and have focused on issues such as trauma, depression, and anxiety, have guided many interventions to rehabilitate and reintegrate former child solders following armed conflict. Although valuable, these approaches face severe limits related to excessive indivudalism, culture bias, narrow focus on the effect of violence, and imposition of outsider diagnostics and intervention. Having analyzed these issues, this presentation will examine an alternate approach that blends Western concepts and tools with local, indigenous concepts and practices. Using ethnographic data from Sierra Leone and Angola, it will show that the impact of child soldiers' experience is mediated by culturally contructed understandings, and that successful reintegrations require the use of local rituals and resources. Using data from large-scale programs of reintegrations, it also shows that psychosocial reintegration requires working through and supporting children's social ecologies, building former soldier's life skills and means of earning a living, and enabling communal intercommunal reconciliation.

No. 5E
SURVEY OF YOUTH, VIOLENCE, AND PUBLIC HEALTH IN BOGOTA, COLOMBIA

Luis Duque, M.D., *Department of Public Health, Harvard University School of Public Health, 677 Huntington Avenue, Boston, MA 02115;* L.F. Klevins, M.D., C. Ramirez

SUMMARY:

Columbia has been wracked by various military conflicts for over a decade. A cross-sectional survey of a random sample of 3,007 inhabitants aged 15 to 60 years, of Bogota, Columbia, based on face-to-face interviews in 1997, found that 60% witnessed physical agression, 27% had been victimized, and 27% were perpetrators; while lifetime prevalence of witnesses, victims, and perpetrators of assault with a weapon reached 70%, 55%, and 5.8%. Less than 32% reported the incident to an authority. Those involved in most types of physical violence tended to be young, male, from lower middle social classes, with some degree of secondary education, and single or divorced. Violence is not equally distributed throughout the population, suggesting the possibility of identifying a population at higher risk for the development of intervention programs.

REFERENCES:

1. Seedat S, et al: Trauma exposure and posttraumatic stress symptoms in adolescents: a schools' survey in Cape Town (South Africa) and Nairobi (Kenya). British Journal of Psychiatry, in press.
2. Keairns YE: The Voices of Girl Soldiers, Report to the United Nations, 2002.
3. Ursano RJ, Fullerton CS, Norwood AE (Eds): Terrorism and Disaster: Individual and Community Mental Health Interventions. Cambridge University Press, Cambridge U.K., 2003.
4. Child Combatants: The Road to Recovery. A case study of former child military combatants in the west-African country of Sierra Leone. Center for Defense Information, Washington, D.C.
5. Cross-sectional survey of perpetrators, victims, and witnesses of violence in Bogota, Columbia. Journal of Epidemiology and Community Health 2003; 57:355–360.

SYMPOSIUM 6—NEW DIRECTIONS IN TERRORISM AND POLITICAL VIOLENCE: CAUSES AND RESPONSES
International Society for Political Psychology and APA Council on Global Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should better understand the collective psychology of terrorism, how the internet propagates communities of hatred, and the requirement that treatment of victims be sensitive to the culture and political context of the victims.

No. 6A
PATH TO COLLECTIVE MADNESS

Dipak Gupta, Ph.D., *Department of Political Science, San Diego State University, San Diego, CA 92182-4427*

SUMMARY:

When we hear about suicide bombings that deliberately target children or read about genocides, or unspeakable atrocities committed during civil wars, we are tempted to question the sanity of the perpetrators. In fact, both scholarly literatures as well as popular writings abound with medical terms, such as "paranoiac," "delusional," or "schizophrenic" to describe such behavior. The problem with attributing medical terms to such events is that psychiatric conditions, unlike a viral pandemic, do not afflict an entire society. Hence, confronting the conundrum of explaining these actions may require a different approach. I, therefore, choose to describe such behavior with a singularly nonacademic term, "madness." I hypothesize that people become part of collective madness when they subsume their individual identities into an overarching collective identity. I argue that political or social leaders, whom I call "political entrepreneurs," skillfully promote these collective identities following a nearly identical path regardless of time, space, or culture.

No. 6B
WHEN HATRED IS BRED IN THE BONE

Jerrold M. Post, M.D., *Department of Political Psychiatry, George Washington University, 1957 East Street, NW #501, Washington, DC 20052*

SUMMARY:

We are seeing an increasing broadening and deepening of values and behavior associated with terrorism within mainstream society, as the new heroes and role models are the *shahids,* the martyrs carrying out acts of suicidal terrorism. These do not represent acts of psychopathologically disturbed youth, but socially valued acts of mainstream individuals responding to powerful social forces. The manner in which radical Islamist leaders foster this culture of death and the three-step process of inducing suicidal terrorism will be explicated. The centrality of the core identity of belonging to a valued social movement will be emphasized. Quotations from interviewed incarcerated terrorists will be used to illustrate the psychology of the terrorists.

No. 6C
TERROR ON THE INTERNET: THE NEW ARENA, THE NEW CHALLENGES

Gabriel Weimann, Ph.D., *Department of Communications, University of Haifa, Haifa 31905, Israel*

SUMMARY:

The nature of the Internet—the ease of access, the chaotic structure, the anonymity, the "liberal spirit," and the international character—all furnish terrorist organizations with a new, easy, and effective arena for action. However, counter-terrorism measures, especially those introduced after the September 11 attacks in New York and Washington, raise serious concerns about restricting free expression and free flow of information. The present research focuses on this new battle, examining both the uses of the Internet by modern terrorist organizations and the costs of the attempts to prevent them. How do modern terrorists use the Internet and for what purposes? How different are these uses from that of the "conventional" means of communication? How can governments respond to this new challenge? This study will examine terrorist sites using a qualitative content analysis to learn about rhetorical structures, symbols, persuasive appeals, target audiences, interactivity, and communication tactics. Finally, the study will examine various implications for policy making regarding terrorism and the Internet, especially with regard to its accessibility, boundaries on freedom of speech and usability for the spread of hate and violence. One should consider that the fear that terrorism inflicts can be and in the past has been manipulated by politicians to pass questionable legislation, undermining individual rights and liberties, that otherwise wouldn't stand a chance of being accepted by the public. What are the trade-offs of various counter-measures in terms of security versus privacy and freedom of expression?

No. 6D
CULTURAL APPROACHES LINKING TERRORISM AND TRAUMAS

Stevan M. Weine, M.D., *International Center on Human Responses, University of Illinois at Chicago, 2216 Lincoln Wood Drive, Evanston, IL 60201*

SUMMARY:

Terrorism may be linked to trauma in part through processes of cultural response to political violence. However, the cultural dimensions of trauma are seldom considered, let alone connected to one another. A view conveyed by trauma psychiatry and other cognitively influenced sciences is that disturbed cognitive mechanisms related to trauma pose risks for terrorism and that these must be eliminated or transformed. This perspective risks misunderstanding or neglecting meanings that can potentially oppose terrorism, because it pays insufficient attention to cultural context and to the dialogic processes that actively shape private and public meanings related to the traumas and terrorism. Furthermore, cognitive interventions do not exist for changing cultures to oppose terrorism, because culture cannot be reduced to cognition. This presentation offers a narrative-focused theoretical approach to processes of cultural response linking terrorism and traumas, based in part on the dialogic work of the Russian literary philosopher Mikhail Bakhtin.

No. 6E
RESOURCE LOSS AND IMPACT ON CIVILIAN POPULATIONS: INDIVIDUALS AND SYSTEM OUTCOMES

Stevan Hobfoll, Ph.D., *Applied Psychiatry Center, Kent State University, Kent, OH 44242*

SUMMARY:

Work on war and disaster suggests that losses that people experience in the domains of personal resources (e.g., self-esteem, optimism), condition resources (e.g., marriage, employment), energy resources (e.g., time, credit), and material resources (e.g., house, car) are the key ingredients predicting people's negative reactivity. These reactions will include a range of negative sequelae ranging from moderate anxiety and sleep problems for those at the periphery of events to full-blown PTSD for those who are most directly impacted. Secondarily, because these events are usually outside of people's own control and coping repertoire and because the threat is often vague as to future possibilities, media construels of events and political processcs will deeply affect people's reactivity. Hence, if politicians and news sources provide a clear message and promote a clear responsive strategy that fits people's value system, it can supplement individuals' meaning systems and coping processes and help them navigate through these unfamiliar waters. In this regard, it is important to add to individual-level knowledge about traumatic stress responsiveness and resiliency, certain key group processes. These include risky-shift, in-group/out-group responding, stress-contagion, the pressure-cooker effect, the tendency of the group to look for easy solutions to gain consensus and lower anxiety, and cognitive narrowing (i.e., difficulty looking ahead in time or to multiple possibilities). These concepts will be presented in light of Conservation of Resources theory, spanning from individual to systems level responding.

REFERENCES:

1. Gupta D: Path to Collective Maddness. Dipak Gupta Praeger Publishers, 2001.
2. Post J, Sprinzak E, Denny LM: The terrorists in their own words: interviews w/ 35 incarcerated Middle Eastern terrorists. Terrorism and Political Violence 2003; 15(1):171–184.
3. Weimann G: The Threat of Terror: Mass Media & Int'l Terrorism. Addison-Wesley Pub Co.
4. Weine SM: When History is a Nightmare: Lives and Memories of Ethnic Cleansing in Bosnia-Hergegovina Rutgers Univ. Press, 1999.
5. Hobfoll SE: Stress, Culture and Community: The Psychology and Philosophy of Stress. Kluwer Academic Publishers, 1998.

SYMPOSIUM 7—I REST MY CASE: AMERICAN ASSOCIATION OF PRACTICING PSYCHIATRISTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the role of litigation in advocating for the rights of the medical profession, with special emphasis on psychiatry, and the doctor/patient relationship.

No. 7A
THE HIPAA SUIT

Robert L. Pyles, M.D., *367 Worcester Street, Wellesley Hills, MA 02481*

SUMMARY:

Amendments buried within the thousands of pages of HIPAA regulations mark the end of over twenty four hundred years of doctor/patient confidentiality embodied in the Hippocratic Oath. The Bush amendments to the HIPAA regulations stipulate that patient consent is no longer required prior to release of medical information to the government, insurance companies, and related businesses. (Related

businesses are so broadly defined that they number in the hundreds of thousands). The regulations force the clinician into acting as an agent of the insurance company rather than on behalf of the patient. This makes HIPAA more egregious than other unfunded mandates generated by the government. In fact, despite purporting to serve as privacy regulations, HIPAA is, in fact, a disclosure law.

The audience will learn how organized psychiatry formed a coalition with patient advocacy groups and individual plaintiffs in order to restore the sanctity of the doctor/patient relationship by safeguarding the patient's right to consent.

No. 7B
SHRAGER VERSUS MAGELLAN

Daniel Shrager, M.D., *2465 Mount Royal Rd, Pittsburgh, PA 15217-2541*

SUMMARY:

Daniel Shrager is a psychiatrist practicing in Pittsburgh, who contracted with Magellan to serve on their panel. Magellan demanded patient charts on the grounds that he was a "high volume provider" and therefore triggered a "quality review." Dr. Shrager reluctantly agreed to a review of charts provided informed consent by the patients was first obtained by Magellan. Magellan refused to seek patient authorization, citing the blanket consent signed by all patients when they enroll as subscribers in the insurance plan. Magellan subsequently and without forewarning removed Dr. Shrager from their panel, and so informed his patients. Dr. Shrager was granted an injunction to prevent his removal from the panel and sued Magellan for their actions. The judge agreed with his principles and found that Magellan was in defiance of Pennsylvania law protecting patient records. In addition, the judge ruled that specific authorization must be obtained prior to the release of the medical record, and that the blanket consent signed by insurance enrollees does not suffice.

The audience will learn how Dr. Shrager developed his suit against Magellan, and how organized psychiatry assisted him in his fight. He will also discuss developments subsequent to the judge's ruling.

No. 7C
THE RICO SUIT

Janis G. Chester, M.D., *49 Hazel Road, Dover, DE 19901*

SUMMARY:

Nearly 30 state and county medical societies, as well as individual physicians, have sued ten managed care companies under the RICO (Racketeer Influenced and Corrupt Organizations) Act. Frustrated with the ineffectiveness of negotiation with the insurance industry and with reliance on enforcement of state laws, the entire group of 700,000 American physicians gained class status and sued the managed care companies for conspiring to withhold or delay payment for medical services; establishing onerous utilization review procedures; downcoding for billed medical services; and otherwise interfering with the practice of good medicine. The primary goal of the suit was not to recoup financial losses, but to change the business practices of the insurance industry in America. Physicians sued to regain the right to clinical authority stolen by the managed care industry. The effect of this suit on psychiatry will be discussed with specific reference to the so-called carve-out companies used to further manage the insurance benefits for psychiatric treatment.

No. 7D
EIST VERSUS MARYLAND BPQA

Harold I. Eist, M.D., *10436 Snow Point Drive, Bethesda, MD 20814*

SUMMARY:

The Maryland BPQA sanctioned Harold Eist, M.D., for his principled refusal to release the medical records of his patients without their consent or due process of law. Dr. Eist treated a mother and two children; the family was in the midst of a divorce including a custody battle. Dr. Eist was reported to the Maryland BPQA by the estranged husband of his patient, who accused him of substandard treatment of his estranged wife and two children. The mother and the court appointed attorney for the children refused to allow release of the medical records; in addition the BPQA sought the opinion of an administrative law judge, who supported Dr. Eist for upholding medical ethics by refusing to release the records, and chastised the board for violating procedures. Despite this, the BPQA sanctioned Dr. Eist, reporting him to the National Practitioner Data Bank and fining him $5,000.

Dr. Eist successfully sued the BPQA and restored his good name. The audience will learn how this suit developed, and the role played by organized psychiatry in his fight.

REFERENCES:

1. Docket 1,334: In Re Managed Care Litigation.
2. Eist V: Maryland Board of Physicians Quality Assurance.

SYMPOSIUM 8—FROM RESPONSE TO RECOVERY: THE CONSUMER AND CLINICIAN COLLABORATION IN DEPRESSION AND PSYCHOSIS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, clinicians will learn the modern pharmacotherapy and psychiatric management of depressive disorder and will learn how to aim their treatment. Efforts to meet the real needs of a variety of real patients.

No. 8A
SARAH'S STRUGGLE: ADOLESCENCE, ABANDONMENT, AND BIPOLAR DISORDER

Sarah Duckworth, *Mental Health, The Jonathan O. Cole, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

This 20-minute vignette will include Sarah's own experience with abandoment from her family, bipolar disorder (cutting, and psychosis, her life within the Department of Social Service system including residential placements, inpatient psychiatric hospitalization, group homes ending with a high school diploma, and hopefully, acceptance to a state college. Sarah will talk of the multidisciplinary approach that was taken in her treatment, and also of her psychopharmacologic treatment, psychotherapy, and community support. Sarah's accomplishments will help to teach clinicians to recognize, diagnose, and treat other adolescents with similar mental illnesses.

No. 8B
TO BE OR NOT TO BE? THE HIDDEN CRISIS OF ADULT AND ADOLESCENT MALE DEPRESSION AND SUICIDE

William S. Pollack, Ph.D., *Cole Resource Center, Mclean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

While the wracking pain of undiagnosed of under-diagnosed clinical depression and its morbid potential for suicidality is an unnecessary tragedy in both genders, recent research supports the hypothesis that the clinical depressions of adult and adolescent males are significantly more likely to go untreated and thereby lead to years of needless personal pain, violent enactment, and the national crisis of male suicide in America, in which adolescent boys and adult men are between four to ten times more likely to take their own lives, as a result of these "covert depressions," than women are. Dr. Pollack will discuss the reasons for our psychiatric scotomas when it comes to recognizing and treating depression in males, suggest a new diagnostic set of criteria for the next edition of the DSM on "Male-Gender Based Depression," and inform consumers and practitioners alike about the specific warning signs for this affective spectrum of illnesses in male patients. His approach will help alert us to a wide range of behaviors previously unnoticed, which have significance in finding and treating men—young and older—who suffer from heretofore undiagnosed forms of affective illness. His aim will be to share new research, inform the audience about life saving interventions, and help to bring men in from the cold world of unrecognized despair, attempting to diminish suicidal enactment. For the potentially unrecognized Hamlets whom we see and/or treat, "tis a consummation devoutly to be wished"!

No. 8C
FROM ILLNESS TO WELLNESS: NEW STRATEGIES FOR RECOVERY

Anne Whitman, Ph.D., *Mental Health, MDDA Cole Resource Center, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

This 20-minute vignette will include Anne's own experience with psychosis and bipolar disorder. Anne is a consumer of mental health services and will describe her own treatment, psychopharmacologic issues, and her recovery process. Dr. Withman will also help to teach clinicians how to understand new strategies for recovery beyond therapy and medications, different organizational cultures and structures that help patients to recover, and most of all the shift from patient to peer advisory and how that takes place. As co-founder of the Jonathan O. Cole M.D., Mental Health Consumer Resource Center, a consumer-to-consumer education and recovery community that is dedicated to help mental health consumers achieve a full and healthy life by responding to their concerns with compassion and pragmatism necessary to alleviate their hardship and aid in their recovery, Anne will speak about her involvement with the center. The Cole Center is dedicated to serving as a model for other resource centers nationwide with a consumer-operated approach and a close partnership with the psychiatric community. The Cole Center is housed at McLean Hospital, in Belmont, Mass.

No. 8D
BIPOLAR AND MDD IN MIDLIFE

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

SUMMARY:

Although mood disorders (major depressive and bipolar disorders) frequently present in late adolescence or the early twenties, patients with these illnesses are often not diagnosed and treated until midlife. This lag between illness onset, diagnosis, treatment, and response is associated with substantial interpersonal, psychosocial, and vocational disruption and impairment. In addition, women are most vulnerable to new-onset mood disorders in the postpartum. In this presentation, research regarding improved screening and recognition of mood disorders will be reviewed. Data regarding the impact of mood disorders on mid-life tasks, such as career development, marital stability, child-rearing, and parenting will be discussed. Psychosocial and pharmacological treatment strategies to prevent recurrence of mood episodes, optimize functioning, and reduce the risk of suicide will be presented. These data will be coordinated with a companion presentation by a consumer who has coped with these issues.

No. 8E
GERIATRIC DEPRESSION, ALCOHOL ABUSE, AND SUICIDALITY

Everet Page, *Mental Health, Jonathan O. Cole, 115 Mill Street Resource Center, Belmont, MA 02478*

SUMMARY:

This 20-minute vignette will include Mr. Everett Page's struggle with depression, alcoholism, and suicide attempts during his lifetime. He will speak about his medical disorder with a biological basis that has affected his thoughts, moods, feelings, behavior, and physical health. His symptoms have included loss of interest in normal daily activities, sleep disturbances, agitation, fatigue, low self-esteem, and impaired thinking and concentration. He will share his thoughts of death and suicide. Everett's experiences have led him to become an active member of the Manic Depressive and Depressive Community and The Cole Resource Center at McLean Hospital. He has served as president as well as peer counselor for many years.

No. 8F
LATE-LIFE DEPRESSION: IS GETTING WELL ENOUGH?

Sumer Verma, M.D., *Resource Center, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

Late-life depression is an underdiagnosed and undertreated condition. It is a ubiquitous condition with poorly defined symptoms and marked by recurrence and relapse that ultimately lead to chronicity and treatment resistance. As with many other chronic conditions like diabetes, asthma, and hypertension, successful treatment outcomes can not be measured solely by short-term treatment response, but must demonstrate sustained functional recovery. It is not enough to get well or even to stay well—successful treatment must restore an individual to productive living. Over time, increasingly effective antidepressant drugs have been introduced. Despite the fact that newer drugs are more effective and have far fewer side effects, outcomes of geriatric depression remain less than impressive.

If better long-term outcomes are to be achieved, the practice of psychiatry needs to undergo a paradigm shift. Clinicians will have to change the focus of treatment from response to relapse prevention.

Treatment adherence is achieved best by an active collaboration between consumer and clinician. It is "faith" that heals and it is what we "wrap around" the drug that makes the difference. Long-term care is an effort involving consumer, clinician, and caregivers.

REFERENCES:

1. Jamison KR: Touched by Fire.
2. Pollack WS: Mouring, melancholia, and masculinity: Recognizing and treating depression in men, in Pollack WS, Levant RF, editors. New Psychotherapy for Men. New York, Wiley, 1998 pp 147–166.
3. Jamison KR: Unquiet Mind.

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5. Johnson JT: Hidden Victims, Hidden Healers.
6. Meyers NM, Reynolds CF: Factors affecting long-term prognosis and maintenance treatment outcomes in depression in late life, Edited by Ellison JM, Verma S. Marcel Dekker, 2003.

SYMPOSIUM 9—RECENT ADVANCES IN THE TREATMENT OF PSYCHIATRIC DISORDERS IN PRIMARY CARE: A U.S./ U.K. PERSPECTIVE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) understand the role of nurse therapists in the stepped care treatment of depressive disorders and anxiety disorders in primary care, (2) implement evidence-based guidelines within primary care, and (3) determine the role of brief psychological treatments for common disorders in primary care.

No. 9A
THE PATHWAYS STUDY: A RANDOMIZED TRIAL OF COLLABORATIVE CARE IN PATIENTS WITH DIABETES AND DEPRESSION

Wayne J. Katon, M.D., *Department of Psychiatry, University of Washington, 1959 NE Pacific, Box 356560, Seattle, WA 98195–6560;* Michael Von Korff, Sc.D., Elizabeth Lin, M.D., Gregory Simon, M.D., Paul Ciechanowski, M.D., Evette Ludman, Ph.D., Edward A. Walker, M.D.

SUMMARY:

Approximately 11% to 15% of patients with diabetes mellitus have been shown to have major depression. Comorbid depression in patients with diabetes has been shown to be associated with increased diabetes symptom burden, increased functional impairment, poor adherence to self-care regimens (diet, exercise, adherence to medication), increased HbAIC levels, and increased medical costs. This lecture will describe the results of a recent NIMH-funded trial that randomized 330 depressed diabetics in eight primary care clinics to a nurse collaborative care intervention versus usual primary care. Nurses were supervised by a team of care providers, including a psychiatrist, a psychologist, and a family physician. Nurses provided intervention patients with a choice of enhancing antidepressant care prescribed by the primary care physician or problem-solving therapy. This intervention was shown to improve adherence to antidepressant medication, satisfaction with depression care, and depressive outcomes compared with usual care. Approximately 70% of intervention patients versus 40% of control patients considered their depression to be significantly improved at six and 12 months. Ongoing analyses about diabetes outcomes, such as HbA1C, will be reported at this meeting.

No. 9B
COGNITIVE-BEHAVIOR THERAPY AND MEDICATION FOR PRIMARY CARE PANIC DISORDER: SUSTAINED SUPERIORITY TO USUAL CARE

Peter P. Roy-Byrne, M.D., *Department of Psychiatry, University of WA/Harborview Medical Cntr, 325 Ninth Avenue, Box 359911, Seattle, WA 98104;* Michelle G. Craske, Ph.D., Murray B. Stein, M.D., J. Greer Sullivan, M.D., Alexander Bystritsky, M.D., Wayne J. Katon, M.D., Cathy D. Sherbourne, Ph.D.

SUMMARY:

Panic disorder is a prevalent, disabling condition for which treatment is often sought in the primary setting. Although numerous studies have assessed the effectiveness of treatments for depression in primary care, few such studies have been conducted for panic disorder. To implement and test the effectiveness of a combined pharmacotherapy and cognitive-behavioral intervention tailored to the primary care setting, patients were randomized to an acute intervention consisting of cognitive-behavioral therapy and algorithm-based pharmacotherapy provided by the primary care clinician with overall management coordinated by a behavioral health specialist, or to treatment as usual. The intervention resulted in substantial and sustained improvement relative to treatment as usual, including anticipatory anxiety, anxiety sensitivity, disability, and quality of life. These effects were obtained in spite of similar rates of delivery of guideline-concordant pharmacotherapy to the two groups. Unlike most previous studies of depression, where effects have been seen to wane beyond the acute treatment period, effects in this study were largely sustained over the 12-month period of observation. Future studies should consider expanding the scope of treatment to accommodate other anxiety disorders (which are often comorbid), and determine how these effective treatments can best be disseminated.

No. 9C
PROBLEM-SOLVING TREATMENT BY NURSES FOR PSYCHOLOGICAL DISORDERS IN PRIMARY CARE

Lawrence Mynors-Wallis, D.M., *Southampton University, Alderney Community Hospital, Ringwood Road, Dorset BH12 4NB, United Kingdom;* Anthony Kendrick, M.D., Christopher Thompson, M.D., Judith Lathlean, M.A., Lucy Simons, B.A., Ruth Pickering, B.S.C.

SUMMARY:

Problem-solving treatment has been evaluated in a series of studies in the U.S. and the U.K. as a brief psychological treatment for use in anxiety and depressive disorders in primary care. Problem solving has been shown to be effective for a range of depressive and anxiety disorders of moderate severity. It has been shown that nurses can be trained to deliver problem solving in primary care and that nurse-delivered treatment can be a cost-effective intervention. It has not been demonstrated, however, whether a nurse-delivered psychological treatment is more effective or more cost effective than family doctor usual care. Results will be presented from a U.K. primary care study in which 247 patients with anxiety and depression in primary care were randomly allocated to receive:

(1) usual care by family doctor,
(2) problem-solving treatment given by community nurses, or
(3) supportive treatment given by community nurses.

Information about the training given to the nurses in problem-solving treatment will be given. Follow-up results at eight weeks (86%) and 26 weeks (75%) will be presented. Outcome has been measured in terms of symptom severity, disability days, cost, and patient satisfaction.

No. 9D
COST-EFFECTIVENESS OF ANTIDEPRESSANTS IN PRIMARY CARE

Robert C. Peveler, M.D., *Department of Mental Health, Southampton University, Royal South Hants Hospital, Southampton S014 0YG, United Kingdom;* Anthony Kendrick, M.D., Christopher Thompson, M.D., Martin Buxton

SUMMARY:

The "AHEAD" study was designed to determine the relative cost-effectiveness of three classes of antidepressants: tricyclics (TCAs), selective serotonin reuptake inhibitors (SSRIs), and the tricyclic-related antidepressant lofepramine, as first-choice treatments for depression in primary care. Most previous health economic comparisons between TCAs and SSRIs have used secondary data. Simon et al (1996) found no difference between tricyclics/SSRI in direct health care costs in a U.S. HMO. The study was an open, pragmatic, controlled trial with three arms. The primary effectiveness outcome was the number of depression-free weeks (HAD-D less than 8, with interpolation of intervening values) and the primary cost outcome total direct health care costs. Incremental cost-effectiveness ratios and cost-effectiveness acceptability curves were computed. There were no significant differences between groups in number of depression-free weeks, or cost per depression-free week. Cost per QALY was significantly greater for SSRIs when compared with TCAs, but the 95% CIs were wide. Given the lack of significant differences in cost-effectiveness, it is appropriate to base the first choice between classes of antidepressant in primary care on doctor and patient preferences.

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SYMPOSIUM 10—MENTAL HEALTH TEAMS: HEALTH PROMOTION AND PRESERVATION IN WAR AND PEACE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand combat stress control and similar mental health team history; recognize the significance of current major mental health efforts in recent wars; discuss future roles of mental health teams in response to disaster or terrorist events.

No. 10A
MENTAL HEALTH TEAMS: BACKGROUND AND RECENT HISTORY

James J. Staudenmeier, Jr., M.D., *Department of Psychiatry, Tripler Army Medical Center, 400A Halawa View Loop, Honolulu, HI 96818;* Bryan Bacon, D.O., William F. Haning III, M.D., Thomas A. Hicklin, M.D.

SUMMARY:

Combat stress control (CSC) units have been deployed to Gulf Wars I and II, Somalia, Haiti, Guantanamo Bay, Bosnia, and Kosovo. They have been flexible and useful mental health tools for commanders in both combat and peacekeeping operations for the past decade. At times, though, the garrison mission remains unclear. This presentation will briefly summarize salient historical facts and highlight the trials and tribulations of CCS and similar mental health units during these past conflicts. This introduction will lead into the later talks in the symposium that will cover more recent mental health team action in the context of current world events.

No. 10B
PSYCHOLOGY OF WAR

Jason L. Engeriser, M.D., *Department of Psychiatry, Tripler Army Medical Center, 1 Jarrett White Road, Honolulu, HI 96859*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize some of the theories regarding why humans engage in war, discuss the perceptual changes that occur in times of war, and describe implications for military psychiatrists.

SUMMARY:

Despite the horrendous tragedies that are inherent in waging war, wars have been ubiquitous in human history. There has been extensive discussion about how wars start, from a variety of different angles, including theories from the disciplines of economics, sociology, political science, anthropology, theology, etc. This talk will focus on the psychology of war and will specifically explore what allows otherwise decent people to behave in a very violent way towards each other in certain circumstances. In general, people value peace and security, love their families, and are good neighbors. But there is also something about us as human beings that allows us to change our frame of reference in times of conflict so that we treat other people with hate and destruction.

When nations go to war, there is a shift in perception to what can be called the mythological perspective. This perspective allows us to see the coflict in black and white terms. A common result of this is the dehumanization of the enemy. The perceptual shifts that shift occur in times of war have implications for military psychiatrists and it is important to understand these perceptual shifts for optimal treatment both in times of war and in times of peace.

No. 10C
RECENT MENTAL HEALTH TEAM EFFORTS IN THE COMBAT-SUPPORT HOSPITAL

Robert D. Forsten, M.D. *Department of Psychiatry, U.S. Army Combat Hospital, 3734 Canyon Heights Drive, Belton, TX 76513*

SUMMARY:

Mental health team assets have been deployed to Gulf Wars I and II, Somalia, Haiti, Guantanamo Bay, Bosnia, and Kosovo. Though these teams have been flexible and useful mental health tools for commanders in both combat and peacekeeping operations, they have had their challenges. This talk will focus on recent experiences from the Iraq War. Examples of problems, interventions, and mental health techniques used in support of a deployed military hospital will be discussed. The similarities and differences between garrison (peacetime) versus operational (in this case wartime) interventions will be discussed with the audience.

No. 10D
MENTAL HEALTH INTERVENTION IN MORTUARY AFFAIRS WORKERS DURING COMBAT

Panakkal David, M.D., *Department of Psychiatry, U.S. Army Reserves, 7 Shady Glen, Ballston Lake, NY 12019-9219*

SUMMARY:

Previous research has shown that mortuary workers during the time of war develop posttraumatic stress disorder (PTSD) as a result of exposure to traumatic death and the gruesomeness of the remains. A previous study had focused on longitudinal assessment of PTSD and depression after exposure to traumatic death. None of the studies had assessed soldiers during the war. This paper will present initial findings of PTSD and related disorders in mortuary workers in the midst of war. The psychiatrist was known to the mortuary workers as someone who came to the mortuary frequently to certify death. This further enhanced the mortuary workers' access to the psychiatrist. A total of 107 were screened. Thirty-four soldiers showed high scores that suggested need for further contact. Eight were clinically diagnosed with mild to severe acute PTSD. One soldier was involved with recovery of remains at the Pentagon after 9/11. Two had exposure to childhood sexual trauma. One had traumatic recollection from childhood unrelated to mortuary work. Another had symptoms related to past trauma and recent encounter with the deceased. With treatment, seven soldiers had significant reduction of symptoms. One individual with PTSD symptoms from past trauma declined treatment.

No. 10E
HEALTH-PROMOTION AND PREVENTIVE-MEDICINE EFFORTS IN THE MOST RECENT GULF WARS

Robert T. Ruiz, M.D., *US MEPCOM East Sec., Surgeon, US Army, 2834 Greenbay Road, North Chicago, IL 60064*

SUMMARY:

Preventive medicine and mental health team assets have been deployed to Gulf Wars I and II, Somalia, Haiti, Guantanamo Bay, Bosnia, and Kosovo. These teams have been flexible and useful tools for military leaders in attempting to keep soldiers fit and ready for operational action, whether at war or humanitarian assistance mode. This talk will focus on recent experiences from the Iraq War from the perspective of a deployed preventive medicine, family practice physician. Examples of problems, interventions, and the overlap of treatment of physical and mental conditions in the battlefield will be discussed. Audience participation and sharing of related or similar experiences will be encouraged.

No. 10F
JEALOUS IN HONOR, SUDDEN IN QUARREL: PSYCHIATRIC PRACTICE IN IRAQI FREEDOM

William F. Haning III, M.D., *Dean, Psychiatry Department, John A. Burns School of Medicine, 11356 Lusitana Street, 4th Floor, Honolulu, HI 96813*

SUMMARY:

Commonalities become readily apparent in any discussion of civilian mass disaster response and military operations, most relating to the scale of relief and the types of disorders or problems that occur. This can contribute to a neglect of the divergent attributes of the two types of events. Military psychiatric management arises out of superficially similar, but in several respects importantly dissimilar, individual, organizational, and strategic needs from the civilian psychiatric model. In this presentation, the author will provide an overview of the medico-psychiatric needs of the combatant employing Operation Iraqi Freedom as a template, and then discuss the organized response to those needs, their effectiveness, and the projected outcomes against the conditions that would prevail in a homeland setting.

Disclaimer: The opinions rendered in this presentation are not intended to represent the position of the Department of the Navy, and their provenance lies solely with the author.

No. 10G
EMOTIONAL CYCLE OF DEPLOYMENT: MILITARY AND FAMILY PERSPECTIVE

Simon H. Pincus, M.D., *Department of Psychiatry, Tripler Army Medical Center, 1 Jarrett White Road, Hinolulu, HI 96859*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the emotional cycle for military families and service members as they progress from alert through homecoming after deployment.

SUMMARY:

Military families have experienced the emotional trauma of deployment on an unprecedented scale since the end of the Gulf War. Humanitatian missions and peace enforcement have sent our troops to Somalia, Cuba, Haiti, Bosnia and Kosovo. Since 9/11, the pace of deployment operations has stretched active duty, gaurd and reserves with massive deployments to Afghanistan and especially Iraq. The impact of these long separations on service members and their families is of increasing concern. Differing coping strategies are needed through the five stages of deployment. Education of health care providers, military leaders, soldiers, and family members to anticipate these stages is crucial to ensure the soldier's safe return and to minimize familial trauma.

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SYMPOSIUM 11—PTSD IN PERSONS WITH SERIOUS MENTAL ILLNESS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the prevalence of PTSD in persons with serious mental illness and to understand the importance of new treatment strategies for this population.

No. 11A
PREVALENCE AND PATTERNS OF PTSD AMONG PERSONS WITH SEVERE MENTAL ILLNESS

David B. Albert, Ph.D., *Department of Psychiatry, Cambridge Health Alliance, 26 Central Street, 4th Floor, Somerville, MA 02143;* Linda A. Teplin, Ph.D., Karen M. Abram, Ph.D., Gary M. McClelland, Ph.D.

SUMMARY:

This study investigated the prevalence and patterns of posttraumatic stress disorder (PTSD) in a multisite stratified probability sample of 1,005 psychiatric aftercare patients in Chicago, Illinois. The results of this study confirm that PTSD disproportionately afflicts persons with severe mental disorders: the rate of 12-month PTSD in our sample was 21.12%. This study also confirms that PTSD is grossly underdiagnosed in clinical settings that serve persons with severe mental disorders: only 2.69% of our subjects had a chart diagnosis of PTSD. Rates of current PTSD were significantly associated with gender, race/ethnicity, and psychiatric diagnosis. Female subjects were significantly more likely than male subjects to have PTSD (26.89% vs. 15.42%). Hispanic subjects had the highest rate of PTSD (29.11%), followed by African-American subjects (20.15%), and non-Hispanic white subjects (12.60%). Rates of PTSD were highest among subjects with bipolar disorder (37.40%), followed by obsessive-compulsive disorder (36.13%), psychotic disorder (32.51%), and major depressive disorder (29.96%). Overall, seven demographic and diagnostic factors emerged as significant risk factors for PTSD (and for underdiagnosis): (1) female gender, (2) African-American race/ethnicity, (3) Hispanic race/ethnicity, (4) a comorbid bipolar disorder; (5) comorbid obsessive-compulsive disorder, (6) a comorbid psychotic disorder, and (7) a comorbid major depressive disorder.

No. 11B
AN EXPLORATION OF PTSD AND MDD COMORBIDITY

Patricia Resnick, Ph.D., *Department of Psychology, University of Missiouri—St. Louis, 8001 Natural Bridge Road, St. Louis, MO 63121*

SUMMARY:

This presentation will examine the results of three different samples of women with regard to the comorbidity between posttraumatic stress disorder and major depressive disorder. The first sample is comprised of an acute prospective sample of women who were raped or physically assaulted who were assessed at two weeks (n = 124) and again at three months post-crime (n = 69). The second sample consists of 140 severely battered women who were assessed between one and six months of their most recent battering incident. The third sample includes rape victims who participated in a treatment outcome study. This sample was examined before and after treatment and three and nine months later. In all three studies, participants were assessed with the CAPS and SCID for diagnosis of PTSD and MDD, respectively. In all three samples, depression in the absence of PTSD was quite rare, less than 5%. In the acute sample, 76% had PTSD at two weeks and 49% at three months. MDD comorbidity was 29% and 13%, respectively. In the chronically abused sample, 79% had PTSD and 49% were comorbid. Among treatment seekers, 91% had PTSD and 40% were comorbid. This presentation will also examine treatment outcome and why comorbidity is so frequent, by examining overlap in symptoms, trauma history and depression history, and cognitive variables.

No. 11C
ASSESSMENT AND TREATMENT OF TRAUMA IN PERSONS WITH SERIOUS MENTAL ILLNESS

Kristina H. Muenzenmaier, M.D., *Department of Psychiatry, Bronx Psychiatric Center, 1500 Waters Place, Bronx, NY 10461;* Lewis A. Opler, M.D., Anne-Marie Shelley, Ph.D., Mary-Jane Alexander, Ph.D., Michelle Fox, B.A.

SUMMARY:

A study of 78 women with serious mental illness (SMI) enrolled in a state hospital outpatient clinic revealed high prevalence rates of childhood sexual abuse (45%), physical abuse (51%), and neglect (22%). Seventy-four percent of the sexually abused women, 70% of the physically abused women, and 94% of the women with a history of neglect reported at least one additional form of abuse or neglect. Half of the women with sexual abuse were abused by a family member. Women who reported childhood abuse presented with higher levels of depressive and psychotic symptoms (CES-D: mean 25 vs 20, respectively; Beliefs and Feelings: mean 9.8 vs 4.6, respectively). In only 20% of the women who had been physically abused and 32% of the women who had been sexually abused had this been previously identified. Based on these findings, the Bronx Empowerment Project was established for persons with co-occurring SMI and childhood trauma. Treating trauma-related symptoms in persons with SMI is leading to better outcomes as reflected by both self-report and objective rating scales.

No. 11D
COGNITIVE-BEHAVIORAL TREATMENT OF PTSD IN CLIENTS WITH SEVERE MENTAL ILLNESS

Kim T. Mueser, Ph.D., *Department of Psychiatry, NH-Dartmouth PRC, 105 Pleasant Street, Main Building, Concord, NH 03301;* Stanley Rosenberg, Ph.D., Kay Jankowski, Ph.D., Jessica Hamblen, Ph.D., Patricia Carty, M.S.

SUMMARY:

Trauma and posttraumatic stress disorder (PTSD) are common in the lives of persons with severe mental illness (SMI) and are associated with a worse course of illness. In order to address the need for effective treatment of trauma-related consequences in persons with SMI we have developed an intervention specifically designed to treat PTSD in this population. The intervention is based on the principles of cognitive-behavioral treatment found to be effective in the general population of persons with PTSD, while omitting formal, directed exposure techniques. Two formats for the intervention have been developed, including a 12-to-16-week individual format and a 21-week group format. Pilot data demonstrating the feasibility and clinical promise of each intervention will be presented. The design of a randomized clinical trial currently under way to evaluate the effectiveness of the individual treatment format will be briefly described.

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SYMPOSIUM 12—BEHAVIORAL DIMENSIONS OF PSYCHIATRIC DISORDERS

EDUCATIONAL OBJECTIVES:

At the end of the symposium, the participant will understand the behavioral aspects of dimensions of psychiatric disorders.

No. 12A
IMPULSIVITY IN PSYCHIATRIC DISORDERS

Alan C. Swann, M.D., *Department of Psychiatry, University of Texas-Houston Medical School, 1300 Moursund Avenue, Room 270, Houston, TX 77030*

SUMMARY:

The initiation of action is a central component of behavior. Normally, ongoing behavior results from a balance between the generation and the screening of potential action. These processes take place outside of consciousness. Failure of this balance can result in impulsivity, where the individual is prone to rapid, unplanned responses that cannot be shaped by reflection. The processes involved in impulsivity are attractive targets for oligogenetic models of illness. Consequences of impulsivity include suicide, aggression, and other rapid, unplanned acts that can have long-term consequences. Impulsivity is prominent in bipolar disorder, in so-called Cluster B personality disorders, in stress-related disorders, in schizophrenia, and in developmental disorders. These illnesses may share certain aspects of the physiology of impulsivity. Impulsivity predisposes to substance abuse, which further can complicate any of these psychiatric illnesses. Impulsivity has state- and trait-related components, which can be measured objectively. Bipolar disorder provides a particularly strong example of dissociation between state- and trait-related impulsivity. Impulsivity is an important component of dimensional models of psychopathology because it is related to a central aspect of behavioral physiology, it can be measured objectively, and it is related to the deadliest and most severe consequences of psychiatric illnesses.

No. 12B
AGGRESSION IN PERSONALITY DISORDERS

Emil F. Coccaro, M.D., *Department of Psychiatry, University of Chicago, 5841 South Maryland Avenue, MC#3077, Chicago, IL 60637*

SUMMARY:

Objective: Impulsive aggression is one of the more common features of the personality disorders. This presentation will review existing and new data regarding the biology and treatment of impulsive aggression in the context of these disorders.

Methods: Studies reviewed come from data related to clinical epidemiology, family history study, pharmco-challenge and CSF neurochemical study, and from pharmacology treatment study.

Results: Impulsive aggression is common among all types of personality disorder clusters. It is significantly heritable and the presence of the trait is transmitted in families across generations. Measures of impulsive aggression correlate with various measures of serotonin, norepinephrine, GABA and vasopressin. Impulsive aggression responds pharmacologically with a number of agents including SSRIs and mood stabilizers. While impulsive aggression is dimensional in nature, examination of the trait as a categorical entity is often useful for the purposes of clinical epidemiology, family study, and clinical trials.

Conclusions: Impulsive aggression is an important endophenotype of personality disorder. The biology and clinical psychopharmacology of impulsive aggression are complex, but critical to understanding the nature of aggression in these types of patients.

No. 12C
MOOD REACTIVITY DIMENSION IN DIAGNOSIS

Conrad M. Swartz, M.D., *Department of Psychiatry, SIU School of Medicine, P O Box 19642, 901 West Jefferson, Springfield, IL 62794-9642*

SUMMARY:

Surely some forms of major depression are as biological as pneumonia, such as major depression with observable features of catatonia or severe melancholia. Conversely, atypical major depression requires reactivity to stresses, such as disappointments, humiliations, losses, and threats. Mood reactivity occurs similarly in anxiety disorders. DSM-IV specifies no exclusion between anxiety and depression, excepting OCD content and mood episode-limited GAD; there is vast co-occurrency. If anxiety and mood disorders were distinctly different, this co-occurrency would represent comorbidity, but otherwise it indicates indistinct overlap and internal inconsistency. Mood reactivity recently showed inconsistency with the other features of major depression.

Treatment corresponds more to mood reactivity than depressive quality of symptoms. Regardless of anxiety or depression diagnosis, reactivity is associated with response to psychotherapy, serotonin enhancing drugs, sedatives such as benzodiazepines, and CNS-active beta-blockers. Likewise, nonreactivity is associated with nonresponse to these but response to tricyclics, ECT, or lithium. MAO-inhibitors and several other agents can affect both groups. A single dose of an acute antianxiety agent, such as a specific sympatholytic agent, is a diagnostic probe of mood reactivity and predictive of treatment response. This is analogous to the edrophonium (Tensilon) test for myasthenia gravis.

No. 12D
THE DIMENSIONAL CONSTRUCT IN PSYCHIATRIC DISORDERS

Stephen B. Shanfield, M.D., *Department of Psychiatry, University of Texas Health Science Center, 7703 Floyd Curl Drive Mail Code 7792, San Antonio, TX 78229-3900*

SUMMARY:

Diagnostic categories serve important functions for our field. They are taxonomic conventions that are justified on the basis of clinical utility. However, their validity as discrete entitles is not clear. There is an overlap of symptoms and syndromes between diagnostic groups as well as normal controls. Moreover, there are no proven biologic markers for the categories. Additionally, treatments are not specific for diagnoses. Also, a particular treatment may be useful for a number of diagnostic categories. Construct validity may not be possible using symptoms alone.

Other ways of organizing behavior involve dimensions or domains that cut across diagnostic categories. A consensus on how to organize these units of behaviors is emerging. They include perception, cognition, mood and anxiety regulation, and impulsive and aggressive regulation. These dimensions are on a continuum with a spectrum from normal to disturbed. In some instances, the dimensions appear

to have a specific course of their own. Some are differentially responsive to various treatments. These dimensions have heuristic value for research into etiology to uncover biological structures and are useful for treatment.

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SYMPOSIUM 13—NEURODEVELOPMENT AND SCHIZOPHRENIA: CLINICAL AND BASIC SCIENCE PERSPECTIVES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand recent evidence supporting disruptions in neurodevelopment as potential etiologic factors in schizophrenia.

No. 13A
IN-UTERO EXPOSURE TO INFECTION AND SCHIZOPHRENIA IN ADULT OFFSPRING

Alan S. Brown, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 2, New York, NY 10032;* Melissa D. Begg, Sc.D., Catherine A. Schaefer, Ph.D., Stefan Gravenstein, M.D., Richard J. Wyatt, M.D., Michaeline Bresnahan, Ph.D., Ezra S. Susser, M.D.

SUMMARY:

Previous studies suggest that in-utero exposure to infectious agents is associated with an increased risk of schizophrenia. We employed the birth cohort of the Prenatal Determinants of Schizophrenia Study to investigate the relationship between prenatal exposure to influenza and schizophrenia risk. Archived maternal serum specimens drawn during pregnancy were analyzed for antibody to influenza. A nested case-control design was used, with 64 cases of schizophrenia and 125 controls matched on date of birth, gender, length of time in the cohort, and availability of maternal sera. Influenza IgG antibody was quantified using the hemaglutination inhibition assay. For influenza exposure in the first trimester, the risk of schizophrenia was increased sevenfold (odds ratio (OR)=7.0, 95% CI=0.7, 75.3, p=.08). For exposure during the first half of gestation, there was a threefold increased risk of schizophrenia (OR=3.0, 95% CI=0.9, 10.1, p=.052). Our data indicate that 14% of schizophrenia cases would not have occurred if influenza exposure during early to mid pregnancy had been prevented. These results provide the first serologic evidence that prenatal exposure to influenza plays a role in the etiology of schizophrenia. Although replication is warranted, these findings suggest that preventing influenza during pregnancy may eliminate a sizable proportion of schizophrenia cases.

No. 13B
PRENATAL VIRAL INFECTION, BRAIN DEVELOPMENT, AND SCHIZOPHRENIA

S. Hossein Fatemi, M.D., *Department of Psychiatry, University of Minnesota, PO Box 14848, Minneapolis, MN 55414-0848;* M. Araghiniknam, Ph.D., Jessica Laurence, B.S., Robert Sidwell, Ph.D., Susanne Lee, Ph.D., Joel Stary, B.S.

SUMMARY:

Schizophrenia is a severe neurodevelopmental disorder with genetic and environmental etiologies. A large body of information points to epidemiological evidence, linking schizophrenic births to prenatal viral infections during the first and second trimesters of pregnancy. We have studied the effects of prenatal human influenza viral infection on day 9 of pregnancy in C57BL 6 mice and their offspring. These studies revealed the deleterious effects of influenza on growing brains of exposed offspring, causing abnormal corticogenesis, pyramidal cell atrophy, and alterations in levels of Reelin, nNOS, SNAP-25, and GFAP. Additionally, exposed animals showed reduction in prepulse inhibition and other abnormal behavior during adulthood. Recently, we used the same infection protocol in the Balb/c mice to determine whether the same pathology would be present in the exposed neonatal and adult mice. Day 9 pregnant Balb/c mice were exposed to sublethal doses of influenza A/NWS/33 (HINI) or vehicle. Pregnant mice were allowed to deliver pups. Whole brains were homogenized and subjected to SDS-PAGE and western blotting and densitometry. The results indicated increased expression of GFAP protein in the exposed brains across all times vs. controls. Levels of GAD65 and GAD67 kDa proteins also increased in all exposed brains. In summary, prenatal human influenza viral infection on day 9 of pregnancy in Balb/c mice leads to upregulation of GFAP and GAD65 & 67 kDa proteins in developing brains of neonatal mice. This work is supportive of previous results in C57BL6 mice and is consistent with the notion that prenatal viral infection may be a potential factor in genesis of brain disorders like schizophrenia.

No. 13C
ADVANCED PATERNAL AGE AND RISK FOR SCHIZOPHRENIA

Dolores Malaspina, M.D., *Department of Psychiatry, Columbia University-NY Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032;* Alan S. Brown, M.D., Ezra S. Susser, M.D., Susan Harlap, M.D., Raymond Goetz, Ph.D.

SUMMARY:

We first demonstrated that schizophrenia risk rises steadily with paternal age. Compared with fathers aged <25, risk is elevated twofold for fathers in their 40s (~1/89) and three-fold for those >50 (~1/47). There are now a half dozen published replications of this association. This relationship could be explained by increased mutations in the sperm of older men, since the human mutation rate for base substitutions increases linearly with paternal age, in large part due to the repeated numbers of cell divisions in the male germ line. Disrupted epigenetic modification (methylation) of the male gamete's DNA might also be responsible for the effect. Another possible explanation for this relationship would be if fathers who carried genetic schizophrenia vulnerability had delayed childbearing. This psychosocial factor cannot explain the risk of schizophrenia from older fathers since paternal age is significantly older in sporadic cases than highly familial schizophrenia cases. The evidence suggests that ~1/4 of schizophrenia cases may have paternal age-related schizophrenia (PARS). If PARS is operationally defined as sporadic schizophrenia with paternal age >35, it reveals a specific pattern of

symptoms, neuropsychological deficits, and physiological findings, further supporting PARS as a particular subtype of schizophrenia.

No. 13D
EARLY GESTATIONAL IRRADIATION IN THE PRIMATE AS A MODEL OF SCHIZOPHRENIA

Lynn D. Selemon, Ph.D., *Department of Neurobiology, Yale University, 333 Cedar Street, Room C303 SHM, New Haven, CT 06510;* John G. Csernansky, M.D., Lei Wang, Ph.D., Patricia S. Goldman-Rakic, Ph.D., Pasko Rakic, M.D.

SUMMARY:

Early gestational exposure to x-irradiation has been used as an experimental tool to disrupt the process of neurogenesis in the primate thalamus. The morphologic consequences of fetal irradiation have been assessed in adult monkeys that were exposed to irradiation either during the period of thalamogenesis (E33-E42) early in gestation (EX) or later in gestation (LX) when thalamogenesis is complete (E70-E82) in comparison to non-irradiated controls (CON). Only EX monkeys, not LX monkeys, had smaller thalamic volumes (> 20%) than CONs. Frontal gray matter volume was only slightly (13%) and non-significantly reduced in EX monkeys, a deficit resembling that previously described in schizophrenic brains. In contrast, frontal gray matter volume was significantly reduced (28%) in LX monkeys compared with CON, a finding consistent with disruption of cortical neurogenesis in late gestation. Both EX and LX monkeys exhibited smaller (>30%) frontal white matter volumes and trend reductions in hippocampal volume (~20%). In a new cohort of EX and CON monkeys, behavioral testing in infancy has revealed that three of four EX monkeys were impaired on the delayed response task, a measure of working memory capacity. These studies suggest that fetal irradiation can reproduce key anatomic and behavioral features of schizophrenia.

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2. Fatemi SH, Araghi-Niknam M, Laurence JA, Stary JM, Sidwell RW, Lee S (2003) Glial fibrillary acidic protein and glutamic acid decarboxylase 65 and 67 kDa proteins are increased in brains of neonatal BALB/c mice following viral infection in utero, Schizophrenia Research. 2003, in press.
3. Malaspina D: Paternal factors and schizophrenia risk: de novo mutations and imprinting. Schizophrenia Bulletin 2001; 27(3):379–393.
4. Schindler MK, Wang L, Selemon LD, Goldman-Rakic PS, Rakic P, Csernansky JG: Abnormalities of thalamic volume and shape detected in fetally irradiated rhesus monkeys with high dimensional brain mapping. Biol Psych 2002; 51: 827–837.

SYMPOSIUM 14—CURRENT CONCEPTS OF THE NEUROBIOLOGY OF THE SELF

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should have an enhanced understanding of the neuroanatomy and neurobiology of the self, and the relationship between self and brain. Participants should be better able to recognize brain pathologies that affect the self, and how the brain-self relationship might impact therapy.

No. 14A
WHAT NEUROPATHOLOGY CAN TEACH US ABOUT THE NEUROBIOLOGY OF THE SELF

Todd E. Feinberg, M.D., *Department of Psychiatry-Neurology, Beth Israel Medical Center, First Avenue at 16th Street, New York, NY 10003*

SUMMARY:

What is the neurobiological basis of the "self"? In order to answer this question, Dr. Feinberg will show videotapes and describe the underlying neurological dysfunction of patients with neurological perturbations of the self:

Asomatognosia is a condition in which the patient rejects an arm on one side of the body. The great majority of asomatognosia patients reject the left arm subsequent to right hemisphere damage.

In the Alien Hand Syndrome ("Dr. Strangelove Syndrome"), the patient's hand performs seemingly purposeful actions beyond their control. The syndrome is often caused by callosal damage and the alien hand, under the control of the right hemisphere, occurs on the left side.

The patient with Capgras for the Mirror Image misidentifies the self in the mirror, while other persons are correctly identified. This syndrome occurs selectively in patients with right hemisphere damage.

In the Phantom Child Syndrome, the patient confabulates the existence of a fictional child that is in fact a metaphorical representation of the patient himself. This syndrome commonly occurs as a result of damage to the frontal lobes, particularly on the right.

Analysis of these cases suggests that many areas of the brain, particularly certain regions of the right hemisphere, make important contributions to the self.

No. 14B
NEUROIMAGING THE SELF

Julian P. Keenan, Ph.D., *Department of Psychology, Montclair State, 219 Dickson Hall, Upper Montclair, NJ 07043*

SUMMARY:

Recent advances in neuroimaging have permitted researchers to investigate more directly the brain correlates of behavior and cognition. The identification of the neural substrates of personal identity has gained attention in the last few years. Beginning with self-face identification, researchers have found that the right hemisphere is particularly engaged in tasks that demand or require positive self-identification. These investigations have employed fMRI, PET, TMS, and rTMS in an attempt to elucidate the correlates of self. In our most recent investigations, we have found that TMS delivered to the right prefrontal cortex disrupts both the understanding of self and other. These data are important in relation to a variety of psychological disorders including schizophrenia, Asperger's syndrome, autism, and dissociative identity disorder. The identification of particular regions in terms of self remains elusive, though a common neural basis may be starting to emerge. These data will be discussed as they relate to psychiatric disorders.

No. 14C
SELF, MEMORY, AND THE BRAIN

Joseph LeDoux, Ph.D., *Department of Psychology, New York University, 4 Washington Place, Room 809, New York, NY 10003-6621*

SUMMARY:

Modern brain science has taught us that all aspects of mental life and behavior depend upon the cells and synapses of the brain. As people, we do not feel like a collection of cells and synapses. But

self-reflection is not a useful way of understanding how the brain works, as only the surface expressions of the brain are visible to the conscious self. While the self is in fact often discussed in terms of consciousness, there is more to the self than meets the mind's eye. One way of approaching the self is through memory, as much of our personality depends on remembering who we are from day to day. Even the genetic aspects of personality must, in some sense, be remembered by the brain. Like the self itself, memory is not the same as conscious memory. There are many different kinds of memory in the brain, some of which function the same in humans and other animals. Study of these different memory systems, and the way they interact, can provide important clues about how the self is remembered.

No. 14D
AFFECT REGULATION, THE RIGHT HEMISPHERE, AND THE SELF

Allan N. Schore, Ph.D., *Department of Psychiatry, UCLA Medical School, 9817 Sylvia Avenue, Northridge, CA 91324*

SUMMARY:

Dr. Schore will present an overview of current neurobiological studies that demonstrate that early social-emotional attachment experiences indelibly influence the development of limbic circuits in the infant brain that endure into adulthood. Research in cognitive and affective neuroscience will be described, which show that for the rest of the lifespan the early developing right hemisphere is centrally involved in appraising trust, fear, aggression, and the sense of the physiological condition of the body, and for the processing of social-emotional information, empathy, self-recognition, and affect regulation. This rapidly expanding body of research suggests that the nonverbal right hemisphere is dominant for the emotional and corporeal self. Other studies indicate that traumatic emotional experience during early phases of life alters the development of these same "emotional" brain circuits, thereby setting the stage for a vulnerability to psychological coping difficulties and disorders of affect regulation in later life. Dr. Schore will also describe how very recent psychoneurobiological conceptions of attachment are now being incorporated into clinical treatment models that impact right brain functions. Developmentally-oriented, emotion-focused psychotherapy that directly accesses and regulates potential brain plasticity offers more powerful treatment models of early forming attachment pathologies and severe personality disorders.

REFERENCES:

1. Feinberg TE: Altered Egos: How the Brain Creates the Self. Oxford, 2001.
2. Keenan JP, Gallup GG, Falk D: The Face in the Mirror: The Search for the Origins of Consciousness. Ecco, 2003.
3. LeDoux J: Synaptic Self. Viking, 2002.
4. Schore AN: Affect Regulation and the Repair of the Self. W.W. Norton, 2003.

SYMPOSIUM 15—THE DEVELOPMENT OF ADAP: THE ADOLESCENT DEPRESSION AWARENESS PROGRAM

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the unique role of depression education in school communities to decrease stigma and promote recognition and treatment of depression.

No. 15A
CURRENT STATUS OF DEPRESSION EDUCATION IN SCHOOLS

Boglarka Szabo, M.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Meyer 3-181, Baltimore, MD 21287-7381;* Todd S. Cox, M.D., Elizabeth A. Kastelic, M.D., Karen L. Swartz, M.D.

SUMMARY:

The need for depression education was highlighted in the Surgeon General's Call to Action to Prevent Suicide in 1999. Depression is a common illness among teenagers. In 1999 the death rate by suicide in 15- to 24-year-olds was 10.3 per 100,000, the third leading cause of death for this age group. The prevalence of depression is approximately 5% in that age group or 5,000 per 100,000. Therefore, the mortality of suicide is a true public health crisis, but the morbidity of depression has a broader impact. The barriers to adequate treatment of depression include stigma and a lack of education, resulting in a failure to recognize the symptoms. The majority of school programs have focused on suicide prevention rather than depression education. In a survey of suicide prevention programs, only 4% of programs adhered to the theory that suicide is usually a consequence of mental illness. This is inconsistent with the finding that approximately 90% of adolescent suicides are associated with a psychiatric disorder. Programs focusing on depression education will be reviewed with emphasis on those that have evaluated their program's effectiveness systematically. The goal of a depression education program should be to *destigmatize* the illness of depression.

No. 15B
DEVELOPMENT OF A MODEL DEPRESSION EDUCATION CURRICULUM

Karen L. Swartz, M.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Meyer 3-181, Baltimore, MD 21287-7381;* Todd S. Cox, M.D., Elizabeth A. Kastelic, M.D., Sallie Mink, B.S.N., Sally G. Hess, B.S.N., Lizza C. Gonzales, B.A., Boglarka Szabo, M.D.

SUMMARY:

The Adolescent Depression Awareness Program (ADAP) is a school-based curriculum to educate high school students, teachers, and parents about teenage depression. Over four years the curriculum has been systematically developed with revisions based upon objective assessments. Over 5,000 students in 28 schools have participated. The majority of students are from a large public district in Maryland, but public, private, and parochial schools from three states and Washington, D.C., are represented. Program development involved a series of comparisons of alternative methods. The effectiveness of each method was tested using pre-test and post-test data gathered from the students. First, a full curriculum with multiple sessions was compared with a limited curriculum with a single one-hour session. Assembly and classroom settings were then compared. Students in the full curriculum performed statistically better as did students in classroom settings. During the program's third year, the curriculum was integrated into health classes in a large public school district.

ADAP data have identified key elements for a depression education curriculum in high schools—multiple sessions in health classes using multiple teaching modalities. The curriculum reinforces that depression is a treatable medical illness. Additionally, parent and faculty education is critical for destigmatizing depression and facilitating referrals.

No. 15C
CREATION OF SUPPLEMENTAL LEARNING TOOLS FOR DEPRESSION EDUCATION

Sallie Mink, B.S.N., *600 North Wolfe Street, M3181, Baltimore, MD 21287-7381;* Elizabeth A. Kastelic, M.D., Todd S. Cox, M.D., Sally G. Hess, B.S.N., Lizza C. Gonzales, B.A., Sandra Durfee, M.L.A., Karen L. Swartz, M.D.

SUMMARY:

In the development of any school-based education program, the use of multiple teaching modalities is a necessity. High school students of the twenty-first century not only benefit from but also expect to be entertained while they learn. Utilizing tools in the process of teaching not only assists in cultivating student interest but also serves to reinforce content and generate a more dynamic exchange between student and teacher. Modern teachers have successfully integrated group activities and projects, role-playing, audiovisual aides, and technology with the traditional lecture format.

The Adolescent Depression Awareness Program (ADAP) has successfully incorporated multiple teaching modalities into its curriculum. The process of this curriculum development has been guided not only by the project team but also by teacher, parent, and teenage focus groups as well as by written anonymous feedback by students.

The three-hour student curriculum now includes major supplemental tools to assist in relaying the message that depression is a common, treatable medical illness. These tools include the Depression and Related Affective Disorders (DRADA) video Day for Night: Recognizing Teenage Depression and book 100 Common Questions About Teenage Depression, the ADAP interactive video Psychiatry 101: Psychiatry One-on-One, a "color activity" that involves role-playing.

No. 15D
EVALUATION OF THE ADAP TEENAGE DEPRESSION CURRICULUM

Todd S. Cox, M.D., *Department of Psychiatry, Georgetown University, 1133 Connecticut Avenue NW, Suite 750, Washington, DC 20036;* Elizabeth A. Kastelic, M.D., Karen L. Swartz, M.D.

SUMMARY:

During the past four years, the Adolescent Depression Awareness Program (ADAP) has developed and administered a school-based educational program on teenage depression. ADAP has continuously evaluated the efficacy of the curriculum. The evaluation process has taken on three forms—focus groups, anonymous written feedback, and pre- and post-testing of the students enrolled in the curriculum.

The assessment tool consists of multiple objective questions that ascertain the students' knowledge of and attitudes about mood disorder prevalence, symptoms, comorbidity, and treatment. The pre- and post-test format allows the students to serve as their own controls with the curriculum as the intervention. Through the four years, the assessment tool has been refined to allow for more discrimination of the evolving curriculum's efficacy.

The evaluation process has helped to guide curriculum length, administration, and content. Comparison of pre- and post-test results of students in a three-hour ("full") curriculum and others in a one-hour ("limited") curriculum revealed statistically significant differences in learning between the groups. Similarly, those students who participated in a classroom-based program learned more than those in an assembly style. Finally, the curriculum has been successful in producing statistically significant improvement in factual knowledge of mood disorders in each year of its administration.

No. 15E
CHANGE IN ADOLESCENT ATTITUDES ABOUT DEPRESSION TREATMENT

Elizabeth A. Kastelic, M.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Meyer 3-181, Baltimore, MD 21287-7381;* Sally G. Hess, B.S.N., Lizza C. Gonzales, B.A., Todd S. Cox, M.D., Karen L. Swartz, M.D.

SUMMARY:

The Adolescent Depression Awareness Program (ADAP) curriculum addresses not only knowledge about depression, but also attitudes about treatment. An observational study of depressed 14- to 16-year-olds found at follow-up increased risks for anxiety disorders, nicotine dependence, alcohol abuse, suicide attempts, educational underachievement, unemployment, and early parenthood, underscoring the importance of early intervention. To address the stigma associated with treatment, the curriculum reviews the symptoms of depression and the process of medical thinking comparing depression with other medical conditions. The ADAP curriculum stresses that suicidal ideation is a serious symptom of depression requiring immediate evaluation.

To test the effectiveness of the curriculum in changing teenagers' attitudes, pre-test and post-test responses to questions addressing help-seeking behavior and perceived treatment barriers are compared. The curriculum resulted in a statistically significant decrease in the percentage of teenagers identifying embarrassment or stigma issues as their response to "What would stop you or make it difficult for you to get help for yourself or a friend?" Following the ADAP curriculum, there is also a statistically significant increase in the percentage of students who would "tell someone" if a friend said he or she was depressed and asked the student to keep it a secret.

No. 15F
TRAINING OF ADAP EDUCATORS: BRINGING THE CURRICULUM TO SCHOOLS

Sally G. Hess, B.S.N., *Department of Psychiatry, Johns Hopkins University, 600 North Worfe Street, Meyer 3-181, Baltimore, MD 21287-7381;* Todd S. Cox, M.D., Elizabeth A. Kastelic, M.D., Sallie Mink, B.S.N., Lizza C. Gonzales, B.A., Boglarka Szabo, M.D., Karen L. Swartz, M.D.

SUMMARY:

The Adolescent Depression Awareness Program (ADAP) has developed a curriculum to teach school communities about teenage depression. During its four years, only psychiatrists or psychiatric nurses have taught the curriculum; this consistency has been essential in development, assessment, and refinement of curriculum content. However, in order to extend the reach of the curriculum and incorporate it into the education community, expansion of the instructor base is required.

The current phase of ADAP includes the development of a training program for future ADAP educators. Training programs have been established for other medical/mental health professionals including psychologists, social workers, occupational therapists, psychiatry residents, medical students, and nursing students. The training of members of state psychiatric societies would allow outreach with local schools in a community service model. Additionally, the training of teachers, school counselors, and administrators allows for the eventual export of the curriculum from medical professionals to those within the school communities.

The training program contains four components: reviewing a training manual, attending an interactive session with current ADAP instructors, viewing a live or video-recorded student session, and teaching the curriculum while accompanied and assessed by a current

ADAP instructor. The development and assessment of the training program will be discussed.

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1. Garland A, Shaffer D, Whittle B: A national survey of school-based, adolescent suicide prevention programs. J Am Acad Child Adolesc Psychiatry 1989; 28:931–934.
2. Shaffer D, Craft L: Methods of adolescent suicide prevention. J Clin Psychiatry 1999; 60(suppl 2):70–74.
3. Fergusson DM, Woodward LJ: Mental Health, Education, and Social Role Outcomes of Adolescents With Depression. Arch Gen Psychiatry 2002; 59:225–231.

SYMPOSIUM 16—THE DEATH PENALTY: LAW AND MEDICAL ETHICS IN THE FACE OF NEW COURT OPINIONS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize the ethical dilemmas facing psychiatrists who become involved in death penalty work.

No. 16A
CAPITAL PUNISHMENT AND AMERICAN EXCEPTIONALISM

Carol Steiker, J.D., *Harvard Law School, 1525 Massachusetts Avenue, Cambridge, MA 02138*

SUMMARY:

The U.S. Supreme Court has recently taken some unprecedented steps to limit the constitutional use of capital punishment. Yet despite these winds of a change blowing in a venue traditionally hostile to claims of criminal defendants, the continued practice of capital punishment in America remains robust. Thirty-eight states and the federal government continue to maintain the death penalty, with one to two executions a week and close to 4,000 inmates on death row. Indeed, the past 30 years have witnessed a sharp upward trajectory from the trickle of executions that slowed to a stop briefly in the 1960s and early 1970s.

Those same 30 years have seen the abolition of capital punishment in the rest of the Western industrialized world. Indeed, the countries that, like the United States, continue to embrace the death penalty, are the countries with which we have the least in common, and tend to be ones that are among the worst human rights abusers in the world.

Why is it that the United States stands so alone with respect to capital punishment? I will explore some of the most commonly offered answers and put forth some thoughts of my own to explain this dramatic example of "American exceptionalism."

No. 16B
HUMAN RIGHTS AND MEDICAL ETHICS: THE AMERICAN CONFLICT

Alan A. Stone, M.D., *Harvard University Law School, 1575 Massachusetts Avenue, Hauser Hall, #400, Cambridge, MA 02138-2996*

SUMMARY:

The U.S., unlike most nations of the world, has not abolished capital punishment. The Supreme Court recently declared it unconstitutional to execute the mentally retarded (2002). Earlier, the Court had ruled that capital punishment was unconstitutional if the person was mentally incompetent to be executed (1986). With these constitutional rulings in place, a psychiatric assessment that leads to a diagnosis of mental retardation or a finding of incompetency to be executed can literally be life saving. Various international organizations have declared capital punishment a violation of human rights. The WPA in its 1996 Declaration of Madrid on Ethical Standards for Psychiatrists adopted a guideline containing a prohibition against psychiatrists participating "in assessments of competency to be executed." The AMA and APA do not prohibit psychiatric assessments of the mental competency of death row inmates. Indeed one might suggest that in light of the Supreme Court decisions on capital punishment American psychiatrists should be encouraged to participate in such assessments. The WPA guideline draws on a doctrine of universal human rights but it has no basis in traditional medical ethics. The presentation will discuss why American psychiatrists, even if they are unalterably opposed to capital punishment, should reject the WPA guideline.

No. 16C
MENTAL DISABILITIES AND THE DEATH PENALTY: EVALUATIONS AND LEGAL PROTECTIONS AFTER ATKINS VERSUS VIRGINIA

James W. Ellis, J.D., *School of Law, University of New Mexico, 1117 Standford NE, Albuquerque, NM 87131*

SUMMARY:

The Atkins decision is relevant to psychiatrists in several respects. Some elements of the decision invite comparison with (and perhaps extension to) other mental disabilities, most notably severe mental illness. But other elements currently lack a mental illness analogue. The paper will explore the possible implications for defendants with such other diagnoses. Also, the early experience in implementing Atkins reveals practical considerations for clinicians presenting evaluations and testimony in death penalty cases.

No. 16D
COMPETENCY TO BE EXECUTED AND FORCED MEDICATION: SINGLETON VERSUS NORRIS, ETHICAL CONSIDERATIONS

Howard V. Zonana, M.D., *Department of Law and Psychiatry, Connecticut Mental Health Center, 34 Park Street, New Haven, CT 06519-1187*

SUMMARY:

Singleton v. Norris is a decision by the Eighth Circuit Court of Appeals stating that forced psychotropic medication can be continued after the date of execution is set if the medication had been given previously to prevent the inmate from being dangerous in the prison setting under a Harper type review. The defendant had argued that after the date of execution was set it was no longer in his medical interests to continue the medication. In the decision, the majority held that the fact that an execution is in the offing does not alter the medical interests for which the medication has been prescribed and physicians should just continue to treat the medical condition. This may raise ethical problems for physicians in such settings as they may be in violation of the AMA Code of Ethics if the original override is dubious.

No. 16E
DIAGNOSIS OF DIMINISHED RESPONSIBILITY AND THE DEATH PENALTY: IMPLICATIONS OF ATKINS VERSUS VIRGINIA

Richard Bonnie, J.D., *University of Virginia School of Law, 580 Massie Road, Charlottesville, VA 22901;*

SUMMARY:

In Atkins v. Virginia, the United States Supreme Court ruled that the Eighth Amendment forbids execution of persons with mental retardation, and probably requires states to preclude death sentences for defendants who are found by a judge or jury to be mentally retarded. What implications, if any, does this ruling have for defendants with other abnormal mental conditions? In particular, does it cover other developmental disorders? Does it cover intellectual deficits attributable to trauma or disease? Alternatively, does it require the states to preclude death sentences for defendants who were mentally ill at the time of the crime, or who were experiencing deficits bearing on diminished responsibility? Whether the Atkins decision reaches beyond mental retardation may depend on the rationale for the decision. This paper will explore the moral and legal grounding of Atkins v. Virginia.

REFERENCES:

1. Steiker CS: Capital punishment and American exceptionalism, 81 Oregon Law Review 97, 2002.
2. Stone AA: Forensic ethics and capital punishment: is there a special problem? Journal of Forensic Psychiatry 2002; 13(3):487–493.
3. Atkins v. Virginia, 122 S. Ct. 2242, U.S. Supreme Court, 2002.
4. Singleton V. Norris, 319 F.3d 1018 (8th Cir. 2003).
5. Atkins v. Virginia 122 S, Ct. 2242, 2002.

SYMPOSIUM 17—THE SCIENTIFIC BASIS OF EXPERT TESTIMONY: ITS APPLICATION TO MATRIMONIAL DISPUTES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the challenges he/she will face as an expert testifying in custody, visitation, or relocation disputes. He/she will know what "science" is available and what to expect from the cross-examining attorney and the judge.

No. 17A
PSYCHIATRIC TESTIMONY: SCIENCE OR WIZARDRY?

Alex Weintrob, M.D., *12 West 96th Street, #1D, New York, NY 10025-6509*

SUMMARY:

Increasingly the psychiatrist testifying in custody, visitation, and relocation disputes is being challenged to demonstrate whether there is any "scientific" basis to his findings. This presentation will address a number of issues related to expert testimony in custody, visitation, and relocation disputes. Emphasis will be on the "science" the mental health professional can begin to rely upon in addressing the following issues: (1) who should be qualified to testify; (2) the research that is available upon which one can count or take with reservations; (3) briefly, use of psychological testing; (4) evaluation of a child or adolescent's stated preference, using a biopsychosocial approach; (5) overnight visitation of the infant or young child, from a biopsychosocial viewpoint; (6) making recommendations regarding relocation better informed than an educated guess; (7) using temperament and fit; (8) the validity and acceptability of syndromes, such as Parent Alienation; (9) is there "science" in predictability issues? (10) perils and pitfalls of quoting literature. Finally, some strategies will be offered regarding testifying, including addressing attorney's "trick" questions, attacks upon one's credibility, how to assess how you're doing, and issues of disclosure (e.g., past associations with attorneys or judge, one's own marital status, etc.)

No. 17B
THE USES AND MISUSES OF PSYCHOLOGICAL TESTS IN CHILD-CUSTODY EVALUATIONS

Paul Hymowitz, Ph.D., *836 President Street, Brooklyn, NY 11215*

SUMMARY:

The continuing reliance on psychological test data by child custody evaluators is being increasingly challenged by legal experts following several U.S. Supreme Court decisions regarding the admissibility of expert testimony more generally. This scrutiny affords an opportunity not only to review the scientific basis for such tests, but also to consider their use and misuse in the context of custody evaluators. Above all, the tests must be integrated with other empirical data and not used in isolation. They can be useful where significant parental psychopathology is suspected, or when the individual's personality traits (or full-blown disorder) can be delineated, especially as it impacts upon parental functioning. However, testing should not supercede the final judgment of the evaluator whose job it is to integrate multiple sources of data. When the tests are promoted as direct reflections of behavior rather than hypothetical information requiring further clinical investigation, misleading conclusions can be drawn. Clinical vignettes, illustrating both positive and negative instances of test data, will be provided.

No. 17C
THE EXPECTATION FOR EVIDENCE-BASED TESTIMONY UNDER DAUBERT

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

SUMMARY:

As of the 1993 Daubert v. Merrell Dow Supreme Court decision, there has been a heightened expectation that expert witnesses present evidence-based testimony that is both relevant and reliable. No longer is it acceptable for the expert to simply opine on his or her theories of what happened to a plaintiff and what impact there was. Dr. Schetky will review requirements for expert testimony under the Federal Rules of Evidence and the Daubert v. Merrell Dow decision. Some subsequent rulings from state courts regarding testimony under Daubert will be reviewed. She will share her own experiences in being cross-examined under Daubert, as well as Daubert challenges to opposing experts.

No. 17D
AN ATTORNEY'S APPROACH TO CROSS-EXAMINATION OF AN EXPERT IN A CUSTODY DISPUTE

Harold A. Mayers, *292 Madison Avenue, New York, NY 10017*

SUMMARY:

In recent years, when confronted with competing claims for custody or the right of a party to relocate with the child(ren) to a distant location, courts have resorted to the use of "neutral" court-appointed experts, generally psychologists or psychiatrists, to provide guidance in making these difficult decisions. Oftentimes these experts are asked to make recommendations and to perform psychological testing of the litigants.

The trend of appointments of "neutrals" is rapidly growing as the courts attempt to both avoid the battle of competing experts retained by opposing litigants and limit over-exposure of young children to involvement with "experts". Notwithstanding these at-

tempts by the courts to streamline custody disputes, custody trials, even with the use of "neutrals" remain a fertile area for imaginative trial attorneys to ply their trade.

For example, matrimonial attorneys will frequently retain their own experts to do a "peer review" of the court-appointed "neutral". In addition, courts differ on whether forensic notes and raw data from administered tests are available to counsel prior to trial for review by their own experts. These materials are generally available when an expert testifies.

No. 17E
THE COURT'S ROLE REGARDING EXPERT TESTIMONY IN CHILD-CUSTODY PROCEEDINGS

Anthony Marano, J.D., *Matrimonial Department, Supreme Court, 400 County Seat Drive, Mineola, NY 11501*

SUMMARY:

I will provide an overview of the many factors the court must consider in determining custody, visitation, and relocation disputes between competing parents.

I will discuss the reasons a court may want to appoint a psychiatrist to undertake a forensic investigative evaluation and render a report.

I will discuss the Frye and Daubert standards of admitting expert testimony and to what extent they are utilized to preclude and/or permit expert testimony in custody proceedings.

REFERENCES:

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3. Gutheil TG, Stein MD: Daubert-based gatekeeping and psychiatric/psychological testimony in court: review and proposal. Journal of Psychiatry & Law 2000; 28:235–251.
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SYMPOSIUM 18—EVOLUTIONARY AND ETHOLOGICAL PERSPECTIVES ON SOCIAL ANXIETY DISORDER

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand application of evolutionary concepts to social anxiety disorder and the study of submissive behavior in humans and animals.

No. 18A
WHAT SOCIAL PHOBIA REVEALS ABOUT OUR EVOLVED HUMAN NATURE AND VICE VERSA

Randolph M. Nesse, M.D., *Department of Psychiatry, University of Michigan, 426 Thompson Street, Room 5261, Ann Arbor, MI 48104;* James L. Abelson, M.D.

SUMMARY:

An evolutionary approach to social phobia seeks to explain why natural selection has left us vulnerable to it and why such a high proportion of the population has symptoms. Social phobia appears to be a dysregulated form of a useful emotion, in which case the crucial questions are how the capacity for normal social anxiety gives a selective advantage, and why it is so prone to excessive expression. A review of data from several hundred cases shows substantial variation in focus of fear, ranging from discomfort with any social attention to more specific discomfort (e.g., with authority figures). There is also substantial phenomenological variation, possibly because selection has shaped subtypes of social anxiety to deal with different social dangers, or because different experiences influence a single adaptive. Why so many individuals now approach the threshold for clinical social anxiety is unclear. Possible explanations include the low costs of false alarms in this system, differences between the ancestral and modern environments, and the frequency of exposure to aversive learning. Genetic variation in vulnerability may represent discrete pathology, but may also reflect the wide range selection leaves around an optimal mean, especially when different payoffs are associated with different social niches.

No. 18B
GENE-ENVIRONMENT INTERACTIONS AND THE DEVELOPMENT OF FEARFULNESS IN MONKEYS

Stephen J. Suomi, Ph.D., *Department of Comparative Ethology, NICHD/NIH, DHHS, 6705 Rockledge Drive, Suite 8030, Bethesda, MD 20892-7971*

SUMMARY:

Recent research has indicated that approximately 20% of rhesus monkeys growing up in naturalistic settings consistently display unusually fearful and anxious-like behavioral and physiological reactions to novel and mildly stressful social situations throughout development. These characteristic patterns of biobehavioral response to stress appear early in life and are remarkably stable from infancy to adulthood. Both genetic and nongenetic mechanisms are implicated, not only in the expression of these distinctive response patterns but also in their transmission across successive generations of monkeys. Although certain components of these patterns appear to be highly heritable, they are also clearly subject to major modification by specific early experiences, particularly those involving social attachment relationships. For example, a specific polymorphism in the serotonin transporter gene (5-HTT) is associated with deficits in neonatal state control and visual orienting in infancy, heightened ACTH response to social separation during the juvenile years, and both diminished serotonin metabolism and excessive alcohol consumption among monkeys who experienced insecure early attachments but not in monkeys who developed secure attachment relationships with their mothers during infancy (maternal buffering).

No. 18C
SUBORDINATE STATUS, SOCIAL ANXIETY DISORDER, AND DOPAMINE FUNCTION

Franklin R. Schneier, M.D., *Department of Therapeutics, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 69, New York, NY 10032;* Richard G. Heimberg, Ph.D., Marc Laruelle, M.D., Michael R. Liebowitz, M.D.

SUMMARY:

Objective: Evolutionary theorists have proposed social anxiety disorder to be related to subordinate social status and submissive behavior, but this has not been studied empirically. CNS dopamine system function has been associated with both social anxiety disorder in humans and social status in animals. The purpose of this study was to assess submissive behavior and social rank in social anxiety disorder, and to explore the association of these characteristics with measures of CNS dopamine function.

Method: Outpatients with generalized social anxiety disorder and matched non-anxious subjects were assessed with the self-rated Submissive Behavior Scale and the Social Comparison Rating Scale, measures of social anxiety, depression, and impairment; and PET

measures of dopamine D2 receptor availability and a SPECT measure of dopamine transporter availability.

Results: Patients reported more submissive behavior and lower social rank than comparison group subjects. Psychometric properties of these scales will be reported, and the association of submissive behavior and perceived rank with dopamine receptor measures will be explored.

Conclusions: Self-rated submissive behavior and subordinate social status are associated with generalized social anxiety disorder and deserve further study as measures that may be more proximally related to biological correlates of generalized social anxiety.

Supported by NIMH 5K02MH064842-02 and the Sycamore Foundation.

No. 18D
EYE CONTACT AS A THREAT IN SOCIAL ANXIETY DISORDER

Justine M. Kent, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 41, New York, NY 10032*

SUMMARY:

Central to the pathology of social anxiety disorder (SAD) is an extreme degree of discomfort with being observed or scrutinized, which is perceived through interpretation of facial expression and eye gaze. As examples of the many systems involved in social cueing, facial expression and eye gaze are of critical relevance in social interaction, and of particular interest in SAD, given patients' tendencies to demonstrate a negative bias when interpreting social cues and to avoid direct eye contact. The avoidance of eye contact and discomfort with direct gaze, which are characteristic of SAD, hinder appropriate social interactions with others. One potential explanation for poor eye contact in SAD is that heightened connectivity between the core visual system for processing eye gaze and the amygdala-based fear neurocircuitry results in fearful responding and avoidant behavior despite a lack of threatening or fearful emotional content. Clarifying the neuroanatomy of social cue processing through neuroimaging techniques may aid in reconciling cognitive models of SAD suggesting heightened attention to negative social cues and clinical observations suggesting avoidance of eye contact and failure to fully process emotional content in social cues. Results of recent neuroimaging studies investigating the neurocircuitry of SAD will be discussed.

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3. Allan S, Gilbert P: A social comparison scale: psychometric properties and relationship to psychopathology. Person Indiv Diff 1995; 3:293–299.
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SYMPOSIUM 19—BEYOND B12: AN UPDATE ON NUTRITION AND PSYCHIATRY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) understand the potential role of nutrition on mental health over century; (2) recognize the potential role of nutritional supplements in treating and preventing mental illness; (3) describe the strengths and limitations of current data on the nutritional supplements presented.

No. 19A
NUTRITION AND PSYCHIATRY: A HISTORICAL PERSPECTIVE

Kathryn M. Connor, M.D., *Department of Psychiatry, Duke University, Box 3812 DUNC, Durham, NC 27710*

SUMMARY:

The role of nutrition in health and disease is widely accepted in medicine, particularly in cardiovascular disease and diabetes. Supported by a wealth of scientific data, the importance of diet in disease etiology and treatment is now considered mainstream. Similar theories have been proposed for mental disorders since the 1950s. However, these opinions have not been widely held and, at times, have been viewed with great skepticism due to a lack of rigorous scientific evidence. At the same time, patient attitudes toward medicine have changed, whereby consumers are actively seeking alternatives to care provided by conventional medicine and eagerly taking nutritional supplements, as demonstrated by epidemiologic data from the National Health and Nutrition Examination Survey and the growing multibillion-dollar supplement industry. In this presentation, we will (1) review developments that have influenced dietary patterns and other environmental influences over the last century and their possible impact mental health/illness and (2) examine the investigation of the interface between nutrition and mental health/illnesses.

No. 19B
OMEGA-3 ESSENTIAL FATTY ACIDS, AND PSYCHIATRIC DISORDERS

Jerry M. Cott, Ph.D., *Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857*

SUMMARY:

The recent death of David Horrobin due to mantle cell lymphoma was a loss to the relatively small field of research regarding the role of essential fatty acids (EFAs) in psychiatry and neurology. In addition to mental health, EFAs abnormalities encompass many diverse pathological conditions of importance to public health, including heart disease, neurodegenerative disorders, diabetes, and chronic inflammatory conditions. Horrobin referred to the psychiatric and neurologic illnesses associated with deficiencies in essential fatty acids as phospholipid spectrum disorders. Evidence for this phospholipid hypothesis was initially based on observations by several groups of reduced EFA concentrations in the membranes of RBCs and other tissues from patients with schizophrenia and major depression. Subsequent controlled trials suggest significant therapeutic effects in mental disorders including schizophrenia, major depression, bipolar disorder, and borderline personality disorder. Of central importance for future trials is to determine the relative contribution of the two major omega-3 fatty acids, docosahexaenoic acid (DHA) and eicosapentaenoic acid (EPA). These fatty acids appear to have different behavioral properties—EPA being more stimulating and DHA more calming. It is unclear whether the conversion of EPA and not DHA to the series 3 eicosanoids is critical for their differences.

No. 19C
SAME, FOLATE, AND B12: ONE-CARBON METABOLISM AND DEPRESSION

Jonathan E. Alpert, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA*

02114; David Mischoulon, M.D., George I. Papakostas, M.D., Timothy J. Petersen, Ph.D., John J. Worthington III, M.D., Andrew A. Nierenberg, M.D., Maurizio Fava, M.D.

SUMMARY:

The B vitamins, folate and B12, participate in the one carbon metabolic pathway that produces S-adenosyl-methionine (SAMe), the major methyl donor in the central nervous system. Endogenous SAMe plays an integral role in a large number of methylation reactions necessary for neurotransmitter metabolism and membrane fluidity. Nearly four decades of gradually accruing data suggest that low folate, and perhaps B12, may increase risk for depressive disorders, antidepressant treatment resistance, and/or depressive relapse. Similarly, some preliminary studies indicate increased risk of depression or treatment resistance due to a common polymorphism of the MTHFR gene (C677T), responsible for the enzyme that normally converts folate to its active form. Both low folate and some depressive states may, in turn, be associated with lower levels of SAMe in the CNS. Reciprocally, recent treatment studies involving augmentation of standard, contemporary antidepressants with folic or folimic acid or SAMe, have shown enhancement of antidepressant benefit for some patients. Meta-analyses have also supported the safety and efficacy of oral or parenteral SAMe as monotherapy for depression, though comparative data with newer antidepressants are still lacking. This talk will focus upon the strengths, limitations, and implications for treatment of emerging data on one carbon metabolism and depressive disorders.

No. 19D
PSYCHIATRIC APPLICATIONS OF CHROMIUM

Jonathan R.T. Davidson,, M.D., *Department of Psychiatry, Duke University Medical Center South, Trent Drive, Room 4082—Yellow Zone, Durham, NC 27710*

SUMMARY:

Chromium is known to produce serotonergic effects, may have stress-modulating properties, and increases the effect of insulin. It would not, therefore be surprising if chromium were to have psychoactive properties. McLeod reported antidepressant effects of chromium in outpatients with dysthymia and treatment-resistant depression, observations which were confirmed in a double-blind pilot study of chromium picolinate and placebo in atypical depression. Other applications of chromium (under study) include premenstrual dysphoric disorder and schizophrenia. Further potential applications could include its use in anxiety, reversal of olanzapine-induced weight gain, and depression comorbid with diabetes. Results of completed studies will be presented in depression, PMDD, and set in context of the known $5HT_{2A}$ downregulating effect of chromium. The side-effect profile will be described.

No. 19E
GLYCONUTRITIONALS: REVIEW AND RELEVANCE TO PSYCHIATRY

Marian I. Butterfield, M.D., *Department of Psychiatry, Durham VA/ Duke University, 508 Fulton Street, Suite 116A, Durham, NC 27705*

SUMMARY:

This presentation will provide an overview of the science of sugars, called glycoscience, and a discussion of potential applications to psychiatry. The role of carbohydrates, more specifically monosaccharide sugars, in cellular functions that relate to health and disease, is being evaluated. For years medical and nutrition students alike were taught that sugars are metabolically synthesized from dietary glucose. However, this theory has been recently challenged by the observation that various monosacharides can be directly absorbed in the gut, perhaps more efficiently than glucose. Of over 200 plant sugars, at least eight essential sugars are involved in human synthesis of two classes of glycoconjugated molecules: glycoproteins and glycolipids. These molecules play important roles in immunity and cell-cell communication. The essential sugars used in glycoconjugates synthesis are mannose, galactose, xylose, fucose, nacteylglucosamine, sialic acid, n-acetylglucosamine, and n-acetylgalactosamine. These sugars can all be readily absorbed and directly incorporated into glycoproteins and glycolipids. These glycoconjugated sugars are biologically active and may have treatment implications in medical illnesses such as cancer and arthritis, as well as psychiatric disorders and stress-related illnesses such as PTSD. Pilot research also suggests glyconutrients may have a role in ADHD treatment. The relevance of research in the field of glycoscience as it pertains to new generations of drug therapies will also be discussed.

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2. Horrobin DF: The membrane phospholipid hypothesis as a biochemical basis for the neurodevelopmental concept of schizophrenia. Schizophr Res 1998; 30(3):193–208.
3. Alpert JE, Mischoulon D: One-carbon metabolism and the treatment of depression: roles of S-adenosyl-methionine and folate, in Natural Medications for Psychiatric Disorders: Considering the Alternatives. Edited by Mischoulon D, Rosenbaum JF. Phila, Lippincott, Williams and Wilkins, 2002, pp 43–61.
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5. Maeder T: Sweet medicines. Scientific American 2002; 42–47.

SYMPOSIUM 20—TELLING STORIES: THE PSYCHIATRIST AS NOVELIST

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify a variety of issues, both philosophical and practical, that concern the psychiatrist/novelist with respect to interplay of practicing psychiatry and publishing fiction.

No. 20A
TWO VIEWS OF HUMAN NATURE: DEPTH PERCEPTION OR DIPLOPIA?

Roderick J. Anscombe, M.D., *31 Eastern Point Road, Gloucester, MA 01930-4134*

SUMMARY:

The presentation contrasts the psychiatrist's perspective of human nature with that of the novelist's. While the psychiatrist is well-versed in dispelling mystification, is privy to many secrets and stories, and is accustomed to persisting in the face of rejection and disappointment, he is also handicapped by his training and experience. The precision that the psychiatrist aims at in his writing is a handicap for the story teller. In addition, psychiatrists tend to believe in the efficacy of words over action, the primacy of affective states in determining action, and the concept of normalcy, whereas the novelist subscribes to the primacy of free will, of responsibility, and the instantaneous moment of truth in determining a person's fate.

No. 20B
TAMING DEMONS: THE NOVEL AS A WAY OF WORKING THROUGH TRAUMA

Alvin A. Rosenfeld, M.D., *54 Canfield Drive, Stamford, CT 06902-1325*

SUMMARY:

Psychiatrists have intense relationships with patients; few have actually translated that closeness into novels. Fiction gives the psychiatrist freedom to express valuable, scientifically unproven, ideas freely. After years spent researching child abuse and issues of trauma, loss, rage, and recovery, and reporting on them in professional journals, the author felt that deeper emotional and interpersonal issues needed exploration.

The resultant novel's central character, Hyman Schwartz, is a Holocaust survivor so traumatized by losing his wife and son that he banishes fecling and becomes an accountant to whom only numbers matter. Ten years later, a young accountant in the office forces Hyman to teach him accounting. Their relationship becomes akin to psychotherapy, its details drawn closely from the process of recovery we psychiatrists see in practice.

The author's experience as a therapist who worked with patients, slowly peeling back layers of defense, led to a writing process that worked in reverse; layers of meaning were woven into every written image, creating a narrative that the reader could decode and see through to its core, hopefully finding a meaning of their own and thereby become partners in the creative—and therapeutic—process.

No. 20C
THE NOVEL AS GRIST FOR THE MILL: WHOSE PSYCHOTHERAPY IS IT ANYWAY?

Paul A. Buttenwieser, M.D., *200 Marsh Street, Belmont, MA 02478-2133*

SUMMARY:

The publication of a therapist's novel can represent a significant intrusion into a patient's therapy. The event itself is comparable to the birth of a sibling, easily seen as more valued. The content of the novel confronts the patient with an almost inexhaustible amount of information, making the therapist less available as a neutral object for projection and transference. Publication of a novel brings the therapist's ambition, his narcissism, and his exhibitionism out of the realm of the patient's unprovoked fantasy and makes it more salient. Writing is a subtle form of exhibitionism, the writer staying ostensibly out of sight while at the same time revealing a great deal about himself in the themes, the narrative, and the characters. The novel gives the patient a window onto the therapist's fantasy life. All of this gives the therapist a licence to make himself the center of attention, always a difficult temptation to resist. Especially difficult for a proud author is to allow the patient to read the novel as though it were about himself—which every reader does with everything he reads—thereby shifting the focus back from the therapist to the patient.

No. 20D
EMPATHY AND THE MYSTERY NOVEL: GETTING TO THE TRUTH

Keith R. Ablow, M.D., *12 49th Street, Newbury, MA 01951-1412*

SUMMARY:

Writing a mystery and treating a patient involve similar uses of empathy and insight. Constructing a storyline that is healing to a client is intellectually akin to fashioning a novel that is satisfying to a reader. For this reason, any competent psychotherapist can become a competent novelist.

No. 20E
NARRATIVE TRUTHS: FICTION AND NONFICTION

Peter D. Kramer, M.D., *Department of Psychiatry, Brown University, 196 Waterman Street, Providence, RI 02906*

SUMMARY:

For the psychiatrist interested in discussing controversial issues in mental health, fiction—and non-fiction—writing present distinctive challenges and opportunities. Nonfiction allows for direct, didactic communication; fiction calls for indirect evolution of moral complexities. Using examples from his own work, and that of other writers, the speaker will contrast the strengths and limitations of the two genres.

No. 20F
FROM THE LAPTOP TO THE BOOKSTORE: ON GETTING YOUR CREATIVE WRITING PUBLISHED

David J. Hellerstein, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 101, New York, NY 10032*

SUMMARY:

In recent years, there has been a dramatic growth of the medical humanities in the United States. One aspect of this is the increasing number of physician writers from all specialties, including surgeons (Atul Gawande), pediatricians (Perri Klass), medical specialists (Abraham Verghese), neurologists (Oliver Sacks), and researchers (Lewis Thomas). There are also many psychiatrist writers. Psychiatrist authors most commonly write in nonfiction genres, including essays, memoirs and biography. A number of psychiatrists have published fiction as well, including Samuel Shem, Peter Kramer, Roderick Anscombe, and Avodah Offit, and it is likely that many more psychiatrists who write fiction have not yet had their work published in book form. This presentation will discuss potential pathways and pitfalls related to seeking publication of creative writing. Focusing first on the importance of making one's work publishable, an often-neglected step, the presentation will then describe specific strategies for seeking publication in various media, including literary journals, magazines, newspapers, and books.

REFERENCES:

1. Anscombe R: Shank, New York, Hyperion, 1996.
2. Rosenfeld A: A Dissenter in the House of God. St. Martins, 1990.
3. Buttenwinser P: Their Pride and Joy. Delacorte Press, 1987.
4. Kramer PD: Spectacular Happiness
5. Hellerstein DJ: Stone Babies. Philadelphia, XLibris, 2001.

SYMPOSIUM 21—DO CHILDREN BENEFIT WHEN THEIR PARENTS WITH DEPRESSION ARE TREATED SUCCESSFULLY?

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the intergenerational transmission of depression, and potential benefits of treating depressed parents.

No. 21A
CHILDREN AT HIGH RISK FOR DEPRESSION: CURRENT KNOWLEDGE AND FUTURE DIRECTIONS

Myrna M. Weissman, Ph.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 24, New York, NY 10032-2603*

SUMMARY:

Objectives: A multigenerational study has investigated the impact of parental depression in children and grandchildren of depressed parents. The objective was to study the impact of parental depression on children of depressed parents.

Methods: Participants were clinically depressed parents and a control group of non-depressed parents (first generation), their children (second generation), and their grandchildren (third generation). Parents, children, and grandchildren received a battery of assessments. Psychiatric symptoms and disorders, and social functioning of children and grandchildren of depressed parents were compared with those of children and grandchildren of non-depressed parents. This is an ongoing long-term longitudinal study of the transmission of depression across three generations.

Results: Children's symptoms begin early in life (prepubertal) and continue into adulthood and are associated with substantial impairment in school and work performance. Children of depressed parents had more anxiety, depressive, and disruptive behavior disorders than their non-depressed counterparts, and as young adults, more substance abuse. The main finding from the study of the children (second generation) is that anxiety symptoms are the earliest presentation of psychiatric disorder (often before puberty), and that early anxiety symptoms increase the risk of subsequent depression. The main findings from the study of the grandchildren (third generation) are that those with both a depressed parent and grandparent had the highest risk for anxiety, and that about half of these children (i.e. grandchildren with both a depressed parent and grandparent) had some form of psychopathology. This presentation will review our current understanding of the risk to the offspring of depressed parents, and potential approaches to early intervention.

No. 21B
STAR-D CHILD STUDY: BACKGROUND AND PRELIMINARY DATA

Daniel J. Pilowsky, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 24, New York, NY 10032;* Jonathan E. Alpert, M.D., Gabrielle M. Cerda, M.D., Judy Garber, Ph.D., Carrol Hughes, Ph.D., Cheryl King, Ph.D., Erin M. Malloy, M.D., Bella Sood, M.D., Myrna M. Weissman, Ph.D.

SUMMARY:

Objectives: This presentation describes STAR-D-Child, a multisite study of the impact of maternal depression remission or symptom reduction on children. STAR-D-Child is an ancillary study to STAR-D (Sequenced Treatment Alternatives to Relieve Depression), a study of treatment alternatives for depressed adults.

Methods: Depressed mothers of children (8–17 years) are recruited from the STAR-D. Maternal depression is treated by STAR-D staff. This presentation is based on baseline data from the first 68 mother-child pairs. (We plan to present data on the first 100 pairs at the APA meeting.) Mean ages of mothers and children are 37.5 years (SD = 6.8) and 11.3 years (SD = 2.8), respectively. Mothers and children are assessed at baseline and every three months thereafter until one year after remission of maternal depression (or 24 months if they do not remit). Multiple family child measures aim at assessing child psychopathology, and social and family functioning. Measures of maternal depression, adjustment, and treatment are collected by STAR-D. We will compare outcomes among children of mothers who do and do not remit.

Results: Mothers' mean baseline HAM-D17 score is 24.6. Children's mean C-GAS score is 70.4. Significant numbers of children meet criteria for major depressive disorder (8.8%), attention-deficit/hyperactivity disorder (17.6%), and various anxiety disorders.

Conclusion: STAR-D-Child represents a major stepping stone in efforts to understand the impact of maternal depression remission on children.

No. 21C
GOOD AND BAD NEWS FOR LOW-INCOME CHILDREN WHOSE MOTHERS ARE TREATED FOR DEPRESSION

Anne Riley, Ph.D., *HPM, Johns Hopkins University, 624 North Broadway, Room 690, Baltimore, MD 21205;* Marina Broitmand, Ph.D., MaryJo Coiro, Ph.D., Judith Robertson, B.S.

SUMMARY:

Objective: To assess the effects of maternal depression treatment on children from disadvantaged families.

Method: Families were recruited once mothers began participation in a larger randomized, controlled trial of depression treatment in low-income, minority communities (Miranda 2003). Mothers and children from the depressed (N=64) and nondepressed control (N=36) groups were interviewed every six months up to one year about children's health, academic performance, and socio-emotional functioning. Children's secondary caregivers and teachers were also interviewed.

Results: Among mothers who improved there were small but significant reductions in negative parenting and family stress. Children of formerly depressed mothers continued to have significantly more psychopathology and poorer functioning than children of mothers who had never been depressed.

Conclusions: Depression treatment that results in mothers' improvement leads to some improvements for their children. However, reduction in maternal depression was not sufficient to provide a positive family environment for child development and did not result in normal functioning among their children. It appears that adjunctive family interventions will be necessary to help formerly depressed mothers develop the skills and resources needed to reduce the impact of depression-related problems on their children.

No. 21D
THE EFFECT ON CHILDREN OF TREATING PARENTS FOR DEPRESSION

Judy Garber, Ph.D., *Department of Psychology, Vanderbilt University, Peabody 512, 230 Appleton Place, Nashville, TN 37203-5701;* Elizabeth McCauley, Ph.D., Guy Diamond, Ph.D., Kelly Schloredt, Ph.D., Ginny Burks, Ph.D., Russ Hanford, Ph.D., Cynthia Flynn, M.S.

SUMMARY:

Objectives: Offspring of depressed parents are at increased risk for psychopathology and dysfunction. Little is know, however, about the extent to which children's problems are temporally linked to their parents' depressive symptoms or the effect of treatment of parental depression on their children. This study examined the extent to which psychopathology in offspring of depressed parents changed from pre- to post-treatment of their parents' depression.

Method: Participants were 98 depressed parents receiving treatment for major depression and one of their children aged 7 to 17; a nondepressed comparison group (n-59) included parents who were free of psychopathology during their child's lifetime and one of their

children matched in age, gender, and race with the offspring of depressed parents. Children's symptoms and diagnoses were assessed with the K-SADS, CDI, P-CDI, CBCL, and YSR. Parents and children also completed measures about the family environment (CRPBI, CBQ).

Results: At baseline (i.e., when parents entered treatment for depression), children of depressed parents had significantly more psychiatric symptoms and disorders and greater levels of parent-child conflict compared with children of nondepressed parents. At the end of parent's acute treatment, offspring of depressed parents showed some decrease in internalizing symptoms and disorders, although they still had more psychopathology than did offspring of nondepressed parents. Using growth analyses, we plotted the growth trajectories of depressive symptoms (CDI) as a function of parental remission across six waves over two years. Whereas the trajectory of change in depressive symptoms was flat for offspring of the nonremitted depressed parents (i.e., they showed little change), there was a significant decrease in depressive symptoms among offspring of remitted parents. With regard to the family environment, non-remitted depressed parents and their children reported greater levels of conflict and less parental acceptance compared with remitted and control parents.

Conclusion: These results suggest that remission of parental depression as a function of treatment has some beneficial effects on child and family functioning.

No. 21E
PREVENTIVE INTERVENTION FOR FAMILIES WITH DEPRESSION: LESSONS FROM A THREE-YEAR FOLLOW-UP

William R. Beardslee, M.D., *Department of Psychiatry, Children's Hospital, Boston, 300 Longwood Avenue, Boston, MA 02115*

SUMMARY:

Over the past 20 years, our group has been involved in developing and testing preventive interventions for families with parents who have mood disorders and youngsters are at risk but not yet ill. Our work moved through the standard phases recommended in the Institute of Medicine's report on the prevention of mental disorders: identifying the problem, assessing risk and protective factors, conducting initial pilot studies, and conducting a large-scale efficacy trial. Much of the work in preventing the transmission of disorder from parent to child or ameliorating the disorder's course is informing parents about what good treatment is and insuring that they and their children receive good treatment when needed. We will present data through the fifth assessment point of our randomized trial comparing a lecture group discussion intervention with a clinician-based intervention culminating in a family conversation about depression run by parents. Both interventions are safe and feasible and both lead to sustained changes in behavior and attitudes. Moreover, parents who change the most in response to intervention have children who increase the most in understanding. These findings will be discussed in the context of the other presenters' findings about the value of treatment when parents are depressed.

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2. Fava M, Rush AJ, Trivedi MH, et al: Background and rationale for the sequenced treatment alternatives to relieve depression (STAR*D) study. Psychiat Clinics North Am 2003; 26:457–494.
3. Miranda J, Chung JY, Green BL, et al: Treating depression in predominantly low-income young minority women: a randomized controlled trial. JAMA 2003; 290:57–65.
4. Goodman SH, Gotlib IH: Risk for psychopathology in the children of depressed mothers: a developmental model for understanding mechanisms of transmission. Psychological Review 1999; 106: 458–490.

SYMPOSIUM 22—OBESITY: LESSONS LEARNED FROM ADDICTION
Collaborative Session with the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the end of this symposium, the participants should have a much better understanding of the neurobiological, neurochemical, and behavioral similarities between obesity and drug addiction.

No. 22A
GENETIC, MOTIVATIONAL, AND METABOLIC FACTORS MODULATE THE NEURAL DRIVE TO MAINTAIN BODY WEIGHT

Barry Levin, *Department of Neurology, VA Medical Center, 385 Tremont Avenue, East Orange, NJ 07018-1095*

SUMMARY:

The brain controls behavioral, neuroendocrine, and metabolic systems that regulate the level of defended body fat. Signals from the internal and external environments interact with genetically and developmentally determined neural substrates to set that defended level. Rats with a genetic predisposition to develop diet-induced obesity (DIO) share many characteristics with polygenic forms of human obesity where increased dietary fat produces obesity and insulin resistance. Once rats develop DIO, the central and peripheral systems controlling energy homeostasis "reset" and they avidly defend their increased adiposity. This type of obesity and the neural systems regulating it are dependent on the adipose-derived hormone leptin, and DIO rats have an inborn reduction in their sensitivity to the catabolic effects of leptin. Other leptin-independent neural pathways respond to diet palatability. Increased palatability causes hyperphagia resulting in massive obesity, which is also avidly defended as long as palatability is maintained. When palatability decreases, rats reduce their intake and adiposity. Finally, perinatal and adult manipulations of dietary availability, content, and palatability can produce long-term, genotype-dependent reorganization of neural pathways involved in energy homeostasis. Thus, the defended body weight is dependent upon a complex interaction among motivational, metabolic, and developmental factors imposed by the environment upon specific sets of interconnected, but separate plastic neural systems.

No. 22B
CORTICO-STRIATAL-HYPOTHALAMIC NETWORKS AND MOTIVATION FOR FOOD: INTEGRATION OF COGNITION, REWARD, AND ENERGY

Ann E. Kelley, Ph.D., *Department of Psychiatry, University of Wisconsin Psychiatric Institute, 6001 Research Park Boulevard, Madison, WI 53711*

SUMMARY:

Two of the greatest threats to public health in the United States in the twenty-first century are obesity and drug addiction. While these two health issues are not obviously related in terms of etiology or phenomenology, they share important commonalities, and can be

conceptualized as "disorders of appetitive motivation." The neural circuits affected by rewarding drugs and presumed to be profoundly altered in addiction are the very pathways that control intake of our most vital natural reward, food. The abundant availability of calorically dense foods such as fats and sweets in modern Western diets is largely responsible for this epidemic. Neuroscience research can make critical contributions to the further understanding and treatment of this problem. Traditionally, major focus has been directed to the hypothalamus, and rightly so, given its crucial role in energy balance and food intake. However, much less is known about how the hypothalamic functions within its associated networks that integrate other factors involved in appetite, such as sensory factors, emotional processing, decision making, and learning. Our laboratory has been particularly interested in the role of neurotransmitter systems within the nucleus accumbens, a brain region implicated in natural reward processes as well as addiction, in the control of food motivation and intake. We have examined local GABAergic, dopaminergic, and opioid peptides systems as well as the influence of input and output structures such as the amygdala and lateral hypothalamus. Our work has shown that these neurochemical systems play specific and dissociable roles in different aspects of food seeking and food intake. The influence of both central and basolateral amygdala as well as lateral hypothalamus in regulating accumbens reward mechanisms appears particularly critical. We propose that the nucleus accumbens integrates information related to cognitive and emotional processing with hypothalamic mechanisms mediating energy balance. This system as a whole enables complex hierarchical control of adaptive ingestive behavior.

Supported by the National Institute on Drug Abuse.

No. 22C
FOOD AND DRUG CRAVINGS: METAPHOR OR COMMON MECHANISM?

Marcia L. Pelchat, Ph.D., *Monell Center, 3500 Market Street, Philadelphia, PA 19104*

SUMMARY:

Objective: The objective of this talk is to provide a better understanding of neural mechanisms for food cravings and to review the evidence for common mechanisms for desires of all kinds, whether healthy or pathological. Food craving (most commonly defined as an intense desire to eat a specific food) is an extremely common, highly compelling psychological experience that has been linked to binge eating, snacking behavior, and maintenance of a varied diet.

Method: The literature review will touch on the effects of neurotransmitters, including endogenous opiates, serotonin, and GABA, on ingestive behavior and drug cravings. Recent neuro-imaging studies on drug and alcohol craving, and on feeding and the chemical senses will also be reviewed. Finally data from our laboratory on food craving in cocaine addicts as well as an fMRI study of food cravings in healthy adults will be summarized.

Conclusions: Taken together, the facts support the hypothesis that there are common brain mechanisms for food and for drug cravings. Such knowledge could prove to be useful in the development of treatments for both substance abuse and for eating disorders.

No. 22D
COMMON AND DIVERGING NEUROBIOLOGICAL FEATURES OF FEEDING AND DRUG SELF-ADMINISTRATION IN HUMANS

Dana Small, Ph.D., *Northwestern University Medical School, 320 East Superior, Room 11565, Chicago, IL 60611*

SUMMARY:

Feeding and drug self-administration share many common behavioral and biological features. Both can be considered ingestive behaviors, both can be abused, and both likely rely on brain mechanisms that evolved to subserve feeding behavior. We have performed a series of neuroimaging studies to elucidate brain mechanisms of food reward in healthy human volunteers. Taken in conjunction with other findings in the literature, our results suggest there is considerable overlap between brain activation produced by drugs of abuse, e.g., and a highly palatable food (chocolate). However, dissociations are also evident. Consumption of a drug has been shown to lead to dopamine release in the ventral striatum, whereas consumption of a favorite food leads to dopamine release in the dorsal striatum. Moreover, dopamine release in response to drugs is correlated with degree of drug wanting, whereas dopamine release in response to feeding is related to perceived meal pleasantness and not to desire to eat or degree of hunger or satiation. In summary, feeding and drug self-administration share many common neural substrates, but there appear to be important differences between the brain mechanisms supporting adapative and non-adaptive ingestive behaviors.

No. 22E
OBESITY AND ADDICTION: NEUROIMAGING STUDIES

Gene-Jack Wang, M.D., *Medical Department, Brookhaven National Lab, 30 Bell Avenue, Upton, NY 11973;* Nora D. Volkow, M.D., Joanna S. Fowler, Ph.D.

SUMMARY:

The increasing number of obese individuals in the U.S. adds urgency to understand the mechanisms underlying pathological overeating. Studies using positron emission tomography (PET) implicate the involvement of brain dopamine (DA) in normal and pathological food intake in humans. In normal body weight fasting subjects, food presentation that could not be consumed was associated with increases in striatal extracellular DA, which provides evidence of an involvement of DA in non-hedonic motivational properties of food intake. Overeating in obese individuals shares similarities with the loss of control and compulsive drug taking behavior observed in drug-addicted subjects. In pathologically obese subjects, we found reductions in striatal DA D2 receptors similar to that in drug-addicted subjects. We postulated that decreased levels of DA receptors predisposed subjects to search for reinforcers; in the case of drug-addicted subjects for the drug and in the case of the obese subjects for food as a means to temporarily compensate for a decreased sensitivity of DA-regulated reward circuit. Different from drug-addicted subjects, we found increased metabolism in somatosensory cortex. In the case of obesity the reduction in receptors coupled with the enhanced sensitivity to food palatability makes them at risk for food overconsumption as their most salient reinforcer.

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SYMPOSIUM 23—ALCOHOL, DRUG, AND PSYCHIATRIC DISORDERS IN THE U.S.: CURRENT STATUS AND TRENDS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should know (1) national prevalence and time trends in alcohol and drug disorders over the last decade; (2) how these affect vulnerable subgroups; (3) patterns of comorbidity of alcohol/drug disorders with major depression; and (4) the prevalence of personality disorders and associated disability.

No. 23A
PREVALENCE, DISABILITY, AND TIME TRENDS IN ALCOHOL ABUSE AND DEPENDENCE IN THE U.S., 1992 to 2002

Frederick S. Stinson, Ph.D., *NIH/NIAAA, 6000 Executive Boulevard, Suite 514, Rockville, MD 20892-7003;* Bridget F. Grant, Ph.D., Deborah A. Dawson, Ph.D., S. Patricia Chou, Ph.D., Mary C. Dufour, M.D., Roger P. Pickering, M.S.

SUMMARY:

This study examines nationally representative prevalence estimates of DSM-IV alcohol abuse and dependence and 10-year time trends. Data come from the NIAAA 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC, N= 43,093) and the NIAAA 1991–1992 National Longitudinal Alcohol Epidemiologic Survey (NLAES, N=42,862). The AUDADIS interview was used in both surveys. In 2001–2002, the prevalences of current (last 12 months) DSM-IV alcohol abuse and dependence were 4.65% and 3.81%. Both disorders were more common among males ($p < 0.01$) and younger participants ($p<.01$). Among racial/ethnic groups, abuse was more common among whites than others ($p < 0.01$), while dependence was more common among blacks than Asians ($p < 0.01$). Concerning 10-year time trends, abuse increased from 3.03% to 4.65% ($p < 0.01$), while dependence declined from 4.38% to 3.81% ($p < 0.01$). While dependence decreased among males ($p < 0.01$), abuse increased among males and females ($p < 0.01$). Increases also occurred in specific subgroups: abuse increased among black males, Asian females, and Hispanic males aged 18—29 ($p < .05$), and dependence increased among black females and Asian males aged 18 to 29 ($p < .05$). The findings highlight the need to address increasing alcohol use disorders among vulnerable groups.

No. 23B
A SECOND LOOK AT BINGE DRINKING AND ALCOHOL USE DISORDERS AMONG COLLEGE AND NONCOLLEGE YOUTH

Deborah A. Dawson, Ph.D., *LOEB, NIAAA, 6000 Executive Boulevard, MSC 7003, Bethesda, MD 20892-7003;* Bridget F. Grant, Ph.D., Frederick S. Stinson, Ph.D., S. Patricia Chou, Ph.D.

SUMMARY:

There is considerable concern about drinking among college students, but it is unknown whether such concerns apply to a broader segment of the young adult population. This study estimated rates of binge drinking, alcohol abuse, and alcohol dependence among U.S. young adults and examined their association with student status and residence. In 2001–2002, 43,093 household and group quarter residents, 18 years and older, were interviewed with the AUDADIS-IV as part of the NIAAA National Epidemiologic Survey on Alcohol & Related Conditions (NESARC). Of young adults aged 18–29, 39.6% reported binge drinking in the previous year, 21.1% binge drank at least monthly, and 11.0% at least weekly. Comparing college students with other young adults, rates of binge drinking were slightly higher among students ($p<0.01$) but place of residence exerted a stronger effect than student status. Overall, 7.0% of young adults met criteria for DSM-IV alcohol abuse in the past year, and 9.2% met criteria for DSM-IV alcohol dependence. Abuse was most prevalent among students living off campus ($p<0.01$) while dependence was most prevalent among students living on campus ($p<0.01$). Binge drinking and alcohol use disorders are not just college phenomena. Prevention campaigns targeted at all youth are needed to supplement campus interventions.

No. 23C
MAJOR DEPRESSION, ALCOHOL, AND DRUG USE DISORDERS IN THE U.S.: VARIATIONS IN CO-OCCURRENCE

Deborah S. Hasin, Ph.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Box 123, New York, NY 10032;* Bridget F. Grant, Ph.D.

SUMMARY:

Major depressive disorder (MDD) and substance use disorders often co-occur in the general population. However, little is known about whether MDD is more strongly associated with alcohol or drug disorders, with abuse or dependence, or whether this varies in major population subgroups. These questions were addressed in the NIAAA 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions, in which 43,093 Americans (residents of households and group quarters such as dormitories) were interviewed with the AUDADIS-IV interview. The association between MDD and a substance use disorder was stronger for drug disorders (OR 3.9) than alcohol disorders (OR 2.2), but the public health impact was wider among the more common alcohol use disorders. MDD was more strongly associated with dependence than abuse for both alcohol and drugs. The association of MDD with alcohol or drug dependence did not differ significantly between African Americans, whites, and Hispanics, or between men and women. However, current MDD was more strongly associated with dependence among those aged 45+ than among younger respondents for both alcohol dependence ($p<.04$) and drug dependence ($p<.03$). Although MDD is less common among older Americans, they are more vulnerable to MDD than others if they have current dependence on alcohol or drugs.

No. 23D
TRENDS IN PREVALENCE OF MARIJUANA USE DISORDERS IN THE U.S., 1992 TO 2002

Wilson Compton III, M.D., *NIH/NIDA, 6001 Executive Blvd MSC5153, Bethesda, MD 20892-9589;* James Colliver, Ph.D., Bridget F. Grant, Ph.D., Frederick S. Stinson, Ph.D.

SUMMARY:

Introduction: Among illicit substance use disorders, marijuana abuse and dependence are the most prevalent in the population. As physicians, especially those in primary care settings, begin to address screening and interventions for illicit substance use disorders, those conditions related to marijuana will be the most likely candidates for intervention. Yet, information about the prevalence of current DSM-IV marijuana abuse and dependence is lacking.

Methods: To examine trends in marijuana use disorders between 1991–1992 and 2001–2002 for the general population and according to age, race/ethnicity, and sex groups, data from large, nationally representative surveys were used to calculate rates of 12-month DSM-IV marijuana abuse and dependence.

Results: One-year prevalence of marijuana use disorders (i.e., abuse and dependence) increased from 1991–1992 to 2001–2002 ($p < .01$) both for the overall population and among users of marijuana. When stratifying by age, the one-year overall prevalence increased significantly ($p < .01$) from 1991–1992 to 2001–2002 among ages 18–29 and 45–64. Among whites, Asian Americans, and American Indians, marijuana use disorders did not increase significantly, but among African Americans and Hispanics, significant increases were found ($p < .01$).

Discussion: More adults in the U.S. population had marijuana use disorders in 2001–2002 than in 1991–1992. Furthermore, rates of disorders increased among users of marijuana, indicating that the tendency for marijuana to be associated with abuse or dependence has escalated in the past decade. All these increases in marijuana abuse and dependence make interventions even more important than they had been, and physicians, especially those in primary care, can play a key role in implementing the interventions.

No. 23E
U.S. PREVALENCE OF PERSONALITY DISORDERS AND CO-OCCURRENCE WITH ALCOHOL AND DRUG USE DISORDERS

Bridget F. Grant, Ph.D., *NIAAA, LOEB Suite 514, 6000 Executive Boulevard, MS 7003, Bethesda, MD 20892-7003;* Frederick S. Stinson, Ph.D., Deborah A. Dawson, Ph.D., S. Patricia Chou, Ph.D., Roger P. Pickering, M.S.

SUMMARY:

Until now, no information was available on DSM-IV personality disorders (PDs) in adults in the U.S. general population. To provide nationally representative data, seven of the 10 DSM-IV PDs were assessed in interviews conducted in the NIAAA 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions ($N = 43,093$). Overall, 14.79% of adult Americans had at least one PD. The most prevalent was obsessive-compulsive, 7.88%; followed by paranoid, 4.41%; antisocial, 3.63% schizoid, 3.13%; avoidant, 2.36%; histrionic, 1.84%; and dependent PD, 0.49%. Avoidant, dependent, and paranoid PDs were more common among females ($p < 0.05$), antisocial PD was more common among males ($p < 0.05$), and no sex differences were observed in other PDs. General risk factors for PDs included minority status, low socioeconomic status, being unmarried. Avoidant PD ($p < 0.0000$), dependent PD ($p < 0.0000$), schizoid PD ($p < 0.0006$), and antisocial PD ($p < 0.0167$) were each statistically significant predictors of disability. The prevalence of PDs is pervasive in the general population and PDs are generally highly associated with disability. This study identifies the need to develop effective and targeted prevention and intervention initiatives for PDs.

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SYMPOSIUM 24—GENETIC AND ENVIRONMENTAL FACTORS CONTRIBUTING TO VULNERABILITY TO ADDICTION
Collaborative Session with the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand some of the major issues and findings on genetic and environmental factors contributing to vulnerability to addiction.

No. 24A
USING TWIN DATA TO IDENTIFY ALTERNATIVE DRUG-ABUSE PHENOTYPES

Ming T. Tsuang, M.D., *Department of Psychiatry, Harvard Medical School/Mass Mental Health Ctr, 74 Fenwood Road, Boston, MA 02115;* Michael Lyons, Ph.D., Stephen V. Faraone, Ph.D., William Kremen, Ph.D., Stephen Glatt, Ph.D.

SUMMARY:

Undoubtedly, some of the difficulty in identifying the susceptibility genes for drug abuse stems from the underlying etiologic complexity of this phenotype. Unlike disorders such as Huntington's disease that are caused by mutations in a single gene, drug abuse is presumed to have a multifactorial polygenic etiology, in which numerous genes and environmental factors all make small contributions to the overall risk for the illness. However, a greater obstacle to risk-gene identification may be the questionable validity and limited utility of the phenotypes that have traditionally been chosen for genetic studies of the liability toward drug abuse. Categorical classifications of drug abuse or dependence (*e.g.,* the DSM) can be reliably used by clinicians to formulate diagnoses, but these disease classes actually may be comprised of clusters of heterogeneous symptoms, each of which has a different genetic basis. In addition to this heterogeneity, a DSM diagnosis of drug abuse may be a rather distant manifestation of the underlying risk genes, and may not map tightly onto its corresponding genetic foundations.

Method: We describe the application of cutting-edge statistical techniques to data from a genetically informative sample to identify alternative drug use/abuse phenotypes.

Results: These alternative phenotypes may be subtypes and/or quantitative traits. Alcohol and tobacco should be evaluated for inclusion in the definitions of the alternative phenotypes. Twin data can be used to assess the genetic and environmental determinants of the subtypes and/or quantitative traits with an emphasis on identifying maximally heritable alternative phenotypes that can be applied in molecular genetic research.

Conclusion: The most genetically informative alternative phenotypes could be applied to existing molecular genetic datasets utilizing linkage analysis in an efficient approach that would capitalize on existing resources.

No. 24B
COMMON AND SPECIFIC GENETIC FACTORS IN THE DEVELOPMENT OF SUBSTANCE DEPENDENCE

Laura J. Bierut, M.D., *Department of Psychiatry, Washington University, 660 South Euclid, Box 8134, St. Louis, MO 63110;* Alison Goate, D.Phil., John Rice, Ph.D., Anthony Hinrichs, Ph.D., Tatiana Foroud, Ph.D., Howard Edenberg, Ph.D., Raymond R. Crowe, M.D.

SUMMARY:

Objective: Individuals with addiction are frequently dependent upon multiple substances, and family and twin studies demonstrate both common and specific genetic factors that contribute to the development of alcohol and other substance dependence. The purpose of this study is to compare and contrast genetic findings for alcohol dependence with other substance dependence diagnoses.

Methods: The Collaborative Study on the Genetics of Alcoholism (COGA) identified individuals with alcoholism in chemical dependency treatment centers. These index cases and their relatives were recruited as a sample at high risk for substance dependence. A total of 262 families with multiple individuals affected with alcoholism and other substance dependence were selected into the genetic study. All subjects were assessed using the Semi-Structured Assessment for the Genetics of Alcoholism (SSAGA) to evaluate alcohol and other substance dependence. Genetic analyses using affected sibling pair methods were used.

Results: Index cases had high rates of habitual smoking, and marijuana and cocaine dependence, and there was significant familial clustering of these disorders. Genetic analyses of COGA data provided further support for chromosomal regions that may be specific in the development of alcohol dependence, but not other substance dependence. Similarly, there was evidence of specific genetic factors in the development of habitual smoking, but not alcohol dependence. There was also evidence of chromosomal regions that may represent shared genetic factors for the development of multiple substance dependence diagnoses.

Conclusions: These data support common and specific vulnerabilities to substance dependence. Thus, there are likely many genetic pathways contributing to the development of dependence.

This work was funded through the NIH Grants U10AA08403 from the National Institute on Alcohol Abuse and Alcoholism and R01DA13423 from the National Institute on Drug Abuse.

No. 24C
ADDICTION MOLECULAR GENETICS: REMARKABLY CONVERGING RESULTS

George Uhl, M.D., *Department of Molecular Neurobiology, National Institute on Drug Abuse, IRP, 5500 Nathan Shock Drive, Baltimore, MD 21224*

SUMMARY:

Objective: The presentation focuses attention on results from my laboratory and others that identify several genomic regions that are highly likely to contain allelic variants that confer vulnerability to addictions, and the nature of some of the candidates for this allelic variability.

Methods: Association and linkage-based genome scans of polysubstance, alcohol, and nicotine abuse.

Setting: Samples of European-American, African-American, Asiatic origins studied in several sites will be cited.

Results: Chromosomal regions that contain association and linkage genome scanning findings in >3 and >4 samples will be emphasized. Genes and gene variants in these regions will be emphasized.

Conclusions: Substance abuse vulnerability is conferred, at least in part, by common allelic variants that predispose to abuse of multiple substances. Allelic variants present in several populations are good candidates for direct use in several clinical applications at this time, including identifying responders/nonresponders to different drug treatments, identifying allelic variants that could predispose to addiction comribidities.

Source of funding for the study: NIDA-IRP, NIH, DHSS.

No. 24D
USING THE SYSTEMS BIOLOGY OF MOTIVATION FOR GENETIC STUDIES IN PSYCHIATRY

Gregory P. Gasic, Ph.D., *Department of Radiology, Harvard Medical School, Mass General Hospital, Building 149-2301, 13th Street, Boston, MA 02129-2060;* Hans C. Breiter, M.D.

SUMMARY:

Objective: To use mMRI and fMRI as a screen for heritable quantitative markers for addictions and mood disorders.

Method: fMRI and MRI combined with multiple paradigms that cover brain systems processing reward/aversion stimuli will probe individuals/families with at least one proband that meets criteria for (1) cocaine addiction. (2) recurrent major depressive disorder, or (3) controls to produce a systems biology map. Circuit-based endophenotypes will be derived from high through-put multimodal imaging paradigms to produce a saturated sampling of a functional domain (e.g. information backbone for motivation, iBM). Comprised of multiple quantitative measures of brain systems functions, these systems biology maps should permit a finer clustering of subjects for gene linkage/association studies.

Results: Data implicating such an iBM comes from neuroimaging studies of humans demonstrating that different types of rewarding and aversive stimuli (e.g. monetary gains and losses, infusions of drugs of abuse, visual processing of beautiful faces, and the somatosensory experience of pain) activate a common set of brain circuits for the perception of pleasure/pain. Other neuroimaging studies indicate that different subsets of this reward/aversion circuitry are dysfunctional in several major psychiatric disorders although they often produce indistinguishable abnormal behaviors.

Conclusion: Circuit-based endophenotype delineation may allow a more biological-based classification of these disorders, and ultimately lead to the identification of susceptibility alleles, loci, and genes.

Support: DA00265 and DA09467, the MGH Department of Radiology, and from the Counterdrug Technology Assessment Center (ONDCP-CTAC), Washington, D.C.

No. 24E
GENETIC AND ENVIRONMENTAL FACTORS MODULATE COCAINE ABUSE IN MONKEY MODELS

Michael Nader, Ph.D., *Department of Physiol/Pharm, Wake Forest University, Medical Center Boulevard, Winston Salem, NC 27157*

SUMMARY:

Objective: Previous research has implicated dopamine D2 receptors in cocaine abuse. The purpose of these studies was to examine the relationship between D2 receptors, the environment, and vulnerability to self-administer cocaine in monkey models of drug abuse.

Method: Positron emission tomography (PET) was used to examine D2 levels in adult male macaques who were also surgically prepared with indwelling intravenous catheters to study cocaine self-administration. In one set of experiments. Individually housed monkeys self-administered cocaine under several conditions of cocaine availability and rates of drug seeking were correlated with baseline D2 levels. In other studies, monkeys were first scanned while individ-

ually housed, and then again after the formation of social groups (n=4/social group), followed by cocaine self-administration.

Results: In individually housed monkeys, there was a significant negative correlation between baseline D2 levels and rates of cocaine self-administration. Social housing produced changes in D2 levels such that subordinate monkeys had lower D2 levels than dominants; moreover, subordinates self-administered cocaine at higher rates. In all monkeys, cocaine exposure produced large and robust reductions in D2 levels.

Conclusions: These findings highlight the importance of D2 receptors and the powerful influence of environmental variables on drug abuse.

Supported by DA10584, DA14637.

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SYMPOSIUM 25—PSYCHIATRIC REHABILITATION: INTEGRATING MIND AND BODY GLOBALLY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe how psychiatric rehabilitation programs are producing positive changes in the brain, yet remain variably integrated around the world, despite evidence of efficacy and low cost.

No. 25A
BRAIN RESPONSES TO THE ENVIRONMENT: SHOWING REHABILITATION WORKS

Robert Cancro, M.D., *Department of Psychiatry, New York University Medical School, 530 First Avenue, New York, NY 10016;* Zebulon C. Taintor, M.D.

SUMMARY:

New methods of showing what is happening inside the brain have resulted in (1) measurements of the size of structures, (2) pictures of electrical and chemical activity in real time, and (3) the ability to track the development of new cells and synapses. Our view of the brain is now very different from what it was a few years ago and continues to evolve. While formerly we thought that the brain was hard wired, with specific localization of functions and losing many cells daily with age, we now see that the brain has an extraordinary ability to adapt and change when presented with the proper stimuli. Most surprising is the way the brain is now seen to react positively and negatively to the environment. The consequences for psychiatric rehabilitation are enormous, as now there is the possibility that the proper rehabilitation program would stimulate the brain to develop new cells and synapses and to adapt other parts of the brain to handle functions that have been impaired. Research should now replicate these findings and focus on what stimuli in what programs produce what changes. Should programs narrowly focus on cognitive remediation or be more generalized?

No. 25B
SCHIZOPHRENIA AND DRUG-ABUSE OUTCOMES: POVERTY, CULTURE, AND COMMUNITY

Gregory C. Bunt, M.D., *Department of Psychiatry, New York University Medical School, 550 First Avenue, New York, NY 10016;* Carole Siegel, Ph.D.

SUMMARY:

The notion that the outcome of schizophrenia is better in developing countries was an understandable conclusion from the 1973 International Pilot Study of Schizophrenia. However, it had the effect of trivializing both poverty and schizophrenia. Why develop if it means that people with schizophrenia will have worse outcomes? Supportive aspects of culture, rather than poverty, did not get considered.

The follow-up International Study of Schizophrenia (IsoS) investigated long-term course and outcome of first-episode psychotic disorders in 14 geographically and socially diverse cohorts. Using historic prospective methodology, 75% of cases were traced and assessed using standardized measures. Aggregate data showed 50% of surviving cases experienced some level of recovery. Early pattern of course predicted long-term outcome. But there was heterogeneity across geographic centers, even after controlling for differences in early pattern of course. Qualitative and quantitative data describing service configurations and local sociocultural settings across the 14 ISoS centers will be presented, contributing further to hypothesis development concerning the role of "cultural setting" in the evolution of psychotic symptoms and disability. The findings are contrasted with substance abuse outcomes and modern community and supportive culture creation. Substance abuse is a disease of prosperity, but amenable to good outcomes.

No. 25C
HUMAN RIGHTS FOR INDIVIDUALS WITH MENTAL ILLNESSES

Humberto Martinez, M.D., *South Bronx Mental Health, 781 East 142nd Street, Bronx, NY 10454-1723*

SUMMARY:

The Human Rights Committee of the American and World Associations for Psychosocial Rehabilitation assisted in the passage of the resolution referenced above. It is the most detailed, comprehensive statement about the rights of the mentally ill internationally. It recognizes (1) the right to informed consent, (2) the right to protection from harm, (3) the right to be free from arbitrary or unnecessary isolation or physical restraint, (4) the right to live, work, and receive treatment within the community, (5) the need for recognition of the patient's cultural background to facilitate comprehensive reintegration into society, and (6) the right to live and be treated in the least restrictive environment possible. Treatment of the mentally ill patient must foster maintaining and furthering the independence of the patient, as well as promoting the patient's participation in the community. We have worked closely with Mental Disability Rights International (MDRI), and other groups. Visits to a dozen countries and reports from others show considerable progress. Psychiatric rehabili-

tation's emphases on empowerment and partnerships lend themselves to respect for human rights. We have moved away from the notion that people "die with their rights on."

No. 25D
THE WORLDWIDE FAMILY MOVEMENT

Geraldine Marshall, *World Schizophrenia Foundation, 3952 West 18th Street, Vancouver, BC V6S 1B7, Canada*

SUMMARY:

The National Alliance for the Mentally Ill does excellent work in the United States, such as the report referenced above, which calls attention to the plight of people caught in the web of criminal justice getting due process rather than treatment for their disturbed behavior. The family movement has become worldwide, with such organizations as EUFAMI spanning the European community, Zengkaren in Japan, the China Disabled Person's Federation, the World Fellowship for Schizophrenia and the Affective Disorders, etc. Similar issues are found in most countries, such as the need for high-quality services and professionals. Often the family movement, with its ability to speak for our loved ones who have difficulty speaking for themselves, finds itself able to support professional quality advocacy in a way that professionals can not, lest they be accused of acting in self-interest. Of course, families do attack bad care wherever they find it. The family movement tries to provide support for its members, who have to work through and experience what they have learned from professionals. Much work remains to be done fighting ignorance, poverty, stigma, and a host of other issues. Specific examples of success and setbacks will be presented.

No. 25E
PENETRATING PRISONS WITH REHABILITATION

Zebulon C. Taintor, M.D., *Department of Psychiatry, New York University School of Medicine, 19 East 93rd Street, New York, NY 10128*

SUMMARY:

In 2002 the prison population of the United States topped the 2 million mark. Of these, it is estimated that 380,000 people have severe mental illness. Other countries have many less. Reasons for this phenomenon include popular suspiciousness that mental illness is unreal, a character flaw, a cop-out, an excuse, etc. Mandatory sentences for substance abuse are often cited as a cause for the population run up, but the decline in crime and, eventually, in prison populations in such key states as New York and Illinois is seen by the public as evidence that the "lock-em up" method has succeeded. However, continuing hazard in the streets is due in part to wandering people with mental illnesses who commit enough random acts of violence both to be arrested in large numbers and to further public distrust in a treatment system that seems unable to contain such behavior. Recidivism in discharged prisoners is significant, since little money has been spent on their rehabilitation. Remedies being tried are identification and diversion of psychiatrically ill people through mental health courts, and better follow up and aftercare of people coming out of prisons. Rehabilitation programs within the prisons and jails constitute the biggest challenge.

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SYMPOSIUM 26—EFFECTIVE TREATMENT OF PTSD: WHAT WORKS BEST FOR WHOM?

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should learn about the relative effectiveness of psychopharmacology, trauma processing, and symptoms stabilization techniques in PTSD, and be informed about the factors that need to be taken into account to determine what treatment modality to choose.

No. 26A
EXPOSURE VERSUS PHARMACOLOGICAL TREATMENT OF PTSD: DIFFERENTIAL RESPONSE AND LONG-TERM OUTCOME

Bessel A. Van Der Kolk, M.D., *Department of Psychiatry, Boston University, 16 Braddock Park, Boston, MA 02116;* Joseph F. Spinazzola, Ph.D., James Hopper, Ph.D., Margaret Blaustein, Ph.D., William Simpson, Ph.D., Elise Hopper, Ph.D.

SUMMARY:

This is the first reported study of PTSD directly comparing a psychological, exposure-based treatment, with a pharmacological approach. This double-blind study compared two widely different treatment approaches commonly used in clinical settings for treating patients with PTSD: fluoxetine (N=31), a psychopharmacological agent that acts directly on biological systems; an exposure treatment, Eye Movement Desensitization and Reprocessing (EMDR) (N=31); and a pill placebo control group (N=27). Blind raters administered well established, validated measures of treatment efficacy: psychological (SCID I & II, CAPS, SIDES, STAI, Beck), social (SAS), neuroendocrine (cortisol) and psychophysiological (reactivity to trauma scripts), before and after termination of treatment, and eight weeks and six months after treatment termination. We will present the changes in psychological, social, and biological functioning in these three treatment groups over time and examine the best predictors to successful treatment in each group. Preliminary analyses show that, post-treatment, the placebo group had a 42% decrease in PTSD (CAPS) scores, fluoxetine 47%, and EMDR 62%. EMDR subject scores remained stable two and six months after treatment termination, while the fluoxetine scores gradually increased after treatment. Preliminary analyses indicate that the long-term differences between EMDR and fluoxetine were primarily in the symptom clusters of avoidance and intrusion.

No. 26B
WHAT WORKS BEST FOR WHOM? CASE STUDIES IN COMBINATION TREATMENT

Randall D. Marshall, M.D., *Department of Anxiety Disorders, NY State Psychiatric Institute-Columbia Univ, 1051 Riverside Drive, Unit 69, New York, NY 10032*

SUMMARY:

The efficacy of the SSRIs and of several trauma-focused psychotherapies is well established. A substantial proportion of patients, however, are left with residual symptoms in time-limited trials. Combination treatment is therefore frequently recommended and provided in practice despite the absence of supporting evidence, in part because the mechanisms of medication and psychotherapy are assumed to be complementary or even additive. Psychosocial treatments presumably exert direct effects through learning mechanisms, and medications, through restoration of homeostasis of dysregulated neural networks. Notwithstanding, these two theoretically distinct treatments have resulted in nearly identical outcomes to date (i.e., reduction of PTSD symptoms). This may be because outcome for common associated features such as dissociation, interpersonal problems, and dysregulation of aggressive impulses has hardly been studied.

In a recent placebo controlled trial of paroxetine for PTSD, we found paroxetine effective for both dissociative symptoms and interpersonal problems. The implications of these findings will be discussed in relation to the above theoretical model. Finally, three patients who received both psychotherapy and medication will be presented to illustrate and discuss three typical outcomes: failure of medication but successful psychotherapy; successful medication treatment with limited additional benefit from psychotherapy; and equally but only moderately successful medication and psychotherapy in a patient with complicating factors.

No. 26C
EMOTION REGULATION AND INTERPERSONAL SKILLS TRAINING FOR CHRONIC PTSD RELATED TO CHILDHOOD ABUSE AND MULTIPLE TRAUMATIZATION

Marylene Cloitre, Ph.D., *New York University Child Study Center, 215 Lexington Avenue, 16th Floor, New York, NY 10016*

SUMMARY:

A phase-based treatment approach for women with complex PTSD related to childhood abuse was tested in a randomized clinical controlled trial. Phase 1 focused on skills training in affect and interpersonal regulation (STAIR), while Phase 2 implemented a modified version of prolonged exposure. Phase 1 is a preparatory/stabilization phase intended to allow time for the therapeutic alliance to develop, improve day-to-day functioning in interpersonal domains, and to strengthen emotion regulation skills in preparation for the emotionally intensive Phase 2 work. Fifty-six women were randomly assigned to active treatment (n = 22) vs. Minimal Attention Waitlist (n= 24). Compared with Waitlist, STAIR/MPE clients showed substantial improvement in three targeted symptom domains: emotion regulation, interpersonal functioning, and PTSD symptoms. Phase 1 improvement in negative mood regulation and the development of a positive therapeutic alliance were significant predictors of PTSD symptom reduction during Phase 2 exposure. This presentation will also provide data on the adaptation of the STAIR/MPE in a sample of adolescent girls with complex trauma, comparing outcome with STAIR alone supportive counseling alone. Differences in the application of exposure-based treatments for adults compared with adolescence will be discussed, as will the interrelated roles of therapeutic alliance, skills building, and imaginal exposure.

No. 26D
PTSD TREATMENT OUTCOME RESEARCH: THE STUDY OF UNREPRESENTATIVE SAMPLES

Joseph F. Spinazzola, Ph.D., *Department of Psychiatry, Boston University, The Trauma Center, 227 Babcock Street, Brookline, MA 02446;* Margaret Blaustein, Ph.D., Bessel A. Van Der Kolk, M.D.

SUMMARY:

This presentation reviews the screening procedures, enrollment, and attrition statistics for 35 gold-standard studies cited in the ISTSS 2000 Practice Guidelines for PTSD Treatment, and provides a comparative analysis of data from a recent study. Findings reveal that a majority of studies omit or incompletely report vital sample composition and enrollment data, including exclusion criteria and rates, demographics, and age of trauma onset. Moreover, subjects with complex clinical presentations, life adversity, or severe comorbid diagnoses are frequently excluded from these studies or drop out. The data suggest that significant subpopulations of trauma victims with PTSD have not been represented in the body of PTSD treatment efficacy research that informs current practice guidelines. Hence, generalizability of these treatments to the range of traumatized individuals encountered across practice settings is not known. Future research and clinical implications for effective treatment of traumatized individuals encountered in real-life practice settings will be discussed.

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TUESDAY, MAY 4, 2004

SYMPOSIUM 27—BEHAVIORAL ACTIVATION, COGNITIVE THERAPY, AND MEDICATION FOR MAJOR DEPRESSION

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the differential efficacy of available treatments for the acute phase intervention and the prevention of relapse in depression; in addition the participant should be able to recognize patient predictors of treatment response and relapse.

No. 27A
METHODS AND ACUTE-PHASE OUTCOMES

Sona A. Dimidjian, *Department of Psychology, University of Washington, Guthrie Annex 1, Seattle, WA 98195;* Steven D. Hollon, Ph.D., Keith S. Dobson, Ph.D., Karen B. Schmaling, Ph.D., Robert J. Kohlenberg, Ph.D., Michael Addis, Ph.D., David L. Dunner, M.D.

SUMMARY:

Introduction/Hypothesis: Antidepressant medication (ADM) is currently the standard of care for moderate to severe major depression, and cognitive therapy (CT) has been the most extensively studied of extant psychosocial treatments; however, neither is without limitation. Behavioral activation (BA) has been recently advanced as a simpler psychosocial treatment with potentially greater public health relevance. The current study aimed to compare the efficacy of BA, CT, and ADM in a large, placebo-controlled trial.

Methods: Two hundred and forty-one patients with major depression were randomly assigned to 16 weeks of BA, CT, ADM (paroxetine), or eight weeks of pill placebo. Patients were treated in outpatient clinics and independent practice offices at the University of Washington. Failure to meet diagnostic status or severity criteria for MDD was the most common reason for exclusion. Primary measures of outcome included the Beck Depression Inventory and the Hamilton Rating Scale for Depression.

Results: BA was comparable in acute phase efficacy to ADM, even among more severely depressed patients, and retained a significantly greater percentage of patients in treatment. Both BA and ADM were significantly more efficacious than CT.

Discussion: Behavioral activation therapy is comparable in efficacy to ADM and may confer unique benefits in regard to patient retention and treatment dissemination.

GlaxoSmithKline provided medications and pill placebos for the study.

No. 27B
PREVENTION OF RELAPSE

Keith S. Dobson, Ph.D., *Department of Psychology, University of Calgary, 2500 University Drive, Admin Bldg 275, Calgary, AL T2N1N4, Canada;* Steven D. Hollon, Ph.D., Sona A. Dimidjian, Karen B. Schmaling, Ph.D., Robert J. Kohlenberg, Ph.D., Shireen Rizvi, David L. Dunner, M.D.

SUMMARY:

Introduction/Hypothesis: Depression is a recurring disorder and none of the extant interventions (ADM; CT) are without limitation. Behavioral activation (BA) has been recently advanced as a simpler psychosocial treatment with potentially greater public health relevance. The current study aimed to compare the relapse prevention effects of BA, CT, and ADM in a large, placebo-controlled trial.

Methods: One hundred and seventy-two patients who responded to acute phase treatment with BA, CT, or ADM (paroxetine) were entered into a one-year continuation, with ADM responders randomly assigned to continuation ADM or placebo withdrawal. Patients who successfully completed the one-year continuation were assessed across an additional one year naturalistic follow-up period. Patients were treated in outpatient clinics and independent practice offices at the University of Washington. Primary measures of outcome included the Beck Depression Inventory, the Hamilton Rating Scale for Depression, and the Longitudinal Interval Follow-Up Evaluation.

Results: Both traditional analyses of mean scores on major outcome variables, as well as survival analyses of different treatment groups and predictors of relapse, will be presented. Overall, psychosocial treatments evidenced an advantage with respect to relapse prevention.

Discussion: The differential preventive value of the treatments, and the optimal research designs to study questions of relapse and recurrence, will be discussed.

GlaxoSmithKline provided medications and pill placebos for the study.

No. 27C
PREDICTION OF TREATMENT RESPONSE

Shireen Rizvi, *Department of Psychology, University of Washington, Guthrie Annex 4, Seattle, WA 98195;* Sona A. Dimidjian, Steven D. Hollon, Ph.D., Keith S. Dobson, Ph.D., Karen B. Schmaling, Ph.D., Robert J. Kohlenberg, Ph.D., David L. Dunner, M.D.

SUMMARY:

Introduction/Hypothesis: Despite the large body of research on treatments for depression, relatively little of this work has addressed the process of change. The current study examined cognitive, behavioral, interpersonal, and diagnostic predictors of acute phase response.

Methods: Two hundred and forty-one patients with major depression were randomly assigned to 16 weeks of BA, CT, ADM (paroxetine), or eight weeks of pill placebo. Patients were treated in outpatient clinics and independent practice offices at the University of Washington. Failure to meet diagnostic status or severity criteria for MDD was the most common reason for exclusion. Primary measures of outcome included the Beck Depression Inventory and the Hamilton Rating Scale for Depression.

Results: Severity was an important prognostic factor. Patients who were currently unemployed and who had histories of chronic and recurrent depression did less well in treatments. Among the high severity patients, problems in patients' social support systems was irrelevant to response in the ADM condition but was associated with poorer outcomes among patients in psychotherapy. Patients with melancholic depression did better in ADM or CT than in BA.

Discussion: The implications of these findings will be discussed with respect to evaluating patient prognosis and with respect to treatment planning and the selection of treatment modalities.

GlaxoSmithKline provided medications and pill placebos for the study.

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4. Whisman MA: Mediators and moderators of change in cognitive therapy of depression. Psychological Bulletin 1993; 114:248–265.

SYMPOSIUM 28—NEW PERSPECTIVES IN THE TREATMENT OF COMPLEX PTSD

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize complexity of post-traumatic responses, and identify the modalities of treatment that help resolve them; identify those treatment modalities that have been associated with good outcomes in complex PTSD.

No. 28A
UPDATE ON THE MEMORY WARS: EVALUATING AND WORKING WITH TRAUMATIC MEMORY

James A. Chu, M.D., *Department of Psychiatry, Mc Lean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

For more than a decade, there has been a fierce debate concerning the nature of memories of traumatic events. Clinicians specializing in the treatment of traumatized patients have described traumatic memory as differing significantly from ordinary memory in terms of vividness, fragmentation, and diminished narrative content. They have also observed amnesia related to trauma and recovered memories that appear to have validity. On the other hand, memory researchers have argued that there is no evidence that distinguishes traumatic memory from ordinary memory, and have questioned the existence and validity of recovered memory. Instead, they have argued that suggestive clinical interventions have sometimes induced "false" memory of traumatic events. This presentation presents recent findings that suggest that both positions have some legitimacy and may contribute to a more inclusive understanding of traumatic memory.

No. 28B
BETRAYAL TRAUMA THEORY: DIMENSIONS OF HARM AND HEALING

Jennifer J. Freyd, Ph.D., *Department of Psychology, University of Oregon, Eugene, OR 97403-1227*

SUMMARY:

The most terrifying events (such as gruesome accidents, war, and violent rape) involve the loss of life, harm to the body, and/or the threat of these consequences. Betrayal traumas (such as emotional and/or sexual abuse by a parent or marital rape) are events and patterns of events that involve profound social betrayal. Both terrifying events and betrayal traumas can harm; however, betrayal trauma theory proposes that the harm caused is specific to the event dimensions, with terrifying events producing arousal and anxiety, and social betrayal producing dissociation and gaps in memory and awareness. When betrayal traumas are also terrorizing and life-threatening, they have the greatest potential to cause a great deal of harm to basic systems of cognition, emotion, behavior, and attachment. While the field of traumatic stress has traditionally focused on terrifying events, complex PTSD likely relates to social betrayal as much as it does to terror. Recent research will be reviewed, including findings regarding fear and betrayal, dissociation, gaps in memory and awareness, health consequences of trauma, and gender differences in exposure to types of trauma. Betrayal trauma theory emphasizes the importance of human relationships in both the harm of trauma and the potential for healing.

No. 28C
SIGNIFICANCE OF RELATIONSHIP IN THE TREATMENT OF COMPLEX TRAUMA

Christine Courtois, Ph.D., *Psychiatric Institute, 4228 Wisconsin Avenue, Washington, DC 20037*

SUMMARY:

Individuals with histories of early, severe childhood abuse and neglect and those who suffer extreme and cumulative forms of interpersonal trauma experience a wide range of difficulties, now referred to as complex trauma. These difficulties often have their origins in disturbed and disrupted primary attachment relationships, abuse and neglect within these relationships, and the additive effects of multiple experiences of trauma. These, in turn, cause considerable psychological damage, both personally and interpersonally. A therapeutic relationship is a primary intervention for distress of this sort, offering a secure base from which to examine and rework attachment difficulties, process the trauma, learn essential life and relational skills, and increase self capacities necessary for constructive relationships; however, developing a therapeutic relationship with complex trauma patients is often a challenging process. This presentation will identify salient relational issues that arise in the treatment of this population and strategies for their identification and management.

No. 28D
USING EMDR TO RESOLVE TRAUMA-BASED DISTORTIONS OF THE SELF IN COMPLEX PTSD

Denise J. Gelinas, Ph.D., *277 Main Street, Northampton, MA 01060*

SUMMARY:

Trauma-based negative distortions of the self are a characteristic of complex PTSD. These can be recalcitrant to resolve in treatment, particularly around issues of felt responsibility for abuses experienced in childhood. For example, patients may report "knowing" that they were not responsible for the abuses they experienced, yet continue to "feel" that they were. Clinical experience has routinely demonstrated that a particular set of techniques in the EMDR approach called "cognitive interweaves" can thoroughly and rapidly change such negative distortions about the self into more appropriate and realistic self-representations. Cognitive interweaves and their uses will be described and illustrated with clinical material. A brief consideration of the change process will be offered.

No. 28E
TREATMENT OUTCOME RESEARCH AND COMPLEX PTSD

Bessel A. Van Der Kolk, M.D., *Department of Psychiatry, Boston University, 16 Braddock Park, Boston, MA 02116;* Joseph F. Spinazzola, Ph.D.

SUMMARY:

Only one in three participants enrolled in cognitive-behavioral treatment studies has been shown to be able to complete the trial and show clear treatment gains. The literature identifies several factors that interfere with effective trauma processing: (1) high levels of anger and sporadic attendance, (2) anger in rape victims, (3) diminished emotional processing, (4) "mental defeat," (5) absence of mental planning, (6) an overall feeling of alienation or permanent damage, (7) guilt and shame. Cloitre has suggested that avoidance or inhibition of feeling states may mute other feelings, resulting in limited emotional processing of traumatic memories. Such processing is thought to be critical to the resolution of PTSD symptomatology. The parallel between these sources of treatment failure and the symptoms delineated in the DESNOS in the DSM-IV field trial for PTSD is striking: the predictors of treatment failure constitute the very symptoms addressed in DESNOS. This presentation will review the literature on treatment dropouts and present the outcome data of a recently completed NIMH-funded study comparing the effects of fluoxetine and EMDR showing the predictors of good outcome of exposure and psychopharmacology. Developmental level at which trauma occurred was not a predictor of outcome, but capacity to engage in the traumatic memory without dissociating was.

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SYMPOSIUM 29—BIPOLAR PATIENTS: TREATMENTS AND CULTURAL ISSUES IN LATIN AMERICA

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the treatment options specific for bipolar patients in Latin-American countries; to stress the importance of cultural approaches in both pharmacology and psychotherapy in this population.

No. 29A
INTERPERSONAL PSYCHOTHERAPY IN BRAZIL: SIMILARITIES AND DIFFERENCES WITH THE U.S.

Ana C.F. Andrade, M.A., *Department of Psychiatry, University of Sao Paulo, Rua Cap. Pedro Bruno Lima 65, Florianopolis, SC 88036-230, Brazil;* Francisco Lotufo-Neto, M.D., Beny Lafer, M.D., Marcelo Feijo

SUMMARY:

Interpersonal problems, as proposed in Interpersonal Psychotherapy (IPT-Klerman et al., 1984), are common in patients with affective disorders, both as triggers and/or consequences of the illness.

Since IPT has been developed in the United States and most research has been done in the U.S. and Europe, we do not know how well this treatment would generalize to the Latin American population. Weissman, Markowitz, and Klerman (2001), indicate that cultural adjustments of IPT may prove necessary for different populations, and argue that the ultimate answer to this question has to come from translation and controlled clinical trials to test the efficacy of IPT in different countries and languages.

We investigated how the IPT concept and treatment focus on interpersonal problem areas might work in a non-U.S. bipolar population, namely, Brazilian.

Forty patients, 20 from an ambulatory research clinic at the Psychiatric Institute in the Clinical Hospital of the University of São Paulo Medical School (Ipq-HC-FMUSP) in Brazil, and 20 patients in the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) at the University of Pittsburgh Medical Center (UPMC) at Western Psychiatric Institute and Clinic, were interviwed by the first author.

Results of this study will be presented, as well as the current status of IPT in Brazil in terms of training, research, and clinical use in academic and community-based treatment centers.

No. 29B
FROM PRACTICE TO THEORY: GROUP MUSIC THERAPY AND MEDICATION COMPLIANCE IN PATIENTS WITH BIPOLAR DISORDER

Ruby C. Castilla-Puentes, M.D., *WW Epidemiology Research and Development, GlaxoSmithKline, 5 Moore Drive, Research and Development, Triangle Park, NC 27709;* James M. Perel, Ph.D.

SUMMARY:

Objective: This study examined the effects of treatment for chronic psychotic disorders on medication compliance. The authors hypothesized that bipolar patients would have better psychotropic compliance with medication and group music therapy (GMT) than with medication alone.

Methods: A total of 85 patients, including patients with schizophrenia (n=38), psychosis NOS (n=19), bipolar disorder (n=18), and schizoafective disorder (n=10) diagnosed according to DSM-III-R criteria were included in the study. Their ages ranged between 15 and 65 years. Patients were randomly assigned to two groups. None of them had had a previous treatment using GMT. Group 1 (n=42) received 60-min GMT, once a week. Patients participated in the study for eight weeks. Group 2 (n=43) was accepted as the control group. By consensus, family members (or primary caregivers), psychiatric nurses, and psychiatrists, complete the medication compliance assessment initially, after thc therapy, and at the end of the sixth month, including number of psychotropic medications used, type, frequency, and an overall degree of compliance. The evaluation consisted of a four-point scale (0=noncompliance, 3=best compliance).

Results: In group 1, there were statistically significant differences in the degree of medication compliance after the therapy program (73.8% vs. 16.2%, P<0.001). Also, six months later in group 1, there was still an improvement in the medication compliance (69.0% vs. 16.3%, P<0.001). Patients with bipolar disorder showed more improvement compared with other groups in the degree of compliance.

Conclusions: Treatment of bipolar patients with medication and GMT is more likely to maintain medication compliance than treatment with medication alone. Cultural and theoretical issues will be discussed.

No. 29C
WHAT IS THE ROLE OF PSYCHOTHERAPY IN PATIENTS WITH BIPOLAR DISORDERS? CULTURAL ISSUES

Carlos Leon-Andrade, M.D., *Department of Psychiatry, Metropolitan Hospital, Av. Mariana de Jesus N 31-190 C.B., Quito, Ecuador;* Roxana Galeno, M.D.

SUMMARY:

Objective: The basic aims of treatments in bipolar disorders (BD) are to alleviate acute symptoms, improve medication compliance, prevent relapse, and restore psychosocial functioning. The mainstay of treatment has been and currently remains pharmacotherapy. However, there is evidence that psychosocial factors may adversely affect prognosis in individuals with BD. Given this scenario, the development of culturally adapted adjunctive psychotherapies appears necessary.

Methods: This presentation will highlight the key characteristics of potentially effective psychotherapies in a psychiatric clinic in Quito, Ecuador. Psychotherapy outcomes are reviewed as to which therapies may be the most helpful given the many different issues faced by individuals with bipolar disorder and by their family or significant others.

Results: The use of adjunctive psychological, culturally oriented therapies leads to significant reductions in relapse rates, significant improvements in medication adherence, and improvements in social functioning in this population.

Conclusions: There is a need for further research in underlying cross-cultural models of the role of psychological issues in relapse and a need to extend psychological treatment studies to larger and more representative populations of patients.

No. 29D
TREATMENT OF SLEEP PROBLEMS IN BIPOLAR PATIENTS

Franklin Escobar, M.D., *Department of Psychiatry, Universidad Nacio, Sleep Disorders Clinic ISS, Bogotá, Colombia;*

SUMMARY:

Novel pharmacological agents for the treatment of bipolar disorder are under investigation. Some of the new treatments attempt to target specific clinical conditions such as insomnia that constitute particular challenges in the management of bipolar individuals. The pharmacological treatment of sleep disorders in bipolar patients is complicated by the phenomenon of cycling, which may make the clinical management of these patients considerably difficult.

Therapeutic agents in Latin American countries, including new anticonvulsants, atypical antipsychotics, and calcium channel blockers are currently being prescribed, and bring the promise of substantial advances in the pharmacological management of bipolar patients. Recent developments in this area are reviewed, with a focus on alternatives for the treatment of sleep disorders in refractory mania, bipolar depression, mixed states, and rapid cycling patients.

No. 29E
SOME USEFUL INTERVENTIONS IN THE COURSE OF BIPOLAR DISORDERS IN ARGENTINA

Jose R. Bozzo, M.D., *Department of Psychiatry, Hospital Britanico, Perdriel 7H, Buenos Aires, Argentina*

SUMMARY:

When a direction in psychopathology fails to resolve all the problems, start a new way in which the conception or technique can be combined with other viewpoints in favor of the person who is ill. This is the support of clinical eclecticism, in which the patient is more important than the theories and scientific schools.

This presentation is about the flexibility that is needed at different times over the course of bipolar disorder. In some situations of the treatment the focus is to cope with symptomatic behavior and anxieties. We use W. R. Brion's conception of beta elements to form the change from a psychodynamic viewpoint to psychoeducational interventions. The role of pharmacology, clinical psychiatry, psychotherapy, and also group interaction of the medical team and family is analyzed as a source of useful therapeutic interventions.

Our ideas come from our experience in a general hospital and our aim is to share these practical concepts and illustrate them with brief case reports.

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SYMPOSIUM 30—PSYCHOTHERAPY AND PHARMACOTHERAPY: DISSOLVING THE MIND-BRAIN BARRIER
APA Committee on Psychotherapy by Psychiatrists

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) identify neurobiological foundations and clinical essentials of integrating pharmacotherapy and psychotherapy in the treatment of specific psychiatric disorders, (2) recognize by case examples the special determinants that facilitate and inhibit alleviation of clinical symptoms and psychological conflict when pharmacotherapy and psychotherapy are combined, (3) distinguish in a practical way among and between the various ways in which medications and psychotherapy are combined: psychotherapeutic aspects of medication management; pharmacotherapy during psychotherapy; splitting treatment between a pharmacotherapist and psychotherapist; developing treatment algorithms for combining the two treatment formats.

No. 30A
DYNAMIC IMAGING OF THE BRAIN: ACTIONS, DYSFUNCTION, THERAPEUTIC TRANSFORMATION

George I. Viamontes, M.D., *Department of Psychiatry, University of Missouri, 165 Plantation Drive, Creve Coeur, MO 63141*

SUMMARY:

Evolutionary forces have given the human brain significant flexibility in the coordination of behavior. Human responses are usually contingent, rather than obligatory. This requires advanced information processing, but facilitates adaptive behavior. The ability to consider multiple factors before acting depends on the frontal lobes. The frontal lobes integrate context, sociocultural norms, and a vision of the future into behavior. Limbic amplification is another key behavioral determinant. It controls reactivity, which can range from explosiveness to apathy. Normal functioning requires frontal lobe integration, and appropriate limbic amplification. Developmental deficits, stressors, and genetic factors can precipitate maladaptive behavior. Chronic stress, for example, can cause hippocampal dearborization (simplifying contextual processing) and activation of the amygdala (increasing limbic amplification). Under these circumstances, the brain responds rapidly, but loses discrimination. Psychotherapy and psychopharmacology use the brain's plasticity to restore adaptive responses through a remodeling of brain structure. The psychotherapist must establish both limbic and cognitive connections with patients. The primitive, dyadic, brain-to-brain interactions that signal empathy and trust, as well as the artful manipulation of brain processing and content, are keys to psychotherapeutic success. Therapeutic transformation, however accomplished, results in structural refurbishment of neural processes, and optimizes the ability to behave adaptively.

No. 30B
PSYCHOTHERAPY AND PHARMACOTHERAPY: THEORETICAL BASIS AND EMPIRICAL STUDIES OF COMBINED TREATMENT

Michael E. Thase, M.D., *Department of Psychiatry, University of Pittsburgh Medical Center, 3811 O'Hara Street, Pittsburgh, PA 15213-2593*

SUMMARY:

Most psychiatrists believe that the optimal treatment of depressive disorders usually should involve the combination of psychotherapy and pharmacotherapy, a position endorsed in the 1993 and 2000 editions of the American Psychiatric Association Practice Guideline for Major Depressive Disorder. The biopsychosocial complexity of the depressive disorders is often cited to justify this position, with psychotherapy and pharmacotherapy combined serving as a "broad-spectrum" intervention (at least with respect to each treatment provided alone). There is, in addition, an empirical justification for combined treatment based solely on the relatively low response rates and high nonadherence rates observed in clinical trials of both monotherapies. More recent advances in understanding the pathways of cerebral dysfunction associated with depression, and the impact of treatments on these disturbances, provide another level of justification: antidepressants and psychotherapy appear to have differential impact on corticolimbic circuitry. Finally, it is argued most studies that have evaluated the efficacy of combined treatment have underestimated the potential additive benefits of psychotherapy and pharmacotherapy by minimizing coordination of the modalities, failing to assess for hypothesized-specific treatment effects, and employing underpowered designs that are insensitive to detecting modest additive effects.

No. 30C
SPLIT TREATMENT: CONFLICT AND COLLABORATION

Michelle B. Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Box 0704, Ann Arbor, MI 48109-0704*

SUMMARY:

Split treatment, the practice by which a psychiatrist or other physician provides the psychotropic medications and other medical interventions while a nonphysician provides the psychotherapy, has recently become a burgeoning treatment plan for psychiatric patients. As a result of the growth of pharmacotherapy and the declining number of psychiatrists, arguments have been made that the need for integrated care involving psychotherapy and pharmacotherapy is pertinent. With this new plan of treatment involving two forms of psychiatric therapy arise various problems involving the ethical boundaries involving the patient and the doctor, communication issues between the psychiatrist and psychologist, and legal queries relating to patient treatment. A defined course of treatment involving three phases is required for proper split treatment procedure: the beginning phase establishing communication and trust with the patient as well as diagnostic evaluation and treatment plan, the middle phase involving transference and countertransference, and the end phase terminating treatment and managing follow-up treatment of the patient.

No. 30D
INTEGRATING PSYCHOTHERAPY AND PHARMACOTHERAPY: THE CLINICAL CHALLENGE

Bernard D. Beitman, M.D., *Department of Psychiatry, University of Missouri, 2 Hospital Drive, Columbia, MO 65212*

SUMMARY:

The effectiveness of psychopharmacological intervention depends upon the expectations of patients receiving and ingesting the substance. Yet little systematic effort in controlled clinical trials has been made to verify this correlation. One study involving readiness to change measures in the treatment of two anxiety disorders, panic disorder and depression, will be reported. Approximately 120 patients randomized to adinazolam or placebo across four sites for each diagnostic category were administered the Stages of Change Questionnaire before entering the placebo wash-out. In both studies, the GAD and panic patients who did not think they had a problem (precontemplators) were less likely to change than those who believed they had a problem and/or were working on it. In the panic study, the SOC predicted outcome as well as did assignment to drug or placebo.

This study prompts clinicians to develop models by which to consider the potential interaction between pharmacological and psychological effects. An amygdala-centric hypothesis suggests: (1) In panic and GAD, the amygdala is hypermetabolic, (2) reduction in amygdala firing is likely to correlate with symptom reduction, (3) prefrontal activity in concert with GABA increases with benzodiazepines and serotonin increases with SSRIs help to quiet amygdala firing.

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SYMPOSIUM 31—PRACTICE GUIDELINES, QUALITY INDICATORS, AND A PRACTICE RESEARCH NETWORK: AN INTERNATIONAL VIEW
World Psychiatric Association

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate an understanding of guideline development in the U.S. and other countries. The participant should also be able to identify methods and tools for monitoring practitioner adherence to guideline recommendations.

No. 31A
TREATMENT GUIDELINES IN PSYCHIATRY: RESULTS OF AN INTERNATIONAL SURVEY

Wolfgang Gaebel, M.D., *Department of Psychiatry, Heinrich-Heine University, Bergische Landstrasse 2, Duesseldorf D-40629, Germany*; S. Weinmann, M.D.

SUMMARY:

Mental disorders pose an increasing burden on societies all over the world. At the same time, treatment variations within and between countries are prevalent. Reasons for this have to be investigated in order to improve care for people with mental disorders. The World Psychiatric Association Section on Schizophrenia, and Section on Quality Assurance, the WHO Regional Office for Europe, and the

German Society of Psychiatry, Psychotherapy, and Nervous Diseases Section on Quality Assurance and Guidelines, have set up a program on treatment guidelines in psychiatry. The program is coordinated by the University Department of Psychiatry, Dusseldorf, Germany. The aim of this project is to collect existing treatment guidelines worldwide; to evaluate these guidelines according to predefined criteria; to compare them with respect to key recommendations; to investigate regional, cultural, and other specific characteristics; and to estimate the impact on psychiatric care in the different countries. National scientific societies and other national institutions concerned with mental health care have been addressed using a specifically developed questionnaire. Results of this survey will be presented.

No. 31B
CLINICALLY-BASED QUALITY INDICATORS

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

SUMMARY:

The American Psychiatric Association, recognizing the need for professionally developed quality indicators and performance measures, created a Task Force on Quality Indicators, and the report of that task force has been published. Subsequently, a standing committee, the Committee on Quality Indicators, was established within the APA Council on Quality Care. 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 developed a strategy to field-test the sample quality indicators already developed, utilizing Practice Research Network data along with other available datasets. In addition, working with the Physicians' Consortium of the American Medical Association, a performance measure set has been developed for use in primary care to monitor treatment of major depressive disorder (MDD), benchmarked against the APA practice guideline on MDD. The evolving work of the Council on Quality Care and 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. 31C
APA PRACTICE GUIDELINE PROJECT: STATUS AND CHALLENGES

John S. McIntyre, M.D., *Department of Psychiatry, Unity Health System, 81 Lake Avenue, 3rd Floor, Rochester, NY 14608*

SUMMARY:

The American Psychiatric Association has published 12 practice guidelines over the past decade. Most of the guidelines are Axis 1-disorder based, but the most recently published guideline is on suicidal behaviors. Last year the first guidelines for a personality disorder, borderline personality disorder, was published. The guidelines are being increasingly used in this country and some of the guidelines have been translated into nine languages. A number of derivative products have been developed, including quick reference guides to increase the use of the guidelines by psychiatrists in their day-to-day clinical work. In further increasing the use of the guidelines, a number of challenges remain. These will be discussed in this presentation and include increasing the exposure to the guidelines in residency programs, developing other derivative products including pocket cards and PDA versions that are being used by managed care organizations and other systems of care.

No. 31D
ASSESSING EVIDENCE-BASED PRACTICE GUIDELINES IN ROUTINE PSYCHIATRIC PRACTICE

Darrel A. Regier, M.D., *Office of Research, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*; Joyce C. West, Ph.D., William E. Narrow, M.D., Farifteh F. Duffy, Ph.D., Joshua E. Wilk, Ph.D.

SUMMARY:

Objective: Characterize treatment patterns and use of evidence-based psychopharmacologic and psychosocial treatments from APA and other national guidelines (e.g., PORT, Expert Consensus) in routine psychiatric practice among patients with (1) major depressive disorder (MDD); (2) schizophrenia; and (3) bipolar disorder.

Methods: Nationally representative data from 615 psychiatrists participating in the 1999 APIRE Practice Research Network Study of Psychiatric Patients and Treatments were used to examine conformance with evidence-based guideline recommendations for 416 patients with MDD, 284 with schizophrenia, and 192 with bipolar disorder.

Results: Most patients were clinically complex, receiving multiple treatment modalities and multiple psychopharmacologic treatments. Although guideline conformance rates were generally higher for psychopharmacologic than psychosocial recommendations, rates varied considerably. Only 37% of patients with bipolar disorder and 46% of patients with schizophrenia received guideline consistent psychotherapy compared with 71% for MDD patients. Although work disability rates were very high, only 1% received vocational rehabilitation. Rates of substance use treatment among patients with substance use disorders were also low.

Conclusion: A significant proportion of patients do not receive guideline consistent treatment, with access to psychosocial treatment a particular problem. Longitudinal research assessing treatment effectiveness is needed to determine if there is an empirically based clinical rationale for deviating from established treatment guidelines.

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SYMPOSIUM 32—THE SCARS OF SARS: ITS' IMPACTS ON PATIENTS, HEALTH CARE WORKERS, AND THE COMMUNITY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize the psychological and societal sequelae of a global outbreak of a novel life-threatening illness.

No. 32A
PTSD AND DEPRESSION IN PATIENTS DIAGNOSED WITH SARS

Rima Styra, M.D., *Department of Psychiatry, University Health Network, 200 Elizabeth Street, 8EN-235, Toronto, ON M5G 2C4, Canada*; Wayne L. Gold, M.D., Susan Robinson, R.N., Laura Hawryluck, M.D., Gerald Devins, M.D., Kenneth Mah, Ph.D.

SUMMARY:

The emergence of a new infectious disease caused by a previously unknown pathogen marked the onset of an alarming and stressful experience for patients with SARS. Patients' short- and long-term adjustment post-SARS has become a critical quality of life issue given the potentially life-threatening nature of the disease.

Patients diagnosed with SARS were assessed at four to eight weeks post-diagnosis using standardized psychometric scales. Thirty-three patients, 22 health care workers (HCW), and 11 non-HCW, were followed. This was a young patient population (mean age 37.1±10.7 years) and mainly (60%) female. There was a high prevalence of PTSD (mean Impact of Event Scale-Revised (IES-R) 24.8±15.0) and depression (mean Center for Epidemiologic Studies-Depression (CES-D) 19.8±9.9) symptomatology, with 48% of patients displaying both PTSD and depression symptoms. Patients with increased avoidance scores on the IES-R (t=2.35, p=0.03) were also less likely to have returned to work. The patients also reported high levels of anger with scores on the STAXI in the 90th percentile of population norms. This may reflect a sense of betrayal from the health care system. Hence, symptoms of PTSD and depression are common in patients with SARS and persist beyond the period of hospitalization. The short- and long-term sequelae of this disease may continue to affect psychological adjustment, and tracking patients over time may form the basis for further understanding of the psychological impact of new emerging infectious diseases.

No. 32B
THE PSYCHOLOGICAL IMPACT OF SARS ON THE UNINFECTED HEALTH CARE WORKER

Wayne L. Gold, M.D., *Toronto General Hospital, 200 Elizabeth Street, 9Es 402, Toronto, ON M5G 2C4, Canada*; Rima Styra, M.D., Laura Hawryluck, M.D., Susan Robinson, R.N., Allison McGeer, M.D., Sidney H. Kennedy, M.D., Calvin Fones, M.D.

SUMMARY:

Background: While health care workers (HCW) were among those diagnosed with SARS, it also had a significant psychological impact on the uninfected HCW. We measured the prevalence of PTSD in HCW at a hospital treating patients with SARS and examined potential associated factors.

Methods: A questionnaire was administered to HCW on high-risk units (SARS unit, ICU, ER) and selected control units. PTSD symptomatology was measured by the Impact of Events Scale - Revised (IES-R); a cut-point of >20 was used to indicate the presence of PTSD symptomatology, corresponding to the mean score measured for journalists working in war zones. Grouping of questions created domains, representing potential risk factors associated with the development of PTSD.

Results: There were 248 respondents (70% nurses). Mean IES-R was 19.1 ± 15.8. Overall, 43% had an IES-R score >20. Mean IES-R was higher on high-risk vs control units (21.9 ± 16.4 vs 13.8 ± 13.2, p <0.001). Multivariate logistic regression showed working on a high-risk unit, perception of risk to self, and perceived impact on work-life were associated with higher levels of distress.

Conclusions: Uninfected HCW experienced high levels of distress during the SARS outbreak. Attention should be paid and support made available especially to those at highest risk.

No. 32C
STRESS IN THE TIME OF SARS: HEALTH CARE WORKERS' REACTIONS TO THE SINGAPORE SARS OUTBREAK

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SUMMARY:

Singapore was affected by an outbreak of Severe Acute Respiratory Syndrome (SARS) from February 25 to May 31, 2003, which affected in particular, health care workers (HCWs). We studied the reactions of HCWs by distributing a self-administered questionnaire to 15,025 HCWs from May-July 2003. A total of 10,511 valid questionnaires were completed (9% were doctors; 43% nurses). HCWs feared contracting SARS, (66% felt "at great risk"), even though 96% felt that implementation of protective measures were "generally effective." The majority (56%) perceived "more stress at work"; occupational and psychosocial factors contributing to this are discussed. The Impact of Events Scale (IES) measured the subjective distress experienced in response to the outbreak. A score of 26 or more (moderate or severe impact) was found in 29% of HCWs. Bivariate and multivariate analyses were conducted to examine the factors associated with high IES scores. Logistic regression showed that females, nurses and attendants, those with children, clinicians directly caring for SARS patients, and those working in intensive care settings were likely to have high IES scores. HCWs are exposed to high levels of stress during a health care crisis like SARS. Attention should be paid to those who are vulnerable and the factors contributing, in order to offer appropriate support and interventions.

No. 32D
IMPACT OF SARS ON HEALTH CARE PROFESSIONALS

Sharon Straus, M.D., *Department of Medicine, Toronto General Hospital UHN, ES9-407, 200 Elizabeth Street, Toronto, ON M5G 2C4, Canada*; Wayne L. Gold, M.D., Kumanan Wilson, M.D., Moira Kapral, M.D., Gloria Rambaldini, M.D., Darlyne Rath, M.S.C.

SUMMARY:

The recent Severe Acute Respiratory Distress Syndrome (SARS) outbreak allows an opportunity to explore the issues of medical professionalism in the context of an emerging health threat. Although it has been compared with situations with HIV, smallpox, tuberculosis, and polio, relatively few patients have been affected by this disease in comparison. Differences also arise in the level of concern that has arisen amongst health care professionals and society at large because of the lack of knowledge about the transmission of this illness. All of these concerns impact on the physician's response to this disease and require reflection on our professionalism. We conducted a series of semi-structured interviews with 17 medical residents and 14 staff physicians who worked at four hospitals associated with the University of Toronto. Domains of inquiry were identified from a literature review. The majority of physicians indicated that they were fearful for their safety and engaged in precautions to protect themselves, friends, and family. Most felt confident in the infection control policy decisions and believed that the infection control staff were doing the best they could. Several examples of unprofessional behavior were noted but respondents felt proud of the medical profession and the way the physicians placed patient care ahead of personal safety. Respondents made several recommendations for improving the approach to future outbreaks such as placing more emphasis on the topic of professionalism during training.

No. 32E
I AM SO ALONE: LESSONS LEARNED FROM EXPERIENCES OF QUARANTINED INDIVIDUALS DURING THE SARS OUTBREAK IN TORONTO

Laura Hawryluck, M.D., *Department of Continuing Education, University of Toronto, 500 University Avenue, Suite 650, Toronto, ON MSG 1V7, Canada*; Wayne L. Gold, M.D., Susan Robinson, R.N., Sandro Galea, M.D., Rima Styra, M.D.

SUMMARY:

Background: By definition an isolating venture, quarantine may exact psychological and emotional burdens from individuals for the greater public good. Little is known about these burdens or how isolated individuals can be supported. The goal of this study is to explore the psychological and emotional impact of quarantine during the recent outbreak of Severe Acute Respiratory Syndrome (SARS) in the Greater Toronto Area.

Methods: Anonymous multiple choice and short answer, internet-based survey of quarantined individuals. The Impact of Event Scale (IES) - Revised, a shortened Medical Outcome Survey Social Support (MOS) Scale, and Center for Epidemiologic Studies-Depressed Mood Scale (CES-D) were used.

Results: Of 129 respondents, 67% were health care workers (HCW). Thirty-one percent had CES-D>16; 28.93% had IES-R score > 20. Chi square revealed correlation between IES-R/ CES-D scores ($p<0.001$). Neither marital status, household contacts, level of education, knowledge, or being a HCW correlated with IES-R or CES-D scores. Knowing someone with SARS, duration of quarantine, and lower socio-economic status did (ANOVA $p=0.01$). Despite supportive families, all respondents felt alone.

Conclusions: Close contact with the effects of SARS, longer duration of isolation, and lower socio-economic status may explain high IES-R/ CESD scores despite high levels of support in quarantined individuals.

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SYMPOSIUM 33—INTERPERSONAL PSYCHOTHERAPY: RESEARCH UPDATE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the use of IPT in different treatment settings and in differing dosing regimens.

No. 33A
GROUP INTERPERSONAL PSYCHOTHERAPY FOR DEPRESSION IN UGANDA

Myrna M. Weissman, Ph.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 24, New York, NY 10032-2603*; Paul Bolton, M.B., Helena Verdeli, Ph.D., Richard Neugebauer, Ph.D., Judith Bass, M.P.H., Kathleen Clougherty, M.S.W., Priya Wickramaratne, Ph.D.

SUMMARY:

Depression is a leading cause of disability in both developed and developing regions of the world. A survey conducted in 2000 in an impoverished part of South-West Uganda that had been severely affected by HIV, found current rates of depression of 21%. Both antidepressants and psychotherapy have been shown to be efficacious in treatment of major depression in numerous controlled trials in developed countries. However, use of antidepressants is not feasible in Uganda because of high cost and limited supply infrastructure. Psychotherapy was therefore the preferred option, although its use raised other issues. While there is substantial evidence for the efficacy of "talking therapies," these have been developed in industrialized nations in the Western Hemisphere. The extent to which the concepts and therapeutic strategies they use are appropriate among other populations is unknown. In sub-Saharan Africa, conditions are very different from those in which psychotherapy was developed in ways that could reduce effectiveness. This paper reports the results of a controlled clinical trial of group IPT in 30 villages in rural Uganda. Our purposes were (1) to test the efficacy of group IPT for Uganda (IPT-G-U) in relieving depressive symptoms and improving functioning and (2) to evaluate the feasibility of such studies in sub-Saharan Africa. To our knowledge, this is the first published controlled clinical trial of a psychological intervention in resource-poor, sub-Saharan Africa.

No. 33B
COMBINATION OF IPT AND MEDICATION IN OUTPATIENTS WITH DEPRESSION: IS IT THE BEST WE CAN DO?

Marc B.J. Blom, M.D., *Parnassia Psychomedical Centre, Monsterseweg 83, Den Haag 2566 SE, Netherlands*; Kosse Jonker, Erik Hoencamp, M.D., Philip Spinhovem, Ph.D., Judith Haffmans, Ph.D., Richard Van Dyck, M.D.

SUMMARY:

Combination of psychotherapy and medication in depression has a clear face value. Studies have so far failed to find an advantage, with the exception of study by Weissman et al. (1979). The main reason for this negative finding is lack of statistical power in most studies.

In the study presented, 191 patients with depression were treated with interpersonal psychotherapy (IPT), IPT combined with nefazodone, IPT combined with placebo, or nefazodone alone. It is also the first large study using IPT in a non-English speaking country.

Conclusions: IPT is effective treatment in the Netherlands, there were no differences in efficacy between medication condition and IPT. The treatment was well received.

We found no advantage for the combination of IPT and nefazodone.

No. 33C
IPT FOR ANXIETY AND DEPRESSION IN PRIMARY CARE IN SCOTLAND

Roslyn Law, Psy.D., *Royal Edinburgh Hospital, Cullen and Rivers, Tipperlinn Road, Edinburgh EHI05HF, Scotland*

SUMMARY:

A total of 288 subjects were recruited from 49 rural and urban general practices. Of these, 157 were randomized into five treatment groups: early intervention interpersonal psychotherapy (IPT), late intervention IPT, early intervention cognitive-behavioral therapy

(CBT), late intervention CBT, and routine GP care (treatment as usual; TAU). Subjects were diagnosed with a range of depressive and anxiety disorders at baseline, and more than half of the subjects met their diagnostic criteria for at least two disorders. All subjects reported a reduction in number of diagnoses and severity of symptoms over the course of treatment. This change was significantly greater for those receiving psychotherapy than those receiving routine GP care. Initial results suggest that IPT yielded the greatest improvement in depressive and anxiety symptoms and overall social functioning, followed by CBT, and then TAU. IPT retained a greater number of subjects in treatment for significantly longer than the other conditions, and further analysis will explore the relative impact of treatment duration and type. Reduction in symptom severity was correlated with a significant improvement in overall social functioning. Subjects receiving early and delayed treatment did not report a significantly different overall change in symptom severity, but early treatment yielded more rapid changes in symptoms and social functioning than delayed treatment and TAU. The groups did not differ in overall frequency of attendance at general practitioners or other health care facilities during the study. All groups sustained the gains reported during treatment over a five-month follow-up.

No. 33D
BRIEF INTERPERSONAL PSYCHOTHERAPY FOR DEPRESSION IN WOMEN

Holly A. Swartz, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213*; Ellen Frank, Ph.D., M. Katherine Shear, M.D., Michael E. Thase, M.D., John Scott, M.A.

SUMMARY:

Objective: Interpersonal psychotherapy (IPT) and pharmacotherapy are both efficacious treatments for depression. *Post hoc* analyses suggest reductions in depressive symptoms occur more quickly with pharmacotherapy than psychotherapy. Brief IPT (IPT-B) is an eight-session psychotherapy for depression. In our pilot study of this intervention, eight-week outcomes following treatment with IPT-B (n=16) or sertraline (n=16) were evaluated with a matched-case control design.

Methods: Adult females meeting DSM-IV criteria for major depression, with HRSD-17 scores > 15, were treated openly with IPT-B. IPT-B treated subjects were matched on age, gender, and baseline depression severity to subjects treated with sertraline (134.38 ± 35.21 mg). Linear mixed-effects regressions compared the two groups over eight weeks of treatment.

Results: Significant time effects for HRSD-17 scores ($F=96.40$, $df=1,30$, $p<0.0001$) and GAS scores ($F=67.71$, $df=1,30$, $p<0.0001$) demonstrated that both groups improved over time. Significant time-by-group interaction effects indicate that the IPT-B group improved significantly faster than the SSRI group (HRSD-17 scores, $F=4.76$, $df=1,161$, $p=0.03$; GAS scores, $F=5.32$, $df=1,161$, $p=0.02$).

Conclusions: Preliminary findings suggest IPT-B is at least as efficacious as sertraline as an eight-week treatment for major depressive disorder in women. The brevity of IPT-B motivates therapists and patients to work quickly, affording rapid relief from symptoms.

No. 33E
LONG-TERM PROPHYLAXIS AND OTHER BENEFITS OF MAINTENANCE INTERPERSONAL PSYCHOTHERAPY

Ellen Frank, Ph.D., *Department of Psychiatry, University of Pittsburgh, Western Psychiatric, 3811 O'Hara Street, Pittsburgh, PA 15213-2593*; Jill M. Cyranowski, Ph.D., Holly A. Swartz, M.D., David J. Kupfer, M.D.

SUMMARY:

While there are data demonstrating the value of targeted psychotherapy for acute depression, little is known about its long-term preventative effects. Long-term prophylaxis with psychotherapy alone has particular appeal to women in the childbearing years. To determine whether more frequent maintenance interpersonal psychotherapy (IPT-M) had greater prophylactic effect than the monthly treatment reported on in 1990, we randomly assigned 99 women with recurrent depression who had remitted with IPT alone to weekly, bimonthly, or monthly IPT-M for a period of two years. Only 19 (19.2%) subjects experienced a recurrence, although the modal patient was in her fifth depressive episode when she entered the trial. Survival analysis of time to recurrence by randomized treatment group showed no effect on recurrence free survival. Women who remained well also evidenced marked reduction in endorsement of SCID-II probes for Axis II pathology. We conclude that a treatment strategy that involves acute IPT followed by monthly IPT-M represents a reasonable approach to treatment of women with recurrent depression and one that should prove particularly attractive to those who are pregnant or nursing a child.

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SYMPOSIUM 34—WOMEN'S SEXUALITY UPDATE: OVERCOMING OBSTACLES TO PLEASURE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be mindful of the medical causes of female sexual dysfunction and consider some of the new and novel treatment options that are available.

No. 34A
HOW SEXUAL ATTRACTIVENESS, PHEROMONES, FERTILITY, AND HYSTERECTOMY ARE RELATED

Winnifred B. Cutler, Ph.D., *Athena Institute, 1211 Braefield Road, Chester Springs, PA 19425*

SUMMARY:

In nature, sex pheromones are powerful agents driving reproduction and perpetuation of the species. First defined by biologists

exploring excreted substances that elicited behavioral and developmental responses from others, evidence suggests pheromonal output varies among individuals and is highest during the most fertile periods of life. Output diminishes consequent to loss of reproductive fertility. In the rhesus monkey, ovariectomy and hysterectomy abolish the natural secretion of sex attractant pheromones. Attractiveness can be restored by topically applying species-specific pheromone or by replacing the missing reproductive hormones appropriately. Reported sexual dysfunctions in ≥29% of women after hysterectomy probably involve pheromonal deficiencies.

Research on both healthy and dysfunctional sexuality has not yet incorporated an investigative vocabulary about attractiveness. It is possible that the almost ubiquitous decline in sexual interest after menopause and hysterectomy is related to the decline in sexual attractiveness.

Three recent double-blind, placebo-controlled experiments reported that a topically applied synthesized pheromone cosmetic increased sexual attractiveness as measured by increases over baseline in sexual activities that require the participation of a willing partner ($p<.01$); it did not increase user's libido. Sexual attractiveness can increase affectionate intimate behavior, which promotes well-being. Pheromone cosmetics may thus serve sexual health.

No. 34B
ANTIDEPRESSANTS AND SEXUAL DYSFUNCTION: A WOMAN'S ISSUE

James Kocsis, M.D., *Psychiatry, Weill Cornell, 525 East 68th Street, Room F-1324, New York, NT 10021*

SUMMARY:

Although antidepressant medications are known to have sexual side effects, the issue is complex. Depression itself is associated with sexual dysfunction. Sexual dysfunction as a symptom of depression and as a sexual side effect of antidepressants may demonstrate important gender differences.

Desire and arousal appear to be more closely linked to the severity of depression in women than in men. In males, erectile and ejaculatory side effects of serotonergic antidepressants appear to respond to phosphodiesterase inhibitors such as sildenifil, whereas the value of these medications in treating antidepressant-induced sexual side effects in women is less clear and is just now being investigated.

The importance of dopamine in the physiology of sexual desire and arousal is well recognized. Medications that increase central dopaminergic neurotransmission appear to ameliorate antidepressant-induced sexual dysfunction. Buproprion, an antidepressant that is not associated with adverse sexual side effects, blocks the synaptic reuptake of both dopamine and norepinephrine. It can be combined with SSRI antidepressants on a standing or prn basis to counteract their sexual side effects.

This presentation will review sexual function in depressed patients and sexual side effects of antidepressants. Methods of assessment, pathophysiology, and treatment of sexual dysfunction, especially in females, will be discussed.

No. 34C
CHANGES IN SEXUAL FUNCTIONING ACROSS THE MENSTRUAL CYCLE AND DURING AND AFTER PREGNANCY

Catherie Birndorf, M.D., *Psychiatry, Weill Cornell, 425 East 61st Street, Penthouse Room 1354, New York, NY 10021*

SUMMARY:

Though a great deal of research has been done on assessing changes in mood and behavior across the menstrual cycle, information on changes in sexual desire and arousal is remarkably lacking. Some studies demonstrate the highest levels of desire and arousal during the premenstruum. Others report exactly the opposite. Still, others found peaks near the time of ovulation. Some declared that there was no relationship at all. One study found that women with premenstrual complaints had highest levels of sexual interest at ovulation, while those without it peaked during the premenstrual phase. Needless to say, results have been inconsistent, due, in part, to methodological flaws, small sample size, and differences in definitions.

Similarly, little is known about changes in sexual desire and arousal during pregnancy and the postpartum period. Some investigators have noted increasing sexual interest and arousal during pregnancy, while others have noted the reverse. In any event, there appears to be tremendous individual variation. However, it is clear that sexual desire and arousal are diminished after childbirth.

This presentation will review the diverse literature on this subject ant attempt to make sense out of an area that is unclear.

No. 34D
NEW TREATMENT OPTIONS FOR WOMEN WITH SEXUAL DYSFUNCTION

Barbara D. Bartlik, M.D., *Department of Psychiatry, Weill-Cornell University Medical College, 425 East 61st Street, Penthouse Room 1306, New York, NY 10021*; Amy Kossoy, B.A., Marina Rozenberg; Julie Kolzet, B.S., Adriel Gerard

SUMMARY:

Since many of the medications commonly taken today inhibit sexual functioning, we need medications now more than ever before to counteract sexual side effects. Though there are many treatment options for men with erectile disorder, there are no FDA-approved pharmaceuticals for female sexual dysfunction.

This presentation will highlight the importance of adequate levels of sex hormones, including testosterone, to healthy sexual functioning in women. The variety of ways that testosterone may be administered to women will be discussed. The EROS-CTD, and FDA-approved suction device that draws blood into the clitoris will be described. New research on the use of the phosphodiesterase inhibitor sildenafil (Viagra) in women will be summarized. Other phosphodiesterase inhibitors approved for use in men, such as vardenafil (Levitra) and tadalafil (Cialis) will be described. There is evidence that both apomorphone (Uprima), which is not FDA approved, and buproprion (Wellbutrin), a popular antidepressant, heighten sexual functioning by boosting levels of the sex-enhancing neurotransmitter dopamine. Prostaglandins, which are used in treating erectile disorder, are currently being tested as topical preparations for women.

In addition, a variety of herbal creams and pills, which do not require FDA approval and are on the market, will be discussed. The information that exists on the efficacy and safety of these products will be presented.

No. 34E
THE POSITIVE USES OF ADULT MOVIES CATERING TO WOMEN

Candida Royalle, *Femme Productions, P.O. Box 268, New York, NY 10012*

SUMMARY:

It is commonly accepted that adult movies are degrading to women and that women do not enjoy watching sexually explicit movies. But what if there were movies that catered to the personal tastes and fantasies of women? Would we then find that women are indeed visually oriented in what turns them on? And could there be positive uses of these types of movies both in terms of sexual stimulation as

well as learning tools and materials that might work in conjunction with counseling?

Candida Royalle, AASECT member and founding board member of Feminists for Free Expression, created Femme Productions in 1984 in order to create just such materials. Her work has been extremely well received by women, utilized by counselors and researchers, and written up in sexuality journals and countless mainstream media. She will discuss her aims, how her work has been used, and the work of others that she feels would be of use to counselors needing sexual visual aids for their clients. She will show clips from her movies to illustrate.

Royalle has presented at several professional conferences including the American Psychiatric Association with Helen Singer Kaplan, the Smithsonian Institution, and the World Congress on Sexology.

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SYMPOSIUM 35—CONTEMPORARY ISSUES IN SPORT PSYCHIATRY
International Society for Sport Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should better understand the phenomena of athlete-to-athlete, athlete-to-coach, and athlete-domestic violence; learn that career termination is quite traumatic, especially for boxers, and about a program that assists them; understand the impact of sudden injury on a star adolescent athlete and his or her parents, while learning how sport psychiatrists intervene in each of the above situations.

No. 35A
FIST: A UNIQUE PROGRAM FOR BOXERS AT CAREER END

Ronald L. Kamm, M.D., *257 Monmouth Road, #A-5, Oakhurst, NJ 07755-1502;* Gerry Cooney, Joseph Sano, Ann Weiss, Michael Smith

SUMMARY:

Though boxing is the oldest professional sport in the United States, it remains the only major sport without a professional player's association and without standardized employee benefits.

Yet leaving the sport of boxing is a real life crisis and is often quite traumatic. Former heavyweight contender Carl Williams described life before and after boxing: "You were on a plateau, now you're in a valley." Former junior featherweight contender Kenny Mitchell added, "When you're on top, you have a lot of friends. When you retire, you're like a nobody."

Of course, not only boxers view retirement negatively. On a national scale, as many as one-third of all retirees suffer from depression, and of those who have voluntarily retired, a majority re-enter the work force in two years.

Unfortunately, the social world that forms around a fighter's sport greatly interferes with this important life transition. Formal education is not stressed as the boxer is developing his or her skills. In fact, many fighters are encouraged by their trainers to drop out of school. Boxing also seldom increases social contacts with people outside of its own tightly bounded world. Professional tennis players and golfers have polar opposite experiences; they play in settings where they meet people with a wide range of social and business contacts.

Whatever their sport, it is often said that an elite athlete dies twice, the first time when his or her career ends. When counseling such athletes, it therefore makes sense to apply the death and dying model of Kubler Ross (1969). Trainers, managers, gym owners, and licensing boards thus have to be educated about the signs of denial: "There's nothing wrong with me, I just have to train harder"; and bargaining: "Just give me one more fight *then* I'll quit" that the "used up" fighter frequently exhibits. Unfortunately, there has been, until now, nowhere for fighters to turn. But in 1998 Gerry Cooney started FIST—The Fighters Initiative for Support and Training—for New York-area retired and soon-to-be-retired boxers. Mr. Cooney asked sport psychiatrist, Ronald Kamm to become involved, and data will be presented by them and other FIST personnel regarding the 250 boxers who have entered the career transition program since 1999: average age, number of years fought, marital status, substance abuse history, etc. Vocational adjustment and placements will also be discussed, as well as the psychiatric, medical, and social-adjustment problems observed in this population.

No. 35B
THE IMPACT OF INJURY ON THE ADOLESCENT ATHLETE AND THE FAMILY

Thomas S. Newmark, M.D., *Department of Psychiatry, Cooper University Hospital, 401 Haddon Ave, E&R Bldg, #356, Camden, NJ 08103*

SUMMARY:

Response to a career ending injury can be that of significant anger and depression. Adolescent athletes are often shocked and outraged at the occurrence of an event as seemingly unfair as an injury. Adolescent athletes develop a true passion for their sport. The adolescent athlete like others of the same age will be wrestling with new emotions and suddenly victory becomes an object of desire. The spirit of the adolescent athlete soars when performing before his or her romantic interest. An adolescent athlete can "live or die" with the fortunes of their team. Success can boost self-esteem, ability to cope, and general outlook on life. Failure can have the opposite effect. Athletes may specialize in a particular sport or aspect of the sport. This is connected to identity formation. Family issues also become paramount during this period. Hellstedt has defined an "athletic family" as a family system that involves parents and children who are involved in an intensive youth sport. Many of these families keep a proper perspective and balance athletic and non-athletic activities. However, overinvolvement and occasionally, underinvolvement in the adolescent athlete's sport can occur, although overinvolvement appears to be more common.

In a case presentation, a Philadelphia area, self-psychologically-oriented psychiatrist will describe how caught up he became with his talented hockey-playing son's exploits, how enhanced he felt to be the father of a "star", and how devastatingly he felt the loss when his son was injured. The adolescent athlete will also speak of his personal experience of the injury of his teammates'; coach's, and parents' reactions; and how this affected his sense of self-esteem. The athlete's mother, a self-psychologically-oriented psychologist, will also share her perspective, after which a sport psychiatrist will discuss the case.

No. 35C
KEEPING THE ATHLETE OUT OF TROUBLE

Eric D. Morse, M.D., *5766 Gold Finch Court, Ellicott City, MD 21043*

SUMMARY:

Since athletes in today's society are often in the public eye, we are drawn to when athletes get into trouble. Many college and professional teams have professionals who help counsel athletes on prevention of common problems, including substance abuse prevention, assistance with domestic violence or sexual assault issues, and conflict resolution between teammates or coaches. Kobe Bryant, Latrell Sprewell, Mike Tyson, Charles Barkley, and Mark Chmura are a few of the athletes who have come to public attention for alleged transgressions.

What can be done to prevent such cases? Some teams consult lawyers, sport psychiatrists, addiction counselors, domestic violence counselors, former athletes, and clergy to assist athletes who present with these problems. Some leagues and teams run urine drug screens to help identify those athletes who may need substance abuse counseling. Others will hire psychiatrists or counselors to give talks on the dangers of substance use and how it can impair judgment or impact performance. This presentation will include discussion of what might be most useful in treating substance-related problems in athletes.

Domestic violence programs can be helpful in assisting both victims and perpetrators of domestic violence. Some colleges have specific honor courts and ways of dealing with this issue. There will be discussion of how helpful peer counseling can be.

Athletes' status and wealth may make them unique targets for entrapment or lawsuits. The damage to an athlete's image, especially when it comes to endorsements, may be too high a price to pay in comparison to a nuisance lawsuit. Former players and lawyers are sometimes consulted by teams to warn athletes of common and potentially dangerous situations and how to deal with them.

In the heat of competitive battle, emotions sometimes run high and out of control. We will discuss how teaching teams, coaches, and athletes' skills in conflict resolution can help prevent problems.

Ex-NFL wide-receiver Stacy Robinson, now Director of Player Development for the NFL Players Association, will share his perspectives on this issue.

Athlete Discussants: Gerry Cooney, Boxer; Auc Bakey, Hockey Player; Howard and Maggie Baker, Parents; Stacy Robinson, NFL Player.

REFERENCES:

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SYMPOSIUM 36—EATING DISORDERS 2004: FROM PETS TO PSYCHE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will be able to discuss how nutrition affects serotonin receptors and emotional regulation, assessing and treating osteopenia/osteoporosis in anorexia nervosa, predicting treatment adherence in anorexia nervosa, eating disorders in bariatric surgery patients, origins and treatment of body image distortions, and other emerging findings in eating disorders research.

No. 36A

EFFECTS OF WEIGHT LOSS ON 5HT ACTIVITY AND SYMPTOMS IN ANOREXIA NERVOSA

Walter H. Kaye, M.D., *Department of Psychiatry, University of Pittsburgh, 38114 O'Hara Street, Suite 600, Iroquis Bldg., Pittsburgh, PA 15213*; Ursula Bailer, M.D., Carolyn Meltzer, M.D., Guido K.W. Frank, M.D., Chet Mathis, Ph.D., Julie Price, Ph.D.

SUMMARY:

Disturbances of serotonin function are common in anorexia nervosa (AN). However, little is known about where disturbed 5-HT activity occurs in the brain or how it contributes to altered appetite, mood, or perception. Positron emission tomography (PET) and [^{11}C]WAY100635 were used to assess binding potential of the $5HT_{1A}$ receptor and PET with [^{18}F]altanserin was used to assess postsynaptic $5HT_{2A}$ receptor binding potential. Several lines of evidence support the possibility that alterations of these receptors could play a role in AN.

A total of 13 women who were ill with AN were compared with 18 healthy control women (CW). Compared with CW, AN women had a significant increase in [^{11}C]WAY100635 binding potential in frontal, cingulate, temporal, and parietal cortex, and raphe nuclei. In contrast, AN women had a significant reduction of [^{18}F]altanserin binding potential in these cortical regions. $5HT_{2A}$ receptor activity was negatively related to harm avoidance in AN women in frontal and other regions. In the lateral orbital frontal cortex, where these two receptors co-exist, both AN and CW showed a negative relationship between $5HT_{2A}$ and $5HT_{1A}$ receptor activity. A ratio between $5HT_{1A}$ and $5HT_{2A}$ receptor activity in the lateral orbital frontal cortex was negatively related to weight for AN women, while no relationship was found for CW.

In summary, AN women had increased activity of 5HT-1A post-synaptic receptors and somato-dendritic autoreceptors, and reduced activity of 5HT-2A post-synaptic receptors. Weight loss appears to increase 5HT1A receptor activity in AN women and diminish 5HT2A receptor activity, which may in turn reduce anxious symptoms. These data support clinical observations that starvation and weight loss serve to reduce dysphoric symptoms in AN. Moreover, weight loss-induced effect on frontal 5HT1A and 5HT2A receptors may contribute to perceptual distortions in AN. These findings may explain the vicious cycle that often occurs in AN, where weight loss drives a desire for further weight loss.

No. 36B

OSTEOPOROSIS AND ANOREXIA NERVOSA: AN UPDATE

David B. Herzog, M.D., *Department of Psychiatry, Massachusetts General Hospital, 725 ACC-EDU 15 Parkman Street, Boston, MA 02114*; Anne Klibanski, M.D., Karen K. Miller, Madhu Misra, M.D., Mary P. Manzo, A.B., Safia C. Abidi, B.S.

SUMMARY:

Osteoporosis is a prevalent complication of anorexia nervosa (AN), affecting approximately 50% of women with this disorder. Since bone mass often stays low even in recovered patients, many women with AN remain at an elevated risk for fracture throughout life. Those who have onset of AN during adolescence are at greatest risk for osteoporosis later in life because they not only lose bone mass but also fail to form new bone during a crucial developmental period during which peak bone mass is achieved. Factors that may contribute to bone loss in AN include under-nutrition, elevated cortisol levels, low insulin-like growth factor levels, hypoestrogenemia, testosterone deficiency, decreased calcium intake, and excessive physical activity.

We have been investigating treatments of osteoporosis for more than a decade. Initial studies indicate estrogen therapy alone does not reverse bone loss in women with AN. Women with AN have a deficiency in IGF-I, a bone trophic hormone, and recent studies at MGH have found that daily IGF-I injections over a nine-month period increased bone density. More recently, bisphosphonates, which are effective at reducing bone resorption and increasing bone density in post-menopausal women, are being investigated in AN. Preliminary data suggest that the bisphosphonate risedronate (Actonel) may reduce bone resorption and markedly increases bone density in women with AN.

Studies are under way to assess the efficacy of the co-administration of physiologic testosterone and bisphosphonates. Clinical recommendations will be discussed.

No. 36C
PREDICTORS OF TREATMENT ACCEPTANCE IN ANOREXIA NERVOSA

Katherine A. Halmi, M.D., *Department of Psychiatry, Weill-Cornell Medical, 21 Bloomingdale Road, White Plains, NY 10605*; W. Stewart Agras, M.D., Scott J. Crow, M.D., James E. Mitchell, M.D., G. Terrence Wilson, Ph.D., Susan Bryson, Ph.D., Helena C. Kraemer, Ph.D.

SUMMARY:

Objective: The major aim of this study was to evaluate over the course of a year the effect of two specific therapies and their combination in the treatment of anorexia nervosa (AN) patients and to examine predictors of treatment acceptance.

Method: Patients from three centers (Weill-Cornell, University of Minnesota, Stanford University) were randomly assigned within each center to cognitive-behavioral therapy (CBT), fluoxetine, or their combination. Treatment acceptance was staying in treatment for at least five weeks.

Results: There was a significant treatment effect for treatment acceptance, with less acceptance for medication compared with the CBT groups ($F(2,113)=4.34p=0.15$). Of the 122 patients randomly assigned, 22 were withdrawn for medical or psychiatric instability. The main reason for dropout of 56 (46%) patients was dissatisfaction with some aspect of the treatment. Of the 122 cases, 73% accepted treatment. The first predictor of acceptance using signal detection analysis was treatment type with 56.1% acceptance of medication and 81.5% acceptance of CBT groups. In the latter, those with high eating disorder preoccupations accepted the CBT groups better than medication. For those with low preoccupations, there was no difference between CBT and medication. Of the 89 patients who were treatment accepters, 50.6% completed treatment. Completion rate with higher esteem was 86% and with low esteem, 39.7%, and the low self-esteem fared worst in the medication-alone group.

Conclusions: Individuals with different characteristics have different outcomes for treatment acceptance and completion of treatment. It is necessary to remediate the acceptance and dropout problems before conducting trials with different treatments.

No. 36D
EATING PROBLEMS AND DISORDERS IN BARIATRIC SURGERY PATIENTS

James E. Mitchell, M.D., *Neuropsychiatric Research Institute, 700 First Avenue, South, P O Box 1415, Fargo, ND 58103*; Martina deZwaan, M.D., Ross D. Crosby, Ph.D., Stephen A. Wonderlich, Ph.D.

SUMMARY:

Bariatric surgery for obesity is becoming an increasingly utilized option, given the marked increase in the prevalence of obesity worldwide and the relative safety of the latest generation of bariatric surgical procedures. However, there are concerns that individuals with certain comorbidities, particularly certain forms of psychopathology, may not be good candidates for these procedures. Also, there has been discussion as to whether or not binge eating in the obese is a relative contraindication to bariatric surgery. This paper will review the types of procedures now being performed, their major medical complications, and their relationships to eating disorders. Such relationships include the development of clinically significant eating problems in a minority of patients' status post surgery, and ongoing problems suggestive of eating disorders symptoms such as episodes of vomiting long term post operatively. The paper will also review the psychosocial outcomes of the various bariatric surgical procedures and the psychosocial interventions that have been developed for this group of patients. Last, the paper will present data on the long-term follow-up of a cohort of patients who underwent bariatric surgery and present data on the impact of binge eating on weight regain.

No. 36E
BODY IMAGE: EVOLUTIONARY NEUROBIOLOGY MEETS PSYCHODYNAMIC PSYCHIATRY IN THE AGORA

Arnold E. Andersen, M.D., *Department of Psychiatry, University of Iowa, 200 Hawkins Drive, 2880 JPP, Iowa City, IA 52242*

SUMMARY:

Body image refers to the internal representation of body size and shape. Its evolutionary neurobiology is vitally related to survival by being functional and interactive, characteristics often neglected in the emphasis on the individual patient's intrapsychic distress. Evolutionary neurobiology uses accurate body image to assess the status of self vs. other in regard to eating, being eaten, mating, aggressing, cooperating, or fleeing, and to a lesser extent, assessing the ability of self to negotiate the physical environment. Psychodynamic distortions of body image involve object relations processes, object idealization, cathexis, condensation, and projective identification. The distress of body image distortion in patients with eating disorders and body dysmorphia has a functional and interpersonal rationale, but a rationale that coopts evolutionary neurobiology into psychopathology. Adequate treatment of body image distortion involves understanding how an individual's maturational goal of identity formation is psychopathologically distorted in a specific sociocultural milieu. Improvement in body image distress requires diagnostic assessment, including measurement of distortion (part vs. whole, shape vs. weight, overvaluation or devaluation) and integrative treatment including psychopharmacology, cognitive-behavioral therapy, psychodynamic psychotherapy, nutritional rehabilitation, psychoeducation, body training, and confrontation. Methods of measuring body image distress and treatment outcomes by various methods will be presented.

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SYMPOSIUM 37—PSYCHIATRIC INTERVENTIONS WITH MEDICALLY-EVACUATED SOLDIERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the variable nature of casualties resulting from combat and recognize the broad role of psychiatric interventions in both treatment and prevention.

No. 37A
A MEDICAL CENTER RESPONSE TO COMBAT CASUALTIES

Thomas M. Fitzpatrick, M.D., *Deputy Command, Walter Reed Army Medical Center, 6900 Georgia Avenue, NW, Washington, DC 20307-5001*

SUMMARY:

Objective: Walter Reed Army Medical Center (WRAMC) is the largest military medical center in the world. Its principal function during world-wide combat operations is to receive casualties evacuated from within the operational theater who require medical treatment available at a tertiary care medical center or who are being redeployed due to medical conditions that disallow them to continue to function within the operational setting. Since the initiation of conflict in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), WRAMC has received hundreds of surgical, medical, and psychiatric casualties.

Method/Results: This presentation will describe the ongoing mission of WRAMC as it relates to OEF and OIF patients. The presenter will discuss the complex nature of returning casualties from the operational theater and the important role that psychiatric services has provided in treating psychiatric casualties, as well as medical and surgical casualties. The necessity of ensuring effective continuity of care through the military medical system will also be highlighted.

Conclusions: The role of psychiatric services in the effective treatment of all categories of military casualties cannot be underestimated. The experience of the senior hospital leadership supports the proactive involvement of psychiatric services in the treatment of medical casualties of all types.

No. 37B
A PSYCHIATRY CONSULTATION SERVICE RESPONSE TO TRAUMA VICTIMS: PROGRAM TO PREVENT PSYCHIATRIC COMORBIDITY

Harold J. Wain, Ph.D., *Department of Psychiatry, Walter Reed Army Medical Center, 6900 Georgia Avenue, NW, Washington, DC 20307-5001*

SUMMARY:

Objective: The combination of war and physical trauma on psychiatric comorbidity has not always received necessary attention. Since fall 2001 over 200 patients have been screened after being injured in combat operations in both Afghanistan and Iraq. The Psychiatry Consultation Liaison Service (PCLS) by virtue of its mission at Walter Reed Army Medical Center is obliged to focus on the impact of trauma on a patient's biopsychosocial well being.

Method/Results: This presentation will highlight the PCLS's approach to handling medical-surgical patients after being injured in a war-related environment. The approach, entitled "Therapeutic Intervention and Prevention of Psychiatric Stress Disorders (TIPPS)", to include screening, developing working alliances and interventions, to include brief psychotherapy, use of humor, pharmacology, hypnotic techniques, and reframing approaches, will be described. The presentation will address topics including survivor guilt, grief, abandonment, family responsibility, pain, phantom limb, and impact of previous traumas. Ways of helping patients to develop coping strategies to control and master their symptoms will be discussed.

Conclusions: The importance of being part of the trauma team, the relationship with the primary physician and nurses, and the therapeutic alliance in dealing with trauma victims will be emphasized along with an awareness of transference and countertransference issues.

No. 37C
GLOBAL WAR ON TERROR: WALTER REED ARMY MEDICAL CENTER INPATIENT PSYCHIATRY'S PERSPECTIVE

Theodore S. Nam, M.D., *Department of Psychiatry, Walter Reed Army Medical Center, 6900 Georgia Avenue, NW Building 2, Washington, DC 20307-5001*

SUMMARY:

Objective: During the first year of the "Decade of the Brain (1990)," the inpatient psychiatric hospitalization rate in the U.S. was about eight per 1,000 compared with one per 1,000 in the military during the first Gulf War (1990–91). In U.S., the delay in obtaining any form of treatment for a psychiatric disorder is between six and 14 years. The *PIES* Principle (*P*roxemity, *I*mmediacy, *E*xpectancy, *S*implicity), first applied during World War I, is still being utilized by the military in the global war on terror. In addition, active preventive, early identification, and treatment of mental disorders with a ready access have all contributed to the mental health of the military. However, the impact of adverse life events such as dealing with exigencies of the global war on terror on the mental health of the soldiers is still profound in terms of new and recurrence of psychiatric disorders.

Method/Results: The data from the WRAMC's preparation and management of inpatient psychiatric admission of the soldiers participating in the GWOT will be presented.

Conclusions: Despite active preventive measures to combat adverse life events, there still is an essential need for inpatient psychiatric treatment in the military facility.

No. 37D
A PSYCHIATRIC CONTINUUM OF CARE SYSTEM IN SUPPORT OF THE GLOBAL WAR ON TERROR

Douglas A. Waldrep, M.D., *Department of Psychiatry, Walter Reed Army Medical Center, 6900 Georgia Avenue, NW, Washington, DC 20307-5001*

SUMMARY:

Objective: Walter Reed Army Medical Center (WRAMC) Continuity Service (CS) was faced with the challenge of providing intermediate care to soldiers from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) who were returning home. The lapse in medical accountability in tracking soldiers from the first Gulf War was one of the principal findings by the General Accounting

Office. Prior to the current war, CS had been tasked to provide a continuum of care for soldiers and their families. This system was effectively applied to this population of returning combat soldiers.

Method/Results: This presentation will discuss the development of this system required for management of all the returning soldiers and the additional challenges of managing National Guard and Reserve soldiers who were assessed, treated, and then provided follow-up in locations throughout the United States.

Conclusions: The CS system of case management has proved an excellent system for providing seamless transitional care to soldiers medically air evacuated (AE) to WRAMC for psychiatric reasons.

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SYMPOSIUM 38—HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE, PART 3

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) develop an individual strategy for launching a successful private practice while maximizing strengths and interests; (2) learn techniques that will give you the necessary edge to succeed in a competitive marketplace; (3) learn to balance the functions of manager, technician, and entrepreneur in a small business.

No. 38A
PERSONAL FACTORS LEADING TO A SUCCESSFUL PRIVATE PRACTICE

William E. Callahan, Jr., M.D., 7700 *Irvine Center Drive, Suite 530, Irvine, CA 92618*

SUMMARY:

Dr. Callahan will discuss the biggest risks for failure, and individual issues that must be accounted for if you are to be successful. Ways to avoid being pulled into unethical behavior are addressed. Having an attorney review your office contracts and avoiding getting taken advantage of in the business and professional world will be detailed. Broad issues for professional success will be covered, including recognizing your own professional value, developing a business plan, and keeping your financial expectations realistic.

No. 38B
OFFICE LOCATION AND DESIGN FOR EFFICIENCY AND SUCCESS

Keith W. Young, M.D., *10780 Santa Monica Boulevard, #250, Los Angeles, CA 90025-4749*

SUMMARY:

Dr. Young will discuss the details of office location and design. He will provide a checklist of features often not thought about that you will want to consider. Factors that are and are not important in where you locate, and tips on how to make that decision are discussed. References to differences based on rural versus urban will also be addressed. The impact on the office on the success of the practice, as well as how well (or not) it represents you will be presented.

No. 38C
STREAMLINING OVERHEAD AND MANAGING YOUR BUSINESS IN PRIVATE PRACTICE

Keith W. Young, M.D., *10780 Santa Monica Boulevard, #250, Los Angeles, CA 90025-4749*

SUMMARY:

Dr. Young will discuss streamlining all aspects of your practice to limit overhead while maximizing earnings and quality. Tips about minimizing personal and office expenses will be offered. Setting fees, billing, scheduling appointments, missed appointments, and other areas are covered.

Dr. Young will also outline necessary insurance, retirement, and banking systems, as well as taxes and areas of potential difficulty for psychiatrists starting a new practice. Finally, the roles of technician, manager, and entrepreneur, which are essential to success in a small business, will be discussed as they apply to psychiatric practice.

No. 38D
MARKETING YOUR UNIQUE PRIVATE PRACTICE

William E. Callahan, Jr., M.D., *7700 Irvine Center Drive, Suite 530, Irvine, CA 92618*

SUMMARY:

Dr. Callahan will highlight how to get the right patients through the door. Concepts of branding so that you are distinguishable from the rest of your peers are examined. Marketing also requires persistent visibility and developing name recognition within a region, and then within segments of that region that you are best equipped to serve.

Dr. Callahan has developed an extensive list of different ideas and ways to do this, which you can tailor to your own area and strengths. The focus in the start-up phase of practice is on methods that will cost you time, but not money, since time is usually more available than money in this phase.

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4. Practice Management for Early Career Psychiatrists: APA Office of Healthcare Systems and Financing, 1998.

SYMPOSIUM 39—USE OF MANDATES AND LEVERAGE IN COMMUNITY-BASED TREATMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the spectrum of mandates and leverage applied to

psychiatric patients in an effort to induce adherence to treatment in the community; present the results of the first national study of the phenomenon, and of a study of patients' reactions; and discuss the legal and ethical issues raised by these practices.

No. 39A
LEVERAGE AND MANDATED COMMUNITY TREATMENT

John Monahan, Ph.D., *School of Law, University of Virginia, 580 Massie Road, Charlottesville, VA 22903-1789*

SUMMARY:

A growing array of legal tools are being used to mandate adherence to mental health treatment in community settings. Social welfare benefits disbursed by *money managers* and the provision of *subsidized housing* are both being used as leverage to assure treatment adherence. Similarly, for people who commit a criminal offense, adherence to mental health treatment may be made a *condition of probation.* Favorable disposition of the cases of defendants with a mental disorder by a newly-created *mental health court* may also be tied to treatment participation. In addition, under *outpatient commitment* statutes, judges have the authority to order committed patients to comply with prescribed community treatment. In response to these influence attempts, a patient may attempt to maximize control over treatment in the event of later deterioration by executing a *psychiatric advance directive* that specifies treatment preferences or a proxy decision maker. The Research Network on Mandated Community Treatment seeks to elaborate a new and broader conceptual framework to encompass all forms of mandated treatment. We are engaged in conducting new research on how frequently different types of leverage are used and how the process of applying leverage operates. This symposium presents the initial results of our efforts.

No. 39B
A MULTISITE STUDY OF MANDATED COMMUNITY TREATMENT: METHODS AND PREVALENCE

Henry J. Steadman, Ph.D., *Policy Research Association, 345 Delaware Avenue, Delmar, NY 12054*

SUMMARY:

Recent broadening of the concept of mandated community treatment has pointed out the paucity of basic information about how often the various forms of such treatment are experienced by persons with mental illness. A study is being completed at five sites (Worcester, MA; Durham, NC; Tampa, FL; Chicago, IL; and San Francisco, CA) of 1,000 people receiving active outpatient treatment for serious mental illness. A 90-minute interview schedule was developed to determine how many subjects had experience with representative payees, housing conditioned on treatment, criminal justice supervision of treatment, psychiatric advance directives, and outpatient commitment in the prior year. Also, their levels of perceived coercion for each experience were assessed. This presentation will focus on the methodology of the study and the initial results of the prevalence rates of each type of mandated treatment.

No. 39C
WHEN ARE MANDATES AND LEVERAGE APPLIED IN COMMUNITY TREATMENT?

Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655*

SUMMARY:

Following the previous presentation's description of the methods of the first national study of mandates and leverage in community treatment, this presentation will describe the characteristics of patients who are susceptible to such pressures. Preliminary analyses from the first site to complete the study suggest that degree of symptomatology and functional impairment (based on BPRS and GAF scores) are the strongest predictors of formal mandates (i.e., outpatient commitment and leverage in the criminal justice system), but that neither of these predicts less formal types of leverage (i.e., control of money and access to housing). Symptom scores did predict the total number of types of mandates and leverage used, with sicker patients experiencing greater pressure to adhere to treatment. Among the variables unrelated to use of mandates and leverage were gender, race, age, decisional capacity, and insight. If these findings are confirmed by the data from all study sites that will be presented at this symposium, they may suggest that sicker patients are more likely to face pressure to adhere to treatment. But such pressure is unexpectedly not dependent on how able patients appear to be to make decisions for themselves. This raises complex questions about the ethics of the use of pressure that will be discussed in the final presentation.

No. 39D
PATIENTS' ATTITUDES TOWARD THE USE OF LEGAL LEVERAGE IN COMMUNITY TREATMENT

Jeffrey W. Swanson, Ph.D., *Department of Psychiatry, Duke University, DUMC Box 3071, Durham, NC 27710*; Marvin S. Swartz, M.D., H. Ryan Wagner, Ph.D., Eric B. Elbogen, Ph.D.

SUMMARY:

To date there has been limited research from the perspective of persons with psychiatric disorders themselves to inform the ongoing debate over the potentially adverse or beneficial effects of involuntary outpatient commitment and other forms of legal leverage used in community treatment. In this study, patients in treatment for schizophrenia and related disorders (N=104) were interviewed to assess their perceptions regarding the fairness and effectiveness of mandated community treatment and other legal pressures to participate in mental health services. The study found that perceptions of the effectiveness and fairness of mandates were highly correlated. Patients who regarded schizophrenia as a biomedical illness and viewed themselves as ill and needing treatment also tended to believe that they, themselves, benefit from a range of formal and informal sanctions to adhere to treatment, and that these sanctions generally are imposed in their best interests and out of concern for their well being. Those who rejected this view also tended to reject a view of themselves as being ill and needing treatment, yet reported higher levels of psychiatric symptoms and were more likely to live in adverse social environments.

No. 39E
MANDATED TREATMENT: LEGAL, ETHICAL, AND POLICY IMPLICATIONS

Marvin S. Swartz, M.D., *Department of Psychiatry, Duke University Medical Center, 2113 Elba Street, Civitan Building, Room 238, Durham, NC 27705*

SUMMARY:

Consumers with mental illness are subject to a host of formal and informal pressures to adhere to treatment. The use of legally sanctioned treatment mandates are controversial, but largely in the absence of empirical data about their benefits and detriments. The use of treatment mandates raises a number of legal, ethical, and

policy issues. In the legal arena, mandates raise both substantive and procedural legal issues. In the ethical realm, with exceptions of those who regard any limits on autonomy as anathema, primary ethical issues involve an assessment of means and ends served by mandatory treatment. The fundamental policy issue is whether mandates "work" and at what cost to whom. The legal, ethical, and policy controversies about mandated community treatment will be reviewed with an eye toward empirical evidence needed to inform these debates.

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SYMPOSIUM 40—PERINATAL DEPRESSION: BURDEN, NEUROBIOLOGY, AND TREATMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to recognize the need to integrate neurobiological, treatment, and health services influences on the development of perinatal depression in order to reduce the overall burden of untreated illness on women and their children.

No. 40A
THE NEUROPSYCHOBIOLOGY OF PERINATAL MOOD DISORDERS: ARE HORMONAL CHANGES RELEVANT?

Meir Steiner, M.D., *Department of Psychiatry, MC Master University, St. Joseph's Hospital, 301 James Street S, Hamilton, ON L8P 3B6, Canada*

SUMMARY:

Pregnancy and childbirth have an enormous combined psychological, physiological, and endocrinological impact on a woman's body and brain.

Since the high incidence/prevalence of changes in perinatal mood coincide with the profound neuropsychobiological changes associated with pregnancy and childbirth, a causal link has been supposed probable. Thus, the focus of research has been on the potential direct/indirect influences of both the reproductive and stress hormonal axes on behavior.

In the animal kingdom, maternal behavior is mediated by neuroendocrine changes associated with reproduction. However, there is a considerable scope for interactions between the neurobiological changes and the varying repertoires of maternal behavior across different species. The relevance to the human condition is as yet unclear.

Studies attempting to correlate neuroendocrine changes along the hypothalamic-pituitary-adrenal/gonadal/thyroid axes, which coincide with perinatal mood fluctuations, will be reviewed. A model incorporating sensory, hormonal, experiential, developmental, and genetic variables in the study of human maternal behavior will be presented.

No. 40B
PERINATAL DEPRESSION: BRIDGING THE GAP BETWEEN MATERNAL DISTRESS AND INFANT WELL-BEING

Sheila Marcus, M.D., *Department of Psychiatry, University of Michigan, 900 Wall Street, Riverview Building, Ann Arbor, MI 48109-0722;* Heather A. Flynn, Ph.D., Delia M. Vazquez, M.D., Juan F. Lopez, M.D., Susan C. McDonough, Ph.D.

SUMMARY:

Purpose: The impact of maternal depressive symptoms on the developing neonate will be explored. Attendees will learn the impact of maternal depression on the infant outcomes, and the implications for infant self-regulation and maternal attachment.

Methods: Following screening of 3,500 women in obstetrics clinics, the relationship between maternal mood symptoms and infant outcomes (such as premature delivery) were examined.

Results: Overall, 13% of women screened delivered prematurely. A significant relationship between depression and premature delivery was found. Neurobiologic correlates of major depression (salivary and plasma cortisol) in both women and neonates were also obtained. Neurodevelopmental and attachment milestones were monitored and will be examined in relation to maternal depression. The development of a Perinatal Psychiatry Program at the University of Michigan Depression Center has grown from this research and will be described.

Conclusion: It is our contention that an interdisciplinary understanding of this developmental process early in life, both in terms of behavior and biological systems, could ultimately lead to better understanding of transmission of affective illness and lead to early identification and intervention of a pediatric population at high risk.

No. 40C
THE UNDERTREATMENT AND MORBIDITY OF PERINATAL DEPRESSION IN OBSTETRICS SETTINGS

Heather A. Flynn, Ph.D., *Department of Psychiatry, University of Michigan, 400 East Eisenhower Parkway, Suite 2A, Ann Arbor, MI 48100-0740* Sheila Marcus, M.D.

SUMMARY:

Objective: Most depressed women will not seek specialty care, thus obstetrics settings are an ideal venue for detection and treatment. This study examined rates of major depressive disorder and current treatment (pharmacological and non-pharmacological) among women presenting for prenatal care in obstetrics clinics, as well as impact on overall functioning.

Methods: A total of 270 women completed a diagnostic interview including SCID.

Results: Overall, 16.5% of women met diagnostic criteria for current major depressive disorder (MDD), and 26% met criteria for significant past history of MDD. Among women with current MDD, the majority (82%) were not taking any antidepressant medications, and 62% of those women were not receiving any form of counseling or psychotherapy. No differences were found on BDI scores or health functioning indices between at risk women receiving treatment

compared with those not receiving treatment, suggesting that inadequate treatment was common.

Conclusions: Clearly, a substantial number of pregnant women with MDD seen in obstetrics clinics are not receiving adequate intervention and may be experiencing marked decrements in functioning as a result. Screening and proper intervention services in medical health care settings are likely to lead to improvement of symptoms and prevention of health complications, and improvement of negative birth outcomes, parenting, and overall disability associated with depression.

No. 40D
MENTAL HEALTH TREATMENT AMONG PREGNANT UNDERPRIVILEGED WOMEN

Kimberly A. Yonkers, M.D., *Department of Psychiatry, Yale University School of Medicine, 142 Temple Street, Suite 301, New Haven, CT 06510*

SUMMARY:

Between 10% and 27% of women experience depressive symptoms during pregnancy. Uunderprivileged women, who may be unstably housed and confronted with trauma and violence, may be at particularly high risk for psychiatric disorders. Many low-income women access health care when they are pregnant and are covered by health insurance that is not available at other times in their lives. Thus, pregnancy constitutes an ideal time to screen and refer women for psychiatric treatment.

Method: Interviewers systematically screened women (N=387) attending prenatal visits. Medical records were reviewed for clinician documentation of psychiatric illness and treatment.

Results: 24% of women screened positive for a depressive or anxiety disorder and 4% had a comorbid mood and anxiety disorder. Only 2% were identified by their health care provider, including 12% of patients evidencing suicidal ideation. Patients with panic disorder and/or a lifetime history of domestic violence were more likely to be identified. All women with panic disorder received prior or current mental health treatment, whereas 26% percent of women with major or minor depression received prior or current treatment outside the prenatal visit.

Conclusion: Treatment referral and receipt were low but women with a co-existing anxiety disorder were more likely to be identified and receive treatment. Hormonal and pharmacological considerations in the treatment of depression in women will be integrated.

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2. Texeira JM, Fisk NM, Glover V: Association between maternal anxiety in pregnancy and increased uterine artery resistance index: cohort based study. Br Med J 1999; 318:153–157.
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SYMPOSIUM 41—NEUROIMAGING SEMINAR

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand neuroimaging tools and current, and be able to evaluate future neuroimaging findings in psychotic disorders, mood disorders, and childhood psychiatric disorders.

No. 41A
TOOLS AND METHODS OF NEUROIMAGING RESEARCH

Perry F. Renshaw, M.D., *Brain Imaging Department, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

The use of neuroimaging in psychiatric research continues to increase at an exponential rate; between 1998 and 2002, the number of NIMH-funded, published imaging studies increased from 58 to 162 articles. This increased level of research activity reflects a number of factors, including the greater availability of scanners and, perhaps more importantly, the development of methods with greater sensitivity to functional and molecular changes that may be related to psychopathology. In this presentation, the basic principles of established and emerging imaging methods, including magnetic resonance imaging, magnetic resonance spectroscopy, functional magnetic resonance imaging, single photon emission computed tomography, positron emission tomography, and optical imaging will be reviewed. This information will serve as an introduction to the more applied talks that will follow in the proposed symposium.

No. 41B
FUNCTIONAL NEUROANATOMY OF PSYCHIATRIC DISORDERS

Deborah Yurgelun-Todd, Ph.D., *Department of Neuroimaging, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

Several lines of investigation suggest that the integrity of the prefrontal cortex may be particularly salient for understanding the pathophysiology of both affective and psychotic disorders. Specifically, the frontal system has been shown to play a major role in the assimilation and integration of information and in the ability to plan, inhibit, and initiate emotional and behavioral responses. The involvement of limbic brain regions has also been posited for over a century; nevertheless, contemporary models implicate more widespread functional interactions between neocortical, limbic, and subcortical brain regions in the pathogenesis of psychiatric illness. This talk will present data describing cortical activation in response to cognitive and emotional challenge paradigms in patients with depression, bipolar disorder and schizophrenia. These functional neuroimaging studies indicate anomalous response of neural circuits both within and between the anterior cingulate cortex, the dorsolateral prefrontal cortex, and the amygdala. Differential fronto-limbic patterns of response for the diagnostic groups will be discussed.

No. 41C
NEUROIMAGING IN PSYCHOTIC DISORDERS

Stephan H. Heckers, M.D., *SBDP, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

Patients who present with the signs and symptoms of psychosis may suffer from a medical or neurological illness, may have ingested illicit drugs, or might suffer from a psychiatric disorder, including schizophrenia, bipolar disorder, or psychotic depression. Structural and functional neuroimaging studies can assist in the differential diagnosis of psychotic patients. Focal lesions can be diagnosed with high-resolution structural images and functional abnormalities can

be detected with functional imaging techniques. In addition to these traditional uses of neuroimaging in the hands of neuroradiologists, many researchers have now entered the field of psychiatric neuroimaging to uncover the neural basis of psychotic disorders.

The presentation will address the clinical challenges in the diagnosis of psychotic disorders using neuroimaging techniques. We will review the timing (onset and progression), the degree, and the constellation of structural and functional abnormalities in the brains of patients with a psychotic illness. Finally, we will outline the requirements for the regular use of neuroimaging techniques in the diagnosis of psychotic disorders.

No. 41D
BRAIN IMAGING STUDIES OF DEPRESSIVE ILLNESS

Michael E. Henry, *Mclean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

Dysfunction of a limbic-cortical-striatal-pallidal-thalamic neuroanatomic circuit has been proposed in the pathophysiology of mood disorders. This presentation will critically review the evidence that supports this hypothesis. It will also present new data on the depressive phenotypes of individuals homozygous for the short and long alleles of the serotonin transporter gene. Lastly, the data on the effects of somatic antidepressant treatments will be reviewed with a particular emphasis on the work of Mayberg, et al and Wu, et al, which suggest that increased metabolism in the anterior cingulate gyrus predicts antidepressant response.

No. 41E
NEUROIMAGING IN CHILDHOOD DISORDERS

Jean A. Frazier, M.D., *Department of Child Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

Objective: To educate the audience about normal brain growth during childhood and to present data from an ongoing neuroimaging study (MRI) on pediatric bipolar disorder.

Methods: Children with DSM-IV BPD (via clinical and semi-structured interview) as well as healthy comparison subjects were scanned on a 1.5 Tesla scanner. Differences in demographic and clinical variables were measured using t tests for continuous and chi-squares for categorical variables. Repeated-measures analyses of variance and covariance were obtained for all brain volumes and symmetry indices. Alpha was set at 0.05.

Results: In youth with BPD, repeated measures ANCOVA found significant differences (total, right, and left): cerebral cortex, cerebral white matter, thalamus, amygdala, accumbens (total and left), and hippocampus and inferior lateral ventricle (total right). For several structures, a significant diagnostic effect was noted in interaction with Tanner stage and/or head circumference. Significant asymmetry differences between subjects and controls were found in a number of structures including the amygdala. Significant interaction was also noted for some structures between Tanner stafe and diagnosis.

Conclusions: Our findings support the hypothesis that limbic structures, the thalamus, and other interconnecting structures known to regulate affect and cognition may underlie the pathophysiology of pediatric BPD.

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SYMPOSIUM 42—SMOKING AND COMORBID MENTAL DISORDERS
Collaborative Session with the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should have greater knowledge of the prevalence, neurobiology, and treatment of comorbid smoking and mental disorders. More specifically, the participant should be able to recognize, diagnose, and treat comorbid nicotine dependence and psychiatric disorders.

No. 42A
PSYCHIATRIC COMORBIDITY OF SMOKING AND NICOTINE DEPENDENCE: AN EPIDEMIOLOGIC PERSPECTIVE

Naomi Breslau, Ph.D., *Department of Epidemiology, Michigan State University, B601 West Fee Hall, East Lansing, MI 48824*

SUMMARY:

Associations of smoking with mental and substance use disorders have been consistently reported in clinical and epidemiologic studies. Both causal and noncausal explanations have been proposed. Recent cross-sectional epidemiologic studies have used retrospective data on age of onset of daily smoking and psychiatric disorders to examine potential causal pathways in the smoking-psychiatric disorders relationship. In addition, a few prospective studies estimated the relationship between smoking and specific disorders. Elevated risks for subsequent first onset of panic disorder and agoraphobia in current smokers were reported in both types of studies. Results on smokers' relative risk for major depression are inconsistent. Smokers were reported to be at increased risk for alcohol and drug use disorders. Major depression and anxiety disorders, except for panic disorder, predicted daily smoking and progression to nicotine dependence. Preexisting psychiatric disorders were unrelated to smokers' potential for quitting for a year or more.

Smoking cessation might reduce the risk for panic disorder and agoraphobia. Early treatment of depression and anxiety disorders might prevent progression to regular smoking. Additionally, current smoking might serve as a marker for targeting interventions to prevent alcohol and drug disorders.

No. 42B
THE NEUROBIOLOGY OF NICOTINE DEPENDENCE AND COMORBID PSYCHIATRIC DISORDERS

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

SUMMARY:

Tobacco addiction is a chronic relapsing disorder characterized by tolerance, withdrawal, inability to stop, and ultimately toxic effects to health. Animal models have been developed for the acute rewarding effects of nicotine and the motivational effects of nicotine withdrawal. Nicotine is readily self-administered by animals and acutely enhances brain reward. Withdrawal from nicotine produces elevations in brain reward thresholds through specific nicotine receptors and glutamate/gamma-aminobutyric acid interactions in the mesolimbic dopamine system. Neuropharmacologic studies have provided evidence for the dysregulation of specific neurochemical mechanisms, not only in specific brain reward circuits but also in brain stress systems, that drives such negative motivational states. Similar changes in reward and stress function (serotonin, dopamine, gamma-aminobutyric acid, corticotropin-releasing factor, norepinephrine, and neuropeptide Y) have been hypothesized to be key elements of affective, anxiety, and psychotic disorders and may link the comorbidity of these disorders with nicotine dependence. The reward dysfunction hypothesis provides a heuristic model with which to integrate molecular, cellular, and circuity neuroadaptations in brain motivational systems involved in addiction and comorbid psychiatric disorders.

No. 42C
NICOTINE-DEPENDENCE TREATMENT IN INDIVIDUALS WITH SCHIZOPHRENIA

Douglas M. Ziedonis, M.D., *Department of Psychiatry, UMDNJ, Robert Wood Johnson Medical School, 675 Hoes Lane, Room D349, Piscataway, NJ 08854*

SUMMARY:

Most individuals with schizophrenia are nicotine dependent, and many have increased morbidity and mortality due to tobacco. Public health tobacco control efforts have helped the general population to not start smoking and to promote quitting; however, not for individuals with schizophrenia. Unique mental health treatment setting and schizophrenia-specific characteristics contribute to the onset and maintenance of nicotine dependence. However, evidence suggests that existing nicotine dependence treatments can be effective. Innovative psychosocial interventions will be discussed, including to engage/motivate and to help quit smoking. Addressing tobacco requires system changes and staff training. There is both an immediate need to address tobacco in this population and to expand research agendas for this population. Under-recognition and under-treatment of nicotine dependence in this population continue to be common. This presentation will review the research supporting medications and psychosocial treatments for this population, including nicotine replacement medication, bupropion, atypical antipsychotics, and modified psychosocial treatments. Effective model programs and system changes will be presented, including the specialized program for schizophrenic smokers at the University of Medicine and Dentistry of New Jersey Tobacco Dependence Program (tobaccoprogram.org). Participants will learn about resources and training materials on this topic.

No. 42D
BEHAVIORAL AND PHARMACOLOGICAL TREATMENTS FOR SMOKERS WITH DEPRESSION

Richard Brown, *Department of Psychiatry, Brown University, School of Medicine, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02818*

SUMMARY:

Research has demonstrated significant associations between depression and cigarette smoking, and evidence suggests that depression (both current and past) is a risk factor resulting in poor smoking cessation outcomes. Early studies suggested that past major depressive disorder was a primary risk factor for poor outcomes in smoking cessation, but more recent evidence suggests that current depressive symptoms and having a history of recurrent major depressive episodes convey the greatest risk in this regard. Investigators have examined both behavioral and pharmacological smoking cessation treatments with regard to their efficacy for smokers with risk factors related to depressive symptoms and depressive disorders. This presentation will review existing clinical research evidence for the efficacy of adding cognitive-behavioral mood management treatment and for the use of antidepressant pharmacotherapy for smokers at risk for poor outcomes due to depression-related characteristics. Clinical and research recommendations will be offered.

REFERENCES:

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SYMPOSIUM 43—TRAGIC EVENTS IN THE EMERGENCY DEPARTMENT: THE ROLE OF PSYCHIATRY AND THE INSTITUTIONAL IMPACT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to begin to plan for tragedies through emergency services; recognize grief reactions among groups, and recognize the need and plan staff support related to working during tragedies.

No. 43A
PREPARATION AND ORGANIZATION FOR TRAGEDIES IN THE EMERGENCY ROOM

Maryfran Hughes, R.N., *Department of Emergency Medicine, Massachusetts General Hospital, 33 Fruit Street, White 125, Boston, MA 02114*

SUMMARY:

In the face of threats of disaster and terrorist acts in our communities, many hospitals are preparing to respond to such calamitous events. Preparation is taking place for disasters of various types, including natural disasters and attacks by biological, chemical, or radiological agents. Hospitals are setting up command structures to be initiated during the occurrence of any disaster. Clarifying the role for each unit of the hospitals is crucial in mounting an organized and effective response to tragic situations. Understanding the command hierarchy and setting up effective means of communication are important elements in disaster response. Additionally, clarifying the hospital's interface with governmental and community agencies is an important aspect of any disaster response. One potential pitfall

is too rigidly planning for the last tragedy that has occurred. Creating a flexible and adaptable system of response is the goal to such planning.

This presentation will provide lessons learned from actual events and will discuss three components of preparation and organization for tragedies in the emergency room:

(1) Hospital Emergency Incident Command System (HEICS), (2) mental health activation without full disaster response team activation, and (3) administrative components of support for the clinical team members

No. 43B
MANAGING GRIEF IN THE GROUP SETTING

Jennifer M. Lafayette, M.D., *Department of Psychiatry, Massachusetts General Hospital, 33 Fruit Street, Warren 605, Boston, MA 02114*

SUMMARY:

Grief is the normal response to loss and is a unique experience for each individual. Acutely, this experience can present as somatic distress, preoccupation with the images of the deceased, guilt, sadness, silence, or hostile reactions. Grieving family or friends may experience anxiety, tension, or pacing. Affect may come in waves. As psychiatrists, we are trained to be calm and organized in the face of intense affect. This prepares us well for assisting patients, families, and staff for overwhelming situations. Emergency psychiatrists can provide immediate expertise in psychosocial interventions and provide education about the grieving process.

Principles of group therapy can be useful in managing grieving groups in the emergency room. As all have experienced the tragedy, they can provide support for each other and varied perspectives. Members of the mental health portion of the disaster response team may be responsible for organizing a large space for this group and providing a supportive atmosphere for sharing this experience.

This presentation will:

(1) describe grief and its clinical manifestations, (2) provide recommendations for recognizing and supporting families and friends of victims of a tragedy, and (3) provide guidelines for managing groups of grieving families and friends in the emergency department setting.

No. 43C
STAFF SUPPORT IN RESPONDING TO TRAGEDIES

Lawrence T. Park, M.D., *Massachusetts General Hospital, 55 Fruit Street, WRN-605, Boston, MA 02114*

SUMMARY:

Responding to tragic events is a stressful experience for those involved. In the past year, our hospital staff has had to endure a variety of tragedies. We have studied their reactions to responding to such events, and have examined how we can better prepare to help staff deal with responding to tragedies. Of note, in the events that occurred at our hospital, we found that hospital employees felt proud to be a part of a response to help others. Also, in the Rhode Island nightclub fire, a positive correlation was found between level of distress and hours spent watching coverage of the fire on television. Regarding how staff can be optimally supported, this study demonstrated that staff would feel better prepared to deal with disasters with more preparatory training and more real-time supervision. After the acute response to tragedy, staff reported feeling supported by ongoing voluntary support groups as well as announcements and informational releases from hospital leadership.

No. 43D
RESIDENCY TRAINING AND TRAGEDY IN THE EMERGENCY DEPARTMENT

Felicia A. Smith, M.D., *Department of Psychiatry, Massachusetts General Hospital, 33 Fruit Street, Warren 605, Boston, MA 02114*

SUMMARY:

Grief is the normal response to loss and is a unique experience for each individual and a very difficult issue for psychiatric residents to face. They often feel overwhelmed by the situations that they witness in the emergency room and the affect that results. Training can be improved by preparing residents for recognizing the grief response; learning ways to interact with patients, families, and friends; and discussing their reactions after the event with trusted supervisors.

This presentation will provide lessons learned in the emergency room and recommendations for how to enhance the residents' training experience in the face of tragic events.

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SYMPOSIUM 44—CULTURE, ETHNICITY, RACE, AND PSYCHOPHARMACOLOGY: NEW RESEARCH PERSPECTIVES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize the role of pharmacogenetics, pharmacokinetics, and pharmacodynamics in the psychopharmacological treatment of ethnic minorities in the U.S.A.

No. 44A
ETHNICITY, PHARMACOGENETICS, AND PSYCHOPHARMACOTHERAPY

Keh-Ming Lin, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center REI, 1124 West Carson Street, B4 South, Torrance, CA 90502*

SUMMARY:

Inter-individual and cross-ethnic variations in response to psychotropics are substantial and clinically significant. Recent studies demonstrated that both genetic and environmental factors are responsible for such variations. Most genes controlling the expression of drug metabolizing enzymes as well as the function of brain receptors and transporters are highly polymorphic. Together they determine therapeutic response as well as the propensity for side effects and appropriate dosing. Environmental factors, such as diet, also exert significant influence on the expression of these genes and thus the metabolism of medications. In addition, culture also profoundly influences patients' expectations of treatment response, adherence, as well as working alliance. Coupled with recent advances in gene array technologies, it is very likely that pharmacogenetic panels could be developed for routine clinical use, such that the results derived from

such tests would be used to inform clinicians regarding the choice of medications, dosing strategies, and risks for different side effects. Advances in the field of pharmacogenetics should thus contribute substantially to the establishment of an increasingly more rational and knowledge-based way to practice psychopharmacology in the nexy century.

No. 44B
PHARMACOTHERAPY IN AFRICAN AMERICANS

William B. Lawson, M.D., *Department of Psychiatry, Howard University Hospital, 2041 Georgia Avenue, NW, Washington, DC 20061*

SUMMARY:

Although there have been new advances in pharmacotherapy, the recent Surgeon General's report and other studies reiterated that ethnic minorities are still less likely to receive appropriate treatment. African Americans are often overmedicated or receive the wrong medication when they receive treatment. Ongoing issues include the problem of misdiagnosis, treatment avoidance, and lack of cultural competence. Recent advances in ethnic pharmacology show that African Americans are, if anything, overmedicated. Newer medications may offer a more side-effect friendly profile compared with older agents, but may lead to newer complications related to ethnic-related medical comorbidities. Additional research needs to be done with ethnic and racial minority populations to address these issues, but such groups are often excluded from clinical trials. We will propse new paradigms to address inclusion of African Americans in research trials.

No. 44C
ETHNICITY, CULTURE, AND PSYCHOPHARMACOLOGY: ASIAN PERSPECTIVES

Edmond H.T. Pi, M.D., *Department of Psychiatry, Charles R. Drew University, 1731 East 120th Street, # 102, Los Angeles, CA 90059*

SUMMARY:

It is estimated that more than half of the world's population is Asian. There are 10.4 million Asian-Americans in the United States. Asians, however, are a very diverse ethnic, cultural, and linguistic group. It is now particularly essential for clinicians to understand the issues regarding the role of ethnicity and culture when diagnosing and providing psychiatric care to diverse populations. The influence of ethnicity and culture on psychotropic medications has become an important clinical consideration. Transcultural psychopharmacology seeks to determine whether there are differences in responses to psychopharmacologic agents among various ethnic groups and the reason for such variations. This presentation will provide an overview on the existing information in regard to Asian perspectives of ethnopsychopharmacology dealing with neuroleptics, mood stabilizers, antidepressants, and benzodiazepines. Clinical implications for the reported differences and the needs regarding how to select the most appropriate psychotropic medications considering target symptoms and side effects for Asian patients will be addressed. Also, recent advances and future directions with respect to transcultural issues of psychopharmacology will be presented.

No. 44D
HISPANICS: DISEASE, GENES, AND TREATMENT OUTCOME

Ricardo P. Mendoza, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center, 1000 West Carson Street, D-5, Box 498, Torrance, CA 90502*

SUMMARY:

Reflecting their increasing population numbers in the United States, a number of biologically oriented scientific research investigations have recently been conducted utilizing Hispanic subjects. Pharmacogenetic research has identified differences in the frequencies of polymorphic variant genes encoding the drug and alcohol metabolizing enzymes among Hispanics. These differences in gene frequencies would appear to profoundly influence treatment outcome and render Hispanics more susceptible to alcohol dependence and alcoholic liver disease. In addition, the pursuit of susceptibility genes underlying the major mental disorders has recently been extended to ethnic minority populations and DNA from a large sib pair cohort of Mexican Americans, as well as Latinos in Mexico and Central America, is now a part of the NIMH resource repository. Genomic scanning of DNA from these subjects will determine (1) whether currently identified candidate genes for schizophrenia are present in Hispanics of Amerindian descent and (2) the possible existence of mutations unique to this population. The importance of biological issues notwithstanding, culture remains a powerful factor in assessing disease progression and overall pharmacotherepeutic outcome when treating Hispanic patients.

No. 44E
AN INTERNATIONAL PERSPECTIVE ON ETHNICITY, CULTURE, AND PSYCHOPHARMACOLOGY

Tarek A. Okasha, M.D., *Department of Neuropsychiatry, Ain Shams University, 3, Shawarby Street, Kasa El-Nil, Cairo, Egypt*

SUMMARY:

As our societies become more diverse and the world evolves into a global village, the need to integrate culture into medicine and psychiatry becomes more critically important. Worldwide increasing ease in international travel and migration and advances in information technology have enhanced interaction and intermingling of people from different cultural and social systems. As a result, practitioners of the health and mental health professions are increasingly being called on to treat patients from backgrounds very different from their own. Are Western and Eastern trained practitioners of physical and mental health well prepared to address the psychological distress of individuals of varying backgrounds? A clearer understanding of culture and its integration into medicine not only can increase clinicians' cultural sensitivity, but also can sharpen their diagnostic acumen and aid in the formulation of patient accepted treatment plans.

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SYMPOSIUM 45—DELUSIONAL DISORDER: A RECONSIDERATION OF THE SCIENTIFIC AND CONCEPTUAL BASIS FOR THE DSM REFORMULATION OF PARANOIA

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the 1987 DSM reformulation of paranoia delusional disorder and the current scientific evidence for the validity and coherence of the diagnosis. Clinical and forensic aspects of the diagnosis will also be highlighted.

No. 45A
THE CONCEPT OF DELUSIONAL DISORDER IN DSM-IV

Nancy C. Andreasen, M.D., *Department of Psychiatry, University of Iowa, University of Iowa Hospital, Room 2911, Iowa City, IA 52242*

SUMMARY:

The boundaries between core schizophrenia and related spectrum disorders are blurred. The most important of these related spectrum disorders include delusional disorder, schizoaffective disorder, and schizotypal disorder—all of which share some components of symptomatology with core schizophrenia. Decisions about subdivision of the psychotic disorders for DSM-IV were based on existing data concerning familial aggregation, course and outcome, and laboratory measures when available. Delusional disorder (previously called "paranoid disorder" or "paranoia vera") is a relatively rare condition, and therefore the data were relatively limited. This presentation will review those data. It will also discuss the strengths and weaknesses of the DSM approach for defining diagnoses, the purposes of diagnosis, and the importance of identifying more valid criteria for formulating diagnostic categories.

No. 45B
THE IMPORTANCE OF NARCISSISM IN DELUSIONAL DISORDERS

C. Robert Cloninger, M.D., *Department of Psychiatry, Washington University Medical School, 4940 Childrens Place, Saint Louis, MO 63110*

SUMMARY:

The importance of narcissism in the differential diagnosis and treatment of delusional disorder will be considered without reference to any particular case or any ongoing litigation. Evidence for the genetic independence of delusional disorder from other psychotic illnesses, particularly schizophrenia and mania, will be reviewed. The differential diagnosis of delusional disorder from other psychoses is most reliably based on the absence of hallucinations and loosening of associations, together with the presence of narcissism. These same diagnostic features have strong implications for the treatment of the disorder. Improvement of patients with delusional disorder requires the relaxation of struggles against oppressive authority figures, real or imagined. Therefore, treating physicians must consistently treat such patients with compassion and respect for their human dignity, not as expedient means to social ends. In particular, effective treatment requires that a psychiatrist steadfastly avoid any threats and coercion beyond the limits required to maintain personal and social safety, even when the patients are provocative because of their illness. Coercive settings, like a prison, may exacerbate rather than ameliorate delusional disorder by reinforcing the perception of the world being hostile and abusive. Available medications may be effective in treating hallucinations and loose associations, but not in treating the narcissistic struggles and conflicts at the core of delusional disorder.

No. 45C
DELUSIONAL DISORDER: THE VALIDITY OF THE DIAGNOSIS

Theo C. Manschreck, M.D., *Department of Psychiatry, Harvard Medical School, 59 Outlook Drive, Lexington, MA 02421-6937*

SUMMARY:

This presentation will provide an overview of certain limitations of the delusional disorder concept, focusing on the central construct of delusions and the validity of the diagnosis. Considered the cardinal symptom of psychopathology, delusions, in terms of definition, pathogenesis, and treatment, remain poorly understood and surprisingly under investigated. This predicament complicates progress in various disorders characterized by delusions and especially in delusional disorder. Diagnosis of this condition is challenging because it is uncommon, idiopathic, and its chief feature, the non-bizarre delusion, may arise in more common diseases. There are practical consequences to these limitations, as is illustrated in forensic cases, wherein judgments about treatment and management may be particularly difficult. Advances in resolving these issues will require empirical research, including development and refinement of more sophisticated models of delusion formation.

No. 45D
DELUSIONAL DISORDER: DOES THE DSM DIAGNOSIS MAKE CLINICAL SENSE?

Alan A. Stone, M.D., *Harvard University Law School, 1575 Massachusetts Avenue, Hauser Hall, #400, Cambridge, MA 02138-2996*

SUMMARY:

This presentation will critically review three aspects of the DSM diagnosis of delusional disorder. First, serious questions remain about the pathognomonic features, if any, of the diagnosis. DSM-III-R proposed that delusional disorder be considered distinct from schizophrenia and mood disorder. This noslogical distinction is implicitly a repudiation of clinical understanding of a paranoid/delusional continuum influenced in its severity by biopsychosocial stressors. This is presented as a paradigmatic example of the DSM's clinical impact. Second, there are now multiple approaches to the etiology of delusional disorder. Five will be briefly considered: (1) neuropathological, the monothematic example of Capgras syndrome, (2) genetic, positing a specific dopamine anomaly, (3) evolutionary, hypothesizing dysfunction of adaptive modules, (4) psychological, Maher's anomalous experience, (5) cognitive models, threat, and self-esteem. Delusions are central to the Anglo-American conception of the McNaghten test. Some of the landmark cases of forensic psychiatry in which defendants were diagnosed as having schizophrenia can retrospectively be considered delusional disorder (e.g. Hinkley). The validity of the distinct diagnosis as opposed to a clinical continuum is central in the forensic context. Gaupp's classic case of Ernst Wagner (1913) will serve as an example to examine the forensic issues.

No. 45E
INVOLUNTARY TREATMENT: THE CONSTITUTIONAL ISSUES

Richard G. Taranto, J.D., *Farr and Taranto, 1220 19th Street, N.W. #800, Washington, DC 20036*

SUMMARY:

The Supreme Court in the case of Sell v. United States ruled on the constitutionality of court-ordered involuntary medication to restore the competency of criminal defendants. Sell had been diagnosed by the experts on both sides as likely having a DSM-IV delusional disorder, but Sell's expert disagreed with the government's psychiatrist on the medical appropriateness of antipsychotic medication as treatment. The court ordered those medications and Sell refused them citing his First, Fifth, and Sixth Amendment constitutional rights. I will discuss the constitutional cases leading up to Sell and the amicus briefs submitted in Sell by the American Psychiatric Association (which I prepared), the American Psychological Association, and the Association of American Physicians and Surgeons. Each professional association took a somewhat different approach in Sell. I will describe what the court decided, what it avoided deciding, and the significance of the Sell decision for the practice of involuntary medication of criminal defendants.

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4. Gaupp R: The Illness and Death of the Paranoid Mass Murderer, School Master Wagner: A Case History (1938), in Hirsch S, Shepherd, M (eds). Themes and Variations in European Psychiatry. Charlottesville, University Press of Virginia, 1974, pp. 134–150.
5. Charles Thomas Sell v. United States (123 S. Ct. 2174).

SYMPOSIUM 46—TRANSLATIONAL RESEARCH ON EATING DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe new findings concerning the controls of eating behavior in animals and relate these findings to the pathophysiology of disturbed eating in humans with eating disorders.

No. 46A
EXCITATORY AND INHIBITORY NEUROBIOLOGICAL CONTROLS OF EATING

Gary J. Schwartz, Ph.D., *Department of Psychiatry, New York Presbyterian Hospital, 21 Bloomingdale Road, White Plains, NY 10605;* Nori Geary, Ph.D.

SUMMARY:

The meal is a critical functional unit for behavioral neuroscience because humans (and most animals) eat episodically, and the meal is clinically important because meal size is abnormal in several eating disorders. A number of excitatory and inhibitory biological controls underlie the initiation, maintenance, and termination of eating during meals. Palatable oral food stimuli typically promote eating and increase meal size, whereas several post-oral food stimuli, especially gastric and intestinal stimuli, generate negative feedback signals that inhibit eating and decrease meal size. Neuroendocrine context is also important; gonadal, adiposity, and stress hormones affect brain processing of excitatory and inhibitory signals arising from preabsorptive food stimuli. Analysis of the operation of these biological controls requires consideration of the biology of learning, of reward, of appetitive behavior (motivated behaviors leading to food access) and of consummatory behavior (eating). Presentations in this symposium will address behavioral and physiological experimental data from animal models and from patients with eating disorders that highlight the increasing potential for translation between basic research and the clinical setting in the development of increased knowledge and more effective therapies.

Supported by NIMH R21 MH65024.

No. 46B
DIETING AND STRESS COMBINE SYNERGISTICALLY TO PRODUCE AN ANIMAL MODEL OF BINGE EATING

Mary M. Hagan, Ph.D., *Department of Psychology, University of Alabama at Birmingham, 415 Campbell Hall, Birmingham, AL 35294-1170;* Pamela K. Wauford, B.S., Paula C. Chandler, B.S., Rachel J. Placidi, M.A., Kimberly D. Oswald, B.S., Jason B. Viana, B.S.

SUMMARY:

We have found that environmental stress causes binge-like eating in rats but only if they have a history of caloric restriction (HCR, i.e., dieting). The binge eating occurs in sated, young female rats; it is robust (>40% kcal increase over a discrete time), and is comprised primarily of the palatable food choice (cookies). If only the less-preferred chow is available, binge eating is inhibited but can be "disinhibited" with just a bite of cookie. Neither stress, nor HCR, alone, produces binge eating, and at least three restriction-refeeding cycles are required, after which even very mild restriction (<0.05% weight-loss) produces the effect. This suggests that binge eating is the product of neuroadaptation evoked by the unique combination of dieting and stress, and is not contingent on metabolic need.

Neuroadaptation candidates include serotonin, dopamine, PYY, and opioid/melanocortin disregulation. Of all groups, the binge-eating rats were most sensitive to SSRI-induced satiety, but SSRI treatment was ineffective if rats were in negative energy (as in anorexia nervosa). Other peptide and amine changes will be reported. This model promises to dissolve the separation of cognitive-behavioral, environmental, and biological factors as independent causes of eating disorders, and in so doing, develop optimal new strategies aimed at preventing and treating them.

No. 46C
AN ANIMAL MODEL OF FOOD ADDICTION THAT MAY RELATE TO BINGE EATING OR BULIMIA

Bartley G. Hoebel, Ph.D., *Department of Psychology, Princeton University, Green Hall, Princeton, NJ 08544;* Carlo Colantuoni, A.B., Nicole N. Avena, A.B., Pedro Rada

SUMMARY:

Rats given 10% sugar drink 12 hr/day, alternating with 12-hr food deprivation, show signs of sugar dependency as follows: (1) increasing sugar intake with large initial meals, (2) dopamine and mu-opioid receptor changes in the limbic system, notably D1 and mu receptor upregulation in the nucleus accumbens, (3) locomotor sensitization to the taste of sugar and cross-sensitization to amphetamine, (4) mild withdrawal signs including anxiety when given the opioid antagonist naloxone, plus dopamine/acetylcholine imbalance in the accumbens typical of drug withdrawal, (5) a "sugar deprivation effect" manifest as augmented sugar intake even after weeks of abstinence, and (6) "relapse-like" behavior shown as increased work (bar pressing) for sips of sugar, compared with nondependent ani-

mals. Rats with a gastric fistula that sham drink sucrose daily to simulate bulimia show dopamine release in the accumbens every day, which is more like taking a drug of abuse than eating a familiar meal. We conclude that animals can become mildly addicted to the release of dopamine and opioids, with signs of dopamine sensitization, opioid withdrawal, and relapse-like behavior. The same processes might occur in some susceptible individuals with eating disorders.

Supported by USPHS grants MH-65024 and DA-10608.

No. 46D
SYMPTOM PROFILES AND 5HT REGULATION IN BULIMIA NERVOSA

David C. Jimerson, M.D., *Department of Psychiatry, Beth Israel Deaconess Medical Center, 330 Brookline Avenue, Boston, MA 02215-5491;* Barbara E. Wolfe, Ph.D., Eran D. Metzger, M.D.

SUMMARY:

Objective: Preclinical investigations, including pharmacological, neurochemical, and gene knockout studies, have provided indirect evidence that altered CNS serotonin function may contribute to impaired satiety, abnormal body weight regulation, and impulsive behavioral patterns associated with bulimia nervosa (BN). The goal of this study was to assess serotonergic modulation of satiety responses and food intake in BN.

Methods: Subjects included women who met DSM-IV criteria for BN and healthy female controls matched for age and BMI. Based on a randomized, double-blind design, subjects participated in test-meal studies following the administration of the SSRI citalopram and, on a separate day, administration of placebo.

Results: Although baseline ratings of hunger and satiety did not differ for the two study groups, placebo day food intake was significantly greater for the BN subjects than for controls. Preliminary results for control subjects demonstrated a decrease in food intake on the citalopram study day in comparison with placebo.

Conclusions: These preliminary test-meal study findings are consistent with other clinical investigations showing diminished serotonergic responses in patients with BN. Future results will help to clarify the effects of SSRI administration on food intake and post-ingestive satiety responses in patients with BN.

No. 46E
INHIBITORY AND EXCITATORY CONTROLS OF EATING IN PATIENTS WITH EATING DISORDERS

Michael J. Devlin, M.D., *Department of Psychiatry, NY State Psychiatric Institute-Columbia Univ, 1051 Riverside Drive, unit 116, New York, NY 10032-2603;* B. Timothy Walsh, M.D., Diane A. Klein, M.D.

SUMMARY:

Patients with bulimia nervosa (BN) and binge eating disorder (BED) regularly consume large uncontrolled meals. Feeding laboratory investigations in these patients have confirmed that binge eating can be elicited in an observed setting, and that patients, when binge eating, appear to exhibit a deficit in the development of satiety. Based on results from animal studies, several hypotheses concerning abnormalities in inhibitory controls of eating have been advanced. Studies in patients with BN have revealed several abnormalities in upper gastrointestinal tract physiology, including delayed gastric emptying, abnormal postprandial gastric relaxation, and blunted release of cholecystokinin. These may, in part, explain the observed satiety deficit. More recent studies have focused on possible abnormalities in excitatory controls of eating in eating disordered patients. Inspired by techniques developed by animal researchers, we have begun to develop "sham-feeding" paradigms in which the influence of post-oral negative feedback mechanisms on meal size is minimized, and meal size is determined primarily by the positive qualities of taste and texture of food. Preliminary studies of sham feeding and cue reactivity in individuals with disorders of binge eating suggest that abnormalities of excitatory as well as inhibitory controls may contribute to the markedly abnormal eating behavior seen in these individuals.

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2. Hagan MM, Chandler PC, Wauford PK, Rybak RJ, Oswald KD: The role of palatable food and hunger as trigger factors in an animal model of stress-induced binge-eating. International Journal of Eating Disorders 2003; 34:183–197.
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5. Walsh BT, Devlin MD: Eating disorders: progress and problems. Science 1998; 280:1387–1390.

SYMPOSIUM 47—WHAT EVERY PSYCHIATRIST NEEDS TO KNOW ABOUT HIV/AIDS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand (1) the medical, epidemiological, and treatment issues associated with HIV/AIDS; (2) be able to identify the most significant diagnostic concerns and treatment issues associated with HIV-related mental illness; (3) be able to identify general and specific drug-drug principles and interactions with an emphasis on P450 drug interactions and on antipsychotic medications and HIV.

No. 47A
HIV TREATMENT UPDATE

Roy Gulick, M.D., *Cornell Clinical Trials Unit, Weill Medical College of Cornell University, Box 566, 525 East 68th Street, New York, NY 10021*

SUMMARY:

We are witness to two clinical decades of HIV/AIDS. This session will offer a historical perspective of HIV/AIDS as well as provide current and future epidemiological trends. The session will also review treatment guidelines, goals in caring for HIV-infected patients, and goals of HIV therapy. Focus will be on current vulnerable and at risk populations; the realities of HIV management; and treatment successes and failures. *5 Things You Need to Know* will end with a look towards the future—new drug development and improved therapy management. This session will provide the most up-to-date epidemiological information and guidelines for antiretroviral therapy. The session includes a lecture and a question and answer period providing participants with the opportunity to voice individual clinical concerns.

No. 47B
TEN THINGS YOU NEED TO KNOW ABOUT BRAIN DYSFUNCTION

Steve Ferrando, M.D., *New York Presbyterian Hospital, Department of Psychiatry, 525 East 68th Street, Box 181, New York, New York 10021*

SUMMARY:

Enormous mental health challenges face a patient with HIV/AIDS. Studies estimate that as many as 75% of all AIDS patients will show symptomatic central nervous system consequences. It is vital for psychiatrists to be involved in the diagnosis and treatment of HIV/AIDS patients. Ten Things You Need to Know About Brain Dysfunction pinpoints key issues surrounding the diagnosis and treatment of HIV-infected persons. The session will review diagnostic concerns and differentiate between neuropsychiatric and psychiatric disorders associated with HIV/AIDS. The session further focuses on the particular challenges of treatment readiness, differential diagnosis, and adherence to antiretroviral medications. A clinical vignette will be incorporated into the session. The session will include a lecture and a question-and-answer period to provide participants with the opportunity to discuss clinical problems.

No. 47C
FIVE THINGS YOU NEED TO KNOW: DRUG-DRUG INTERACTIONS

Marshall Forstein, M.D., *Department of Psychiatry, Harvard University, 24 Olmstead Street, Jamaica Plain, MA 02130*

SUMMARY:

More HIV-infected patients are living longer with the advent of antiretroviral medications. Drug-drug interactions and toxicities, though common in HIV treatment, may be avoided or even minimized. The purpose of this session is to provide a framework for how to understand drug metabolism and to provide a practical clinical approach to the management of overlapping toxicities and drug-drug interactions. The presenter will offer essential information about drug metabolism and Cytochrome P450, taking a drug history, medications used to treat HIV, and specific drug interactions.

REFERENCES:

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3. O'Brien LW: Common HIV drug-drug interactions. AIDS Read 1999; 9(2):104–9.
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SYMPOSIUM 48—PERSONALITY DISORDERS IN THE WORKPLACE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand how workers' different personality disorder traits may impact the workplace. This would include how these traits manifest themselves and approaches for management.

No. 48A
PERSONALITY, JOB STRESS, AND MENTAL HEALTH AMONG PHYSICIANS

Per Vaglum, M.D., *Department of Behavioral Sciences, University of Oslo, Sognsvannsveien 9, P.O. Box 1111 Blindern, Oslo N-0317, Norway*

SUMMARY:

Mental health problems as depression and suicidal behavior are increased among physicians. One crucial question is whether this is a result of stressful working conditions or a vulnerable personality, or both. It is also important to identify the personality problems that predict later job stress, suicidal behavior, and mental health problems, and may prevent help seeking.

We have explored this question in two nationwide samples of Norwegian physicians: (1) a prospective longitudinal study of last-term medical students followed through the next four years (N=522), and (2) one cross-sectional study of all physicians (N=836). Results from these two studies will be reviewed. Concerning mental health and suicidal ideation among interns, both neuroticism and job stress as interns was independently related to mental health. Concerning mental health in the last year of residency, high level of extraversion and wishful thinking in medical school were independently related to mental health.

In the cross-sectional sample, two personality traits, "perfectionism" and "need for approval," were related to depressive symptoms. Finally, the problems that they may generate in the physician's relationship with patients and colleagues are discussed.

No. 48B
AVOIDANT AND DEPENDENT PERSONALITY TRAITS IN THE WORKPLACE

James H. Reich, M.D., *Department of Psychiatry, Stanford Medical School, 2255 North Point Street, Unit 102, San Francisco, CA 94123;*

SUMMARY:

Avoidant personality traits are present in at least 1% of the population. This disorder can cause problems in the workplace through several avenues. Difficulties with fellow employees can be due to poor interpersonal skills, poor team participation (due to lack of social skills), and inadequate or inappropriate assertiveness skills. Upon occasion, they may be even perceived as hostile or angry. This presentation will present a case of workplace difficulties in a worker with avoidant personality traits. I will examine how the problem evolved as well as positive and negative workplace interventions. I will use this case to discuss general interventions and approaches that can be taken with this particular problem.

No. 48C
THE RELATIONSHIP BETWEEN PERSONALITY DISORDERS AND MILITARY SERVICE

Paul S. Links, M.D., *Department of Psychiatry, University of Toronto, 30 Bond Street Shuter Wing RM 2011, Toronto, ON M5B 1W8, Canada; D. Randall Boddam, M.D.*

SUMMARY:

Given the controversy about personality disorders (PDs) in the workplace, the relationship between military service (MS) and PDs in military personnel is reviewed. A complex interrelationship was found between MS and persons suffering with PDs. MS might affect, in positive and negative ways, the personality characteristics of service members. These effects come about through a number of potential activities, including screening of recruits if such an activity is required upon entry, the self-selection of certain personalities for

particular service roles, the exposure to the stress of combat or other operational environments, and, given the unique workplace demands, through defining certain behaviors as maladaptive. Having a PD will affect a person's work performance in several potential ways. Experiencing a PD increases the risk for the co-occurrence of syndromal disorders (Axis I disorders), affects the prognosis and outcome of syndromal disorders, increases the risk for disturbing behaviors, and can directly lead to functional impairment. The implications of these findings for workplace policies regarding employees with PDs are discussed.

No. 48D
INTERVENTIONS FOR PERSONALITY DISORDERS IN THE WORKPLACE

David P. Bernstein, Ph.D., *Department of Psychology, Bronx VAMC/ Fordham University, 130 Kingsbridge Road, Dealy Hall, 3rd Floor, Bronx, NY 10568;*

SUMMARY:

Rationale: In this presentation, I will address some of the difficulties posed by coworkers who have personality disorders, and introduce a treatment approach, Schema Therapy, that can be effective in dealing with them.

Methods: Coworkers with personality disorders "push our buttons"—they may enrage, frustrate, or intimidate us. The key to dealing with such individuals is to conceptualize their behavior—and our own reactions to it—in terms that are more objective and dispassionate. The Schema Therapy model provides a vehicle for accomplishing this. Schema Therapy is an integrative form of cognitive therapy that focuses on maladaptive schemas and maladaptive coping mechanisms. Early maladaptive schemas (EMSs) are self-defeating patterns or themes, like defectiveness, abandonment, and unrelenting standards, that have their origins in childhood and play out over a lifetime. In this presentation, I will present four case studies of coworkers with personality disorders. In each case, the coworker's colleague used the Schema Therapy model to intervene effectively to resolve a difficult situation.

Conclusions: The Schema Therapy approach holds considerable promise for managing relations with "difficult" coworkers who have personality disorders.

No. 48E
PERSONALITY CHARACTERISTICS THAT SUPPORT RESUMING OF INTERRUPTED CAREERS

Elsa F. Ronningstam, Ph.D., *Department of Psychiatry, Harvard University, 71 Elm Street, Belmont, MA 02178;*

SUMMARY:

Objective: To examine personality characteristics of a group whose career had been interrupted by personality factors or major depression. (The Interrupted Career Group.) It also examined their response to treatment.

Method: Twenty participants filled out a questionnaire about their experience. They identified specific emotional reactions to their interrupted career. These feelings tended to be feelings of shame, rage, humiliation, inferiority, worthlessness, and envy. Twelve patients were treated in group therapy.

Results: Of those who responded to treatment, six had primarily feelings of anger and rage, while two had primarily feelings of humiliation and shame. The four participants who did not respond also had feelings of rage, shame, anger, and humiliation. It appears that in non-responders the treatment may have failed due to a comorbid affective disorder.

Conclusions: Progress toward resuming professional or vocational acitivites appears to be dependent on resolving feelings of anger, rage, shame, and humiliation.

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SYMPOSIUM 49—OBSESSIVE-COMPULSIVE SPECTRUM DISORDERS: UPDATE ON CLINICAL MANAGEMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to understand the neurobiological basis supporting a spectrum of disorders related to OCD, recognize the symptoms of these disorders and their differential diagnoses, and be familiar with both psychotherapeutic and pharmacological treatment.

No. 49A
NEUROBIOLOGY OF THE OCD SPECTRUM

Dan J. Stein, M.D., *National Institute on Drug Abuse, Francis S. Key Medical Center, Baltimore, MD 21224*

SUMMARY:

Several approaches have been made to exploring the neurobiology of the OCD spectrum. Pharmacotherapeutic dissection fueled early interest in the concept of an OCD spectrum—showing that clomipramine, a potent serotonin reuptake inhibitor, was more effective than desipramine, a potent noradrenaline reuptake inhibitor, in the treatment not only of OCD, but also of a range of conditions with unwanted repetitive behaviors. A neuroanatomical approach to the OCD spectrum has advanced because of the availability of novel structural and functional imaging technologies, and has demonstrated that cortico-striatal-thalamic-cortical (CSTC) loops are crucial in mediating not only OCD, but also a number of other possibly related conditions. Work falling in the area of neuroimmunology has shown that OCD, tics, as well as other psychiatric symptoms can be found after childhood infection with streptococcus (also called PANDAS, or pediatric autoimmune neuropsychiatric disorders associated with streptococcus). Increasingly, there is also strong interest in genetic approaches to OCD and related conditions; researchers have long been aware of a strong familial relationship between OCD and Tourette's disorder, and the hope is that the precise genetic basis of such relations can now be delineated. This presentation will review these approaches to the neurobiology of the OCD spectrum, and also consider their implications for understanding the relationships between OCD and impulsive/addictive disorders.

No. 49B
OBSESSIVE-COMPULSIVE PERSONALITY DISORDER: ITS TREATMENT AND RELATIONSHIP TO OCD

Jane L. Eisen, M.D., *Butler Hospital, Brown University, 345 Blackstone Boulevard, Providence, RI 02906*

SUMMARY:

Obsessive-compulsive personality disorder (OCPD) is characterized by features such as perfectionism, rigidity, control, and a preoccupation with details and rules. These features often resemble obsessive-compulsive disorder (OCD) and may cause diagnostic confusion, particularly because the two disorders frequently co-occur. In addition, OCPD is associated with a range of affective, cognitive, and behavioral dysfunction. The etiology of OCPD is not yet fully understood. Although relatively common among psychiatric patients, treatment for OCPD has received little investigation. This presentation reviews the diagnostic overlap between OCPD and OCD, offers suggestions on how to recognize OCPD, and discusses an integrated approach to clinical management of this disorder.

No. 49C
UPDATE ON THE CLINICAL FEATURES AND TREATMENT OF BDD

Katharine A. Phillips, M.D., *Department of Psychiatry, Butler Hospital/Brown University, 345 Blackstone Boulevard, Providence, RI 02906*

SUMMARY:

Body dysmorphic disorder (BDD) is a relatively common and often disabling OCD-spectrum disorder that often goes unrecognized in clinical practice. BDD consists of a distressing and impairing preoccupation with imagined or slight defects in appearance that can focus on any body area. Insight is usually poor or absent; nearly half of patients are delusional. Typical associated behaviors include skin picking, mirror checking, excessive grooming, and camouflaging. It appears that higher SRI doses and longer treatment trials than those used for many other psychiatric disorders, including depression, are often needed to effectively treat BDD. Cognitive-behavioral therapy also appears efficacious and is currently considered the psychotherapy of choice for BDD. Core techniques are cognitive restructuring, behavioral experiments, response (ritual) prevention, and exposure. This presentation will review BDD's clinical features, including similarities with OCD (e.g., obsessions and compulsive behaviors) as well as differences (e.g., poorer insight, higher rates of depression and suicidality). The presentation will also emphasize recent research findings on effective pharmacologic and psychotherapeutic treatments, and will offer practical advice on how to successfully treat patients with this often difficult-to-treat disorder.

No. 49D
IDENTIFYING AND TREATING HYPOCHONDRIASIS

Jonathan Abramowitz, Ph.D., *Department of Psychiatry, Mayo Clinic, 200 First Street SW, Rochester, MN 55905*

SUMMARY:

This presentation will review contemporary theoretical and conceptual perspectives on hypochondriásis and evaluate evidence regarding its relationship to obsessive-compulsive disorder. Whether hypochondriasis belongs among the disorders proposed as "OC spectrum disorders" will be addressed. On the basis of clinical similarities and parallels in underlying phenomenology, it is concluded the hypochondriasis is likely related to OCD and other anxiety disorders, such as panic disorder. Treatment strategies are also reviewed, with an emphasis on the two most effective interventions: serotonergic pharmacotherapy and cognitive-behavioral psychotherapy.

No. 49E
CLINICAL MANAGEMENT OF PATHOLOGICAL GAMBLING AND KLEPTOMANIA

Jon E. Grant, M.D., *Department of Psychiatry, Brown Medical School, Butler Hospital, 345 Blackstone, Providence, RI 02906*

SUMMARY:

Impulse control disorders such as pathological gambling and kleptomania are characterized by: (1) repetitive or compulsive engagement in a behavior despite adverse consequences, (2) diminished control over the problematic behavior, (3) an appetitive urge or craving state prior to engagement in the problematic behavior, and (4) a hedonic quality during the performance of the problematic behavior. Patients with pathological gambling and kleptomania experience repetitive behaviors and preoccupation with those behaviors, characteristics consistent with those found in other obsessive compulsive spectrum disorders. Patients with pathological gambling and kleptomania, however, also exhibit characteristics distinct from these other disorders. Proper characterization of impulse control disorders is important as treatment for pathological gambling and kleptomania may differ significantly from that used to manage obsessive compulsive disorder. This presentation will present the clinical features of both pathological gambling and kleptomania, two disorders that often lead to severe occupational, marital, financial, and legal difficulties. With the recent explosion of research concerning the clinical understanding and management of these disorders, available data will be presented indicating the efficacy of cognitive-behavioral therapy and several classes of medications (including serotonin reuptake inhibitors, opioid antagonists, and mood stabilizers) in treating these disorders.

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SYMPOSIUM 50—GENETIC CORRELATES IN BIPOLAR DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants will recognize the complex interactions between genes and environment in the pathogenesis of bipolar disorder, and become familiar with evidence to support a genetic role for disease phenomena, illness course, suicidality, and treatment response.

No. 50A
PHENOTYPE IN GENETIC STUDIES OF BIPOLAR DISORDER

Martin Alda, M.D., *Department of Psychiatry, Dalmousie University, 5909 Jubilee Road, Halifax, NS B3M 2E2, Canada*

SUMMARY:

Genetic research of bipolar disorder (BD) is complicated by many factors, including the complexity of the relationship between the genetic susceptibility and the clinical manifestation of the illness. In view of the less-than-convincing results of mapping studies, researchers started to re-examine the question of phenotype definition for genetic research. In this presentation, we will review the *pros* and *cons* of alternative phenotype definitions and summarize the most promising results to date. The traditional approach has been to consider as a phenotype of interest the diagnosis of BD together with other, presumably related affective disorders. Given the likely heterogeneity of BD and high degree of comorbidity, the diagnostic boundaries of the phenotypic spectrum are still unclear. The research focused on other phenotypes such as age of onset, mental health as opposed to an illness (possible linkage to chromosome 4p and 4q markers), sleep disturbance, or suicidal behavior. Especially, clinical variables already shown to be familial should be examined with priority. In a series of studies, we have shown that such variables include the clinical course response to lithium prophylaxis, and suicidal behavior. Beyond clinical traits, there are other potentially relevant traits, so-called endophenotypes (biological traits presumably heritable, associated with the illness, but with a simpler genetic architecture). Such traits are now sought extensively in areas such as brain imaging, neurocognitive performance, or biochemical markers.

No. 50B
PHARMACOGENETICS OF BIPOLAR DISORDER

Anil K. Malhotra, M.D., *Department of Psychiatry, Zucker Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004;* Youssef Hassoun, M.D., Joseph F. Goldberg, M.D.

SUMMARY:

Amidst the growing pharmacopoea for bipolar disorder, increasing efforts have sought to identify the heritability of psychotropic drug response. Although multiple factors influence treatment outcome, current evidence supports a heritable component for unequivocal responsivity to lithium. A growing database has begun to support genetic correlates for antidepressant response to selective serotonin reuptake inhibitors (SSRIs). Retrospective studies suggest a possible genetic component to antidepressant-induced mania. Genetic contributions to tachyphylaxis, longevity of initial response, or response to rechallenges after drug discontinuations remain largely unknown. Pharmacokinetic events (e.g., rapid metabolism) may be recognizable through cytochrome P450 polymorphism analyses. Genetic components also may influence adverse effects such as weight gain or sexual dysfunction.

At present, limited data suggest that an identified polymorphism of the promoter region for the serotonin transporter gene (locus SLC6A4) may contribute to outcome states during an SSRI trial. Other candidate genes involving the serotonin system (e.g., tryptophan hydroxylase, the 5HT1A receptor) have also been suggested to play a role in treatment outcome, but await replication. Similarly, treatment response relative to functional polymorphisms of known targets of lithium or divalproex (e.g., protein kinase C, the inositol monophosphate system, glycogen synthase kinase 3-β) remain speculative. This presentation will provide an overview of current findings involving candidate genes associated with treatment outcome, alongside future research directions and possible clinical applications.

No. 50C
BIPOLAR DISORDER AND ALCOHOL ABUSE: ARE THERE SHARED GENETIC CONTRIBUTIONS?

Joseph F. Goldberg, M.D., *Department of Psychiatry, Zucker Hillside Hospital, 79-59 263rd Street, Glen Oaks, NY 11004*

SUMMARY:

Clinical overlap between bipolar illness and alcohol use disorders has long been recognized. The extent to which both conditions may emanate from shared genetic substrates has become an increasing focus of investigation. Phenomenologically, both conditions are typically associated with impulsivity, affective dysregulation, and an increased potential for self-damaging or suicidal behaviors. Shared endophenotypes (e.g., impaired working memory) also point to common genetic susceptibilities. From a population-based perspective, alcoholics have been shown in some studies to have higher rates of bipolar disorder than controls (e.g., the Collaborative Study on the Genetics of Alcoholism [COGA]) while bipolar patients may have elevated prevalence rates of familial alcohol abuse (e.g., the Stanley Foundation Bipolar Network). Suicide and alcoholism also have been found to subcluster across generations in bipolar families. However, other studies fail to identify cross aggregation of mood and alcohol use disorders in probands and families.

From a molecular perspective, alcohol abuse and bipolar disorder have been associated with several candidate gene polymorphisms, including those of the 5HT1B receptor, the dopamine D2 receptor, and catechol-o-methyltransferase (COMT), among others. Chromosomal linkage studies also suggest common susceptibility loci, particularly involving chromosomes 4 and 16.

This presentation will review current evidence for the shared genetic contributions to bipolar disorder and alcoholism. Efforts to clarify phenotypes (e.g., by early versus late onset, illness course, and treatment response) will also be discussed.

No. 50D
GENETICS OF SUICIDAL BEHAVIOR IN BIPOLAR DISORDER

Maria A. Oquendo, M.D., *Department of Neuroscience, New York State Psychiatric Institute, 1051 Riverside Drive, Box 42, New York, NY 10032*

SUMMARY:

Adoption, twin, and family studies have shown that suicidal behavior is familial. In vivo and postmortem studies have uncovered low serotonergic functioning in those exhibiting suicidal behavior. In addition, a close association between suicidal acts and aggression/impulsivity has been observed and, similarly to suicidal behavior, aggression/impulsivity is linked to low serotonergic function. It is known that central serotonin activity is under partial genetic control and thus, studies of the genetics of suicidal behavior in mood disorders, in general, and bipolar disorder, in particular, have focused on serotonin candidate genes. In addition, the genetic underpinnings of aggression impulsivity are relevant. The extant findings with regard to six candidate genes—the serotonin transporter (HTTR), HTR1A, HTR2A, HTR1B, tryptophan hydroxylase (TPH), and the monoamine oxidase promoter (MAO-P) will be reviewed. Reasons for studying these genes include: (1) reports of higher 5-HT_{1A} binding in the midbrain of male, depressed suicide victims and higher 5-HT_{1A} binding localized to the ventral prefrontal cortex of suicide victims negatively correlated with serotonin transporter binding; (2) HT1B knockout mice are impulsive and aggressive; (3) MAO-P gene has four reported haplotypes, one of which has been associated with impulsive aggression in male community volunteers with isoenzymes of different activity; to name a few. The limitations of candidate gene association studies will be discussed, as well as recent

advances in molecular genetics that make it possible to directly sequence candidate genes and identify multiple single nucleotide polymorphisms (SNPs), which should allow for more specific and statistically powerful tests of association.

No. 50E
GENETIC EVIDENCE FOR A BIPOLAR SPECTRUM

J. Raymond DePaulo, Jr., M.D., *Department of Psychiatry, Johns Hopkins University, 600 N Wolfe Street, Meyer 4-113, Baltimore, MD 21287*

SUMMARY:

Family, twin, and adoption studies provide strong evidence for a genetic etiology in bipolar (BP) disorder. Based on the epidemiological and genetic evidence, the diathesis appears to be multi-genic. The ultimate aims of genetic studies will be to use the genes involved with bipolar disorder to illuminate the pathogenesis and environmental factors associated with the illness, to develop diagnostic tests, to predict treatment response, and to develop new rational treatments.

Genome-wide genetic studies have made it clear that single gene forms of BP disorder, if they exist, must be very uncommon. Nonetheless, positive linkage findings in multiple independent samples have coalesced in several chromosomal regions on which attractive candidate genes have emerged for further study. An intriguing corollary to the emergence of the evidence for a multigenetic basis for bipolar disorder has been the realization that phenotypic heterogeneity between families probably reflects differing combinations of genetic as well as non-genetic factors. This presentation will focus on our recent work isolating families in which either severe (psychotic BPI) or less severe (BPII) forms of BP disorder cluster. The possible mechanisms for these familial subtypes and their differences in clinical responsiveness and treatment will be discussed.

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SYMPOSIUM 51—CRITICAL PERSPECTIVES ON GENDER IDENTITY DISORDER IN CHILDREN AND ADOLESCENTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand how gender atypicality in youth has been diagnosed and treated, and what the current controversies and issues are for the mental health of these youths.

No. 51A
DIAGNOSING GENDER-ATYPICAL YOUTH: A HISTORY OF GENDER IDENTITY DISORDER IN CHILDHOOD

Karl E. Bryant, M.A., *Department of Sociology, University of California, Ellison Hall, Santa Barbara, CA 93106*

SUMMARY:

Objective: Gender identity disorder of childhood (GIDC) was formalized as a psychiatric diagnosis in 1980, and has undergone revisions in DSM-III-R and DSM-IV. The initial inclusion of GIDC in DSM-III drew on over 20 years of studies and treatment of gender atypical children. This paper outlines the history of the making of a formal diagnosis for gender atypical youth, as well as changes to the diagnosis and treatment practices over time.

Methods: This paper draws on reviews of the clinical and research literatures on GIDC, archival research tracing the formation of GIDC, and interviews with GID researchers, clinicians, critics, and patient advocates.

Results: The history of GIDC shows how current practices are shaped in part by specific institutional pressures and ongoing debates. It also reveals that existing practices have been limited in their ability to provide meaningful support to gender atypical youth.

Conclusion: Alternative approaches are available that can guide clinicians and researchers in their work with gender atypical youth. This paper concludes with recommendations about institutionalizing those approaches, including the possible role therein of DSM-V.

No. 51B
HISTORICAL AND ETHICAL PERSPECTIVES ON GENDER-ATYPICAL AND TRANSGENDER YOUTH

Richard R. Pleak, M.D., *Department of Child Psychiatry, Schneider Children's Hospital, 269-01 76th Avenue, Suite 135, New Hyde Park, NY 11040*

SUMMARY:

Objective: The concept of transsexualism was incorporated into DSM-III as a psychiatric diagnosis, while children referred for gender atypical behavior and wishes were categorized as having gender identity disorder. This paper will review how nosological notions of transgenderism and these diagnoses have changed over the past three decades, and what the ethical considerations and controversies are in diagnosis and treatment of gender atypicality in youths.

Methods: The presenter has considerable experience working with gender atypical children and transgendered (TG) youths and adults, and has had extensive discussions with patients and family members regarding the use of diagnoses and the recommendations and treatment plans of other clinicians. The literature was reviewed for diagnostic, treatment, and ethical considerations. Practical considerations for ethical assessment, diagnosis, and treatment will be addressed.

Results: There is much confusion, difference of professional opinion, and debate about how to handle gender atypicality in terms of diagnosis and treatment in youth. Unethical practices have and can be the result.

Conclusion: A more thorough understanding of gender atypical youth and of the history and current status of diagnostic and treatment controversies can better inform clinicians about more effective and ethical care of these youths.

No. 51C
TRANSGENDER TEENS: GENDER ATYPICALITY AT PUBERTY AND BEYOND

Sarah E. Herbert, M.D., *Department of Psychiatry, Morehouse Medical School, 49-C Lenox Pointe NE, Atlanta, GA 30324*

SUMMARY:

Objective: Less attention has been paid to gender atypical adolescents than adults. Yet depression, suicidality, rejection, and violence may bring them to mental health providers. Clinicians may be uncomfortable or confused about how to handle these youths' cross-gender behaviors.

Methods: This presenter has had experience working with gender atypical children, adolescents, and adults. The literature has been reviewed. An approach to the assessment and treatment of gender atypical youth at puberty and beyond will be discussed. Case examples will illustrate the dilemmas that clinicians face in working with these youth.

Results: Transgender issues in the teen years are much less likely to resolve with acceptance of a typical gender identity. Consequently, complex dilemmas face youth, their families, and treating clinicians. There is little acceptance of cross-dressing in institutional settings for minors, such as schools or residential facilities, and there are no consensus guidelines for mental health professionals on how to handle these issues.

Conclusion: It is no longer acceptable to equate transgender issues in the teen years with severe psychopathology or to ignore the issue until the teen becomes an adult. Psychiatrists who are knowledgeable about the issues facing transgender youth should be able to provide appropriately respectful evaluation and treatment.

No. 51D
GENDER VARIANCE IN CHILDREN AND ADOLESCENTS: A CRITICAL REINTERPRETATION OF CASE STUDIES

Darryl B. Hill, Ph.D., *Department of Psychology, State University of New York, Staten Island, Building 45, Staten Island, NY 10314*

SUMMARY:

Objective: Case studies of gender variant children and adolescents (most of whom meet the DSM-IV criteria of gender identity disorder) often characterize these patients as extremely disordered and pathological. This paper is a re-interpretation of 61 case studies, comprising the complete published literature on this topic.

Method: A critical re-reading of these 61 case reports was done.

Results: Key dimensions of the gender variant youth and their circumstances emerge, other than previously reported. These case studies reveal a high preponderance of comorbidity and family pathology. Families and significant others often encourage cross-gender expressions. It is also evident that these youth exist in highly homophobic and transphobic contexts, which often dichotomize gender and pathologize any exceptions to stereotypical portrayals of gender. A deeper exploration of what gender variant youth are saying shows that many have complex understandings of gender.

Conclusion: While classic interpretations portray gender variance as a source of pathology, this re-analysis shows that many youth use gender variance as a strategy of empowerment.

No. 51E
CHILDHOOD GENDER IDENTITY DISORDER: WHAT SHOULD WE TREAT AND WHY?

Edgardo J. Menvielle, M.D., *Department of Psychiatry, Children's Hospital, 111 Michigan Ave NW, Washington, DC 20010-2916*

SUMMARY:

Objective: Children with gender-variant behaviors are diagnosed as having Gender identity disorder in DSM-IV and treated for this disorder. A different approach is proposed.

Methods: A support group for parents of children (age 3 years and up) who exhibit strong and persistent gender variant behaviors has been meeting since 1999. We also provide workshops for professionals and have published a booklet to guide parents. Our presentation will review the program, provide clinical examples, and describe how the program relates to the symposium objectives.

Results: Although there is no consensus on treatment of gender-variant children, some psychiatrists recommend reducing gender-variant behaviors through psychotherapy or behavior modification. This approach is flawed and promotes stigma. Our professionally-facilitated group helps parents overcome barriers to acceptance within themselves and in society, and developing affirming parenting behaviors and advocacy skills.

Conclusion: We propose that gender variance in children should be regarded as a normal variation of childhood sexual development that is met with social stigma, much as gender variance in adults does. Instead on focusing on changing the child's behaviors, children are best served by being helped to deal with the stigma and parents with the significant challenges in parenting these children.

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SYMPOSIUM 52—THE ART AND SCIENCE OF BRIEF THERAPIES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should have a working overview of eminently schematized and teachable approaches to short-term therapy: solution focused therapy, behavior therapy, and CT.

No. 52A
SOLUTION-FOCUSED BRIEF THERAPY: DOING WHAT WORKS

Brett Steenbarger, Ph.D., *Department of Psychiatry, State University of New York, Upstate Medical, 750 East Adams Street, Syracuse, NY 13210;*

SUMMARY:

Solution-focused therapy is a highly manualized approach to brief therapy that is particularly applicable for patient populations with adjustment disorders and normal developmental life concerns. Accordingly, it is one of the easiest and least threatening therapies for residents who are beginning to learn psychotherapy. In this presentation, the practice essentials of solution-focused therapy are outlined

in engaging flow charts and case examples, mirroring the way in which they are taught to developing therapists. Particular emphasis is placed on using the practice elements of solution-focused brief therapy to teach, model, and practice such core therapeutic skills as establishment of a working relationship, assessment, development of a treatment focus, active intervention, and relapse prevention. The symposium presentation will also highlight process and outcome research into solution-focused therapy and implications for practice. These include ways in which solution-focused methods can be adapted for use in inpatient therapy and in the context of longer-term supportive modalities.

No. 52B
BRIEF BEHAVIOR THERAPY

Edna B. Foa, Ph.D., *Department of Psychiatry, University of Pennsylvania, 3535 Market Street Suite 600 North, Philadelphia, PA 19104*

SUMMARY:

Cognitive-behavior therapy [CBT] has gained attention recently for its clinical efficacy in a wide array of conditions and the vast number of studies that provide strong research support. First, a brief overview of the general principles of CBT as an empirically based, time-limited, problem-focused, present-centered, active, collaborative, rationale-supported, and very effective therapy will be provided. Then, three kinds of CBT that are particularly suited to the treatment of pathological anxiety will be described: exposure therapy, stress inoculation training (SIT), and cognitive therapy. Two well studied, exposure therapy programs—exposure and response prevention for patients with obsessive compulsive disorder and prolonged exposure therapy for patients with chronic PTSD—that have been pioneered and developed by the author and her colleagues in Philadelphia—will be taught. This presentation will be liberally enriched with clinical vignettes.

No. 52C
COGNITIVE THERAPY: PRACTICE AND TRAINING

Judith S. Beck, Ph.D., *Cognitive Therapy & Research, The Beck Institute, 1 Belmont Avenue, Suite 700, GSB Bldg, Bala Cynwyd, PA 19004*

SUMMARY:

Cognitive therapy has demonstrated clinical efficacy for a variety of presenting concerns, including depression, anxiety, and personality disorders. This presentation uses case examples to present the practice basics of cognitive therapy and seven components of teaching cognitive therapy to residents in psychiatry. These steps include: formulating cases according to the patient's diagnosis, conceptualizing individual patients according to the cognitive model, using case formulation to plan treatment within and across sessions, establishing and maintaining a strong therapeutic alliance, structuring therapy sessions effectively, implementing cognitive and behavioral techniques, and assessing the efficacy of their treatment. Specific strategies for conducting and teaching cognitive therapy will be reviewed for each of the steps. These strategies include the use of didactic lectures, text material on cognitive therapy, demonstration roleplays, audio and videotapes of master cognitive therapists, conceptualization worksheets, and case formulation exercises. Also highlighted is the use of the Cognitive Therapy Rating Scale, a standardized instrument for assessing competency and guiding clinical supervision.

No. 52D
THE IMPACT OF COMMON FACTORS ON PSYCHOTHERAPY OUTCOMES

Roger P. Greenberg, Ph.D., *Department of Psychiatry, State University of New York, Upstate Medical, 750 East Adams Street, Syracuse, NY 13210*

SUMMARY:

Research has consistently shown that psychotherapy is beneficial to patients. For example, a classic meta-analysis of 375 studies found that 75% of patients receiving psychotherapy treatments did better than those who did not. However, head-to-head studies comparing different models of psychotherapy have typically demonstrated equivalent outcomes among different brands of psychotherapy. This has led to the speculation that psychotherapy benefits are more a product of factors common to different approaches than to ingredients unique to any single psychotherapy model. Objectives for this presentation are to review the case for the common factors explanation of psychotherapy benefits and to highlight the importance of variables like the therapy relationship, patient expectations, and pre-therapy patient characteristics in determining how successful psychotherapy will turn out to be. The presentation will also look at the placebo effect and suggest it is a potent (and not inert) factor in generating therapeutic results for psychotherapy, as well as medication treatments. Implications for practice will also be addressed in terms of therapist behaviors that have proven to be either helpful or harmful.

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SYMPOSIUM 53—THE BOUNDARIES OF BPD

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand evidence concerning the differential diagnostic boundaries between BPD and other common psychiatric diagnoses.

No. 53A
A NEW EXAMINATION OF THE INTERFACE BETWEEN BPD AND MDD

John G. Gunderson, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478-9106*

SUMMARY:

Data from the Collaborative Longitudinal Personality Disorder Study (CLPS) offer insights into the relationship of BPD and MDD. Analyses of data on 175 BPD patients at two-year and three-year follow ups show that improvement of borderline psychopathology is often followed by remissions of MDD, but not vice versa. Close examination of those 16 borderline patients with particularly early remissions indicate this is rarely due to treatment of comorbid mood

disorders (one or two cases), but is more apt to be due to adaptive situational changes (eight or nine cases). These findings are joined by the results from recent treatment research (i.e. Kool et al 2003, Stevenson & Meares, unpublished) to provide strong support for the clinical axiom: for patients with BPD and MDD, treatment strategies should be primarily targeted at borderline psychopathology.

No. 53B
BORDERLINE OR BIPOLAR?

Donald W. Black, M.D., *Department of Psychiatry, University of Iowa, Psychiatry Research MEB, Iowa City, IA 52442*

SUMMARY:

The symptomatic overlap of borderline personality disorder (BPD) and bipolar disorder creates considerable diagnostic confusion. Comorbidity studies suggest great overlap between these disorders; bipolar disorder type II is particularly common as a comorbid diagnosis with BPD. Likewise, a high proportion of those diagnosed with bipolar disorder type II meet the criteria for BPD. Symptoms that create diagnostic confusion include mood instability, suicidal thoughts and self-harm, impulsivity, irritability and anger, and unstable relationships. Is this overlap between these disorders true or artifactual? Are borderline patients being inappropriately diagnosed as bipolar, or vice versa? The author argues that many BPD patients are being inappropriately diagnosed with bipolar disorder (usually type II) resulting in the prescription of treatments that may have little relevance to the underlying condition, or may prevent referral for more appropriate treatment modalities.

No. 53C
SUBSTANCE ABUSE AND ITS RELATIONSHIP TO REMISSION FROM BPD

Mary C. Zanarini, Ed.D., *McLean Hospital, 115 Mill Street, Belmont, MA 02478;* Frances R. Frankenburg, M.D., John Hennen, Ph.D., D. Bradford Reich, M.D.

SUMMARY:

Objective: The purpose of this study was to assess the prevalence of axis I disorders among patients with borderline personality disorder (BPD) over six years of prospective follow-up.

Method: The axis I comorbidity of 290 patients meeting both DIB-R and DSM-III-R criteria for BPD was assessed at baseline using the SCID I. Over 96% of surviving borderline patients were reinterviewed about their co-occurring axis I disorders at three distinct follow-up waves: two, four, and six-year follow-up.

Results: Borderline patients experienced declining rates of axis I disorders over time. However, the rates of mood and anxiety disorders remained quite high. Ever-remitted borderline patients experienced substantial decline in all concurrent disorders assessed, while never-remitted borderline patients reported consistently high rates of co-occurring disorders. When the absence of comorbid disorders was used to predict time-to-remission, substance use disorders were a far stronger predictor of remission than PTSD, mood disorders, other anxiety disorders, and eating disorders, respectively.

Conclusions: The results of this study suggest that axis I disorders co-occur less commonly with BPD over time, particularly for remitted borderline patients. They also suggest that substance use disorders are the axis I disorders that are most closely associated with the failure to achieve symptomatic remission from borderline personality disorder.

Funding Source: NIMH grants MH47588 and MH62169.

No. 53D
WHY PSYCHIATRISTS DO NOT DIAGNOSE BPD

Joel F. Paris, M.D., *Department of Psychiatry, SMBD Jewish General Hospital, McGill Univer., 4333 Cote Ste-Catherine Road, Montreal, PQ H3T 1E4, Canada*

SUMMARY:

Objective: To discuss some of the reasons why BPD is underdiagnosed in clinical settings.

Methods: A literature review (MEDLINE and PSYCLIT) was conducted on all studies of BPD since 1980.

Results: Clinicians tend to focus on Axis I rather than on Axis II diagnoses. Structured interviews find many cases of BPD that have been missed. Patients may be diagnosed with major depression, bipolar disorder, dysthymia, schizophrenia, primary substance abuse, or eating disorders. Some of the reasons for ignoring BPD derive from assumptions about treatability.

Conclusions: BPD is underdiagnosed in clinical settings.

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SYMPOSIUM 54—ANTICONVULSANTS FOR TREATING MULTIPLE COMPONENTS OF ALCOHOL-DEPENDENCE SYNDROME

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should have (1) new insights into basic and applied (including neuroimaging and genetic) underpinnings of alcoholism, (2) new knowledge on the use of anticonvulsants for treating withdrawal and craving and for preventing relapse, and their delivery in general practice, (3) A review of other pharmacotherapies for treating alcoholism.

No. 54A
WHAT ARE THE CRITICAL NEUROBIOLOGICAL SUBSTRATES INVOLVED IN THE DEVELOPMENT OF ALCOHOL-DEPENDENCE?

Raymond F. Anton, Jr., M.D., *Psychiatry, Medical University of South Carolina, 67 President Street, P.O. Box 250861, Charleston, SC 29425*

SUMMARY:

The developmental course, pathoneurobiology, and neuroscience of alcohol dependence are becoming better understood. In the last decade, there has been considerable development of neurobiological models upon which has been predicated the development of new medications for treating alcoholism. An important aspect of this development has been not only the identification of the mesocorticolimbic dopamine pathway as the critical substrate for alcohol reward, but the role played by other co-neurotransmitters such as those associ-

ated with serotonergic, opioid, gamma-amino-butyric acid, and glutamate function. This knowledge has been extrapolated, using both behavioral pharmacology and neuroimaging techniques, to the studies of humans consuming alcohol in the laboratory.

This presentation will highlight what is known about the development of alcoholism, focusing on the neurobiological basis of alcohol as an addictive substance. As such, studies that have been done to elucidate the biological and neuroanatomical mechanisms of alcohol-seeking behavior will be discussed. The integration of neurobiology, neuroanatomy, and pharmacological concepts will be attempted. New data from brain imaging studies, clinical lab models of drinking, and, where possible, the role of heritable factors that might explain substantial inter-individual differences in drinking behavior will be presented.

No. 54B
WHAT IS THE UTILITY OF VARIOUS CLASSES OF PHARMACOLOGICAL AGENTS IN TREATING DIFFERENT COMPONENTS OF THE ALCOHOL-DEPENDENCE SYNDROME?

Robert M. Swift, M.D., *Department of Psychiatry, Brown University, Box G-BH, Providence, RI 02912;* George Kenna, Ph.D.

SUMMARY:

More than 20 medications, combined with psychosocial treatments, have been shown to reduce alcohol consumption in placebo-controlled clinical trials. These include aversive agents, which cause accumulation of toxic acetaldehyde (disulfiram); anticraving agents, such as opiate antagonists (naltrexone and nalmefene), dopamine antagonists (tiapride and clozapine), and serotonergic medications (SSRIs and the serotonin-3-receptor antagonist ondansetron); and anti-withdrawal agents, which block neuronal hyperexcitability due to chronic alcohol use (acamprosate, the antiepileptics topiramate, carbamazepine, gabapentin, and valproic acid, and the sedative gamma-hydroxyburyrate), and the GABA-B antagonist (baclofen), which blocks alcohol sensitization. Several medications have general effects to reduce appetitive behaviors and possibly multiple mechanisms of action.

Given that the benefits of current medications to reduce drinking or to increase abstinence are modest, researchers are attempting to improve medication response by identifying new medications, combining medications (naltrexone plus acamprosate in the COMBINE Study), and developing new routes of administration (depot injectable naltrexone) and new psychotherapies to enhance medication compliance. Furthermore, there is interest in identifying patient genotypes and phenotypes that predict response to a specific medication.

This presentation discusses discoveries on the neurobiology of alcohol dependence. First, I will highlight how different classes of pharmacological agents have been used to treat different components of the alcohol-dependence syndrome. Then, I will outline the relative efficacy of these therapies as pharmacological treatment for the alcohol-dependence syndrome.

No. 54C
WHAT IS THE EFFECTIVENESS OF VARIOUS CLASSES OF PHARMACOLOGICAL AGENTS AT REDUCING CRAVING FOR ALCOHOL?

Nassima Alt-Daoud, M.D., *Department of Psychiatry, University of Texas Health Science Center, 7703 Floyd Curl Drive, San Antonio, TX 78229*

SUMMARY:

Craving has been used by both practitioners and experts to define a wide range of behaviors associated with maintaining alcohol-seeking behavior, and to explain the negative mood-related consequences of drinking cessation. Despite the lack of universal consensus as to what constitutes craving, new knowledge from animal and human laboratory studies has shown that dopamine neurons associated with the orbitofrontal circuit may play a critical role in the expression of craving. Thus, I will first outline some of the basic neuroscience associated with craving. Next, I will appraise the general approach to the measurement of craving in pharmacotherapy trials in the alcoholism field. Basically, the multi-component rating scales, such as the Obsessive Compulsive Drinking Scale (OCDS), capture the important and complex factors associated with craving. Multi-component craving rating scales, being more reliable than single-item measures, might be better predictors of actual drinking behavior. Indeed, I will show that the OCDS is a reliable predictor of drinking behavior in treatment-seeking, alcohol-dependent individuals. As illustrative examples, I will provide evidence on two types of anti-dopaminergic medication—the combination of ondansetron (serotonin-3 antagonist) and naltrexone (mu-opioid antagonist), and topiramate (GABA facilitator and glutamate antagonist)—on craving behavior, and its relationship with drinking behavior, in alcohol-dependent individuals. Finally, I will discuss how the concept of craving can be operationalized in general psychiatric practice to monitor treatment outcome.

No. 54D
HOW EFFECTIVE ARE ANTICONVULSANTS AT TREATING ALCOHOL-WITHDRAWAL SYMPTOMS?

Robert J. Malcolm, Jr., M.D., *Department of Psychiatry, Medical University of South Carolina/IOP, 67 President Street, PO Box 250861, Charleston, SC 29425-0001;* Hugh Myrick, M.D., Elizabeth Noll, M.S.W., Brent Taylor

SUMMARY:

Anti-epileptic drugs (AEDs) have been used widely in Europe for over two decades to treat alcohol withdrawal. In controlled trials, AEDs have compared favorably with benzodiazepines in suppressing symptoms of withdrawal. Our group has considerable experience with studying a variety of AEDs in this capacity. An initial double-blind study found carbamazepine (CBZ) to be equal to oxazepam in the inpatient treatment of alcohol withdrawal. Open label experience with valproate also resulted in reduced symptoms of alcohol withdrawal. Recently, our group has reported that CBZ was superior to lorazepam for the outpatient treatment of alcohol withdrawal. CBZ-treated subjects also reported a reduction in post-detoxification drinking ($p = 0.003$), improved sleep ($p = 0.02$), and reduced anxiety ($p = 0.0007$) compared with lorazepam-treated subjects. A 12-week, double-blind, placebo-controlled trial of valproate found a reduction in relapse to heavy drinking in valproate-treated subjects ($p = 0.094$) but no significant differences in other alcohol-related outcomes. Because of unfavorable drug interactions and potentially serious side effects of older AEDs, our recent work has focused on evaluating novel AEDs with more acceptable safety profiles such as gabapentin and tiagabine. Preliminary results with tiagabine and gabapentin indicate adequate suppression of withdrawal symptoms. Newer-generation AEDs may represent safe, non-abusable, and effective alternatives to benzodiazepines for the treatment of alcohol withdrawal and post-detoxification relapse.

No. 54E
HOW EFFECTIVE ARE ANTICONVULSANTS AT IMPROVING THE OVERALL CLINICAL PICTURE OF ALCOHOL DEPENDENCE?

Bankole A. Johnson, M.D., *Department of Psychiatry, University of Texas Health Science Center, 7703 Floyd Curl Drive, MS 7793, San Antonio, TX 78229-3900*

SUMMARY:

Anticonvulsants possess a range of pharmacological properties that make them suitable candidates for the treatment of important components of the alcohol dependence syndrome associated with long-term success. While there have been growing data on the use of anticonvulsants in treating alcohol withdrawal, they also may have neuropharmacological effects at reducing alcohol craving. As an example, topiramate, a sulfamate fructo-pyranose derivative, may antagonize alcohol reward associated with abuse liability by inhibiting mesocorticolimbic dopamine release, presumably via facilitation of gamma-amino-butyric acid activity and suppression of glutamate function. New knowledge from a double-blind, randomized, controlled clinical trial (N = 150) shows that individuals who received topiramate, compared with placebo, experienced 27.6% fewer (p = 0.0003) heavy drinking days in an alcohol-dependent population. In addition, topiramate, compared with placebo, improved overall life satisfaction (OR = 2.28, 95% CI 1.21 to 4.29, p = 0.01) and reduced the harmful drinking consequences (OR = −0.07, 95% CI −0.12 to −0.02, p = 0.007). While topiramate's therapeutic effects at reducing drinking can be attributed to its anti-craving properties, we will present additional information showing that another possible mechanism enabling the stabilization of symptoms is its ability to prevent post cessation withdrawal symptoms.

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SYMPOSIUM 55—ADHD SUBTYPES AND SUBGROUPS AT RISK FOR SUBSTANCE USE DISORDERS
Collaborative Session with the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate knowledge about the characteristics and subgroups of children with ADHD who are at increased risk for substance abuse, and the research approaches and challenges to addressing this important clinical and public health issue.

No. 55A
SUBTYPES OF ADHD YOUTH AT RISK FOR SUBSTANCE ABUSE

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

SUMMARY:

Objective: The co-occurrence of ADHD and substance use disorders (SUD, including drug and alcohol abuse and dependence) has been increasingly reported in clinical and research settings and is associated with substantial impairment and a chronic course. However, it remains unclear what factors are mediating this association. This presentation will evaluate the existing literature depicting the developmental relationship of SUD in ADHD males and females.

Methods: Prospective studies of boys, girls, and their siblings and parents as well as retrospective studies of adults with ADHD were evaluated for the relationship between SUD and ADHD. Specific developmental issues with an emphasis on the role of psychiatric comorbidity were evaluated. Data from epidemiologic and clinic samples were reviewed.

Results: Studies in ADHD children growing up as well as those in adults with ADHD demonstrate an increased risk of SUD in those with persistent ADHD. Psychiatric comorbidity with conduct disorder continued to be the most robust risk factor for SUD in ADHD. Moreover, ADHD individuals with conduct or bipolar disorder had the earliest onset of SUD. A positive family history of SUD or exposure to parental SUD as adolescents also increased the risk for SUD. ADHD adults with SUD have a different course and longer duration in the development of their SUD relative to non-ADHD adults.

Conclusions: While debate remains as to the risk of non-comorbid ADHD on later SUD, associated comorbidity with conduct and bipolar disorder appears as a major risk for SUD.

No. 55B
CHILDHOOD ADHD, COMORBIDITY, AND RISK FOR LATE-ADOLESCENT DRUG ABUSE

Ken C. Winters, Ph.D., *Department of Psychiatry, University of Minnesota, F282 2A West 2450 Riverside Avenue, Minneapolis, MN 55454;* Gerald August, Ph.D., George M. Realmuto, M.D.

SUMMARY:

Although some exceptions exist, there is a converging body of studies suggesting that ADHD children are probably at increased risk for later drug use and substance use disorders (SUD), and this risk is elevated by tendencies toward an externalizing disorder. However, the literature is generally characterized by studies with small sample sizes, too short a longitudinal study period, and nonspecific measures of drug use behaviors. We present findings from a young adult (mean age 20) follow-up (wave 4) assessment as part of the University of Minnesota ADHD Prospective Study. Community-recruited ADHD (n = 118) and control (n = 74) children have been regularly assessed during an eight-year span. The presentation will focus on the drug use behavior outcomes of the young adults with respect to several measures of drug use behaviors, including SUDs. The findings indicate reliable elevations in drug use behaviors for the ADHD + Externalizing group when compared with controls, but no group differences were found for the other comparisons (ADHD alone vs. controls and ADHD + Internalizers vs. controls). Implications of the findings in light of the community-based ADHD sample will be discussed.

No. 55C
DEVELOPMENTAL TWIN STUDIES OF RELATIONS BETWEEN SUBSTANCE USE AND ADHD

James J. Hudziak, M.D., *Department of Psychiatry, University of Vermont, Given Room B229, Burlington, VT 05405-0001;* Dorett Boomsma, M.D., Richard D. Todd, M.D.

SUMMARY:

Many studies have reported oppositional defiant disorder (ODD), conduct disorder (CD), and perhaps attention deficit disorder (ADD, ADHD), as examples of child disorders that predispose children to developing substance use (SU) problems. Longitudinal studies aimed at following children from childhood into adolescence provide a cogent approach to dissecting the relations between ADHD and SU. Indeed, recently Molina et al (2003) used this approach in singletons and reported that severity of ADHD symptoms and persistence, predicted ODD and CD, which in turn predicted SU. In this talk, we will combine two approaches, a developmental twin study of 25,000 Dutch twin pairs followed since birth (Boomsma, P.I.) in order to determine the contributions of maternal smoking and drinking behavior to offspring ADHD, ODD, and other psychopathologies; to determine the genetic and environmental contributions to these phenotypes; and lastly, to determine the stability of these behavioral problems across the 12 years of development. The MOTWIN data set (Todd, P.I.), will be presented in order to shed light on the relations between ADHD and its subtypes and substance use. Lastly, data will be presented that indicates natural age of onset for substance use behavior and how inattention, delinquency, and aggressive behavior problems of childhood both precede and predict later substance use behavior.

No. 55D
VARIABILITY IN RISK FOR SUBSTANCE USE AND DISORDER AMONG CHILDREN DIAGNOSED WITH ADHD

Brooke S.G. Molina, Ph.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213;* William E. Pelham, Jr., Ph.D., Elizabeth M. Gnagy, B.S.

SUMMARY:

Diagnosis of childhood attention-deficit/hyperactivity disorder (ADHD) has been shown, in clinical samples, to be a risk factor for early substance use and abuse among early to late-aged adolescents. Questions remain regarding the persistence of this risk into adulthood and about the characteristics that explain differences in vulnerability to substance disorder in this population. We will report results from our longitudinal research on children with ADHD (Pittsburgh ADHD Longitudinal Study, funded by NIAAA/NIDA), in which we are following over 350 children diagnosed with ADHD, through adolescence into early adulthood, and 240 individuals without ADHD. Unique features of this study include a wealth of standardized and objective childhood data that characterize the probands in childhood, a large sample size that allows previously underpowered examinations of comorbidity, and a comprehensive assessment at follow-up of alcohol, tobacco, and drug use/disorder through adolescence and early adulthood with annual interviews. We will report variability in these characteristics in our sample and relations to risk for later substance-related outcomes such as frequency and quantity of consumption and substance-related impairment. Implications for clinicians and future research will be discussed.

No. 55E
BEHAVIORAL AND COGNITIVE PREDICTORS OF ADOLESCENT SUBSTANCE USE IN CHILDREN WITH ADHD

Jeffrey Halperin, Ph.D., *Department of Psychology, Queens College of CUNY, 65-30 Kissena Boulevard, Flushing, NY 11367*

SUMMARY:

Children with ADHD are at heightened risk for substance use during adolescence. However, the degree to which this association is specific to ADHD or whether it is more closely linked to (1) the presence of early conduct disorder (CD); (2) the persistence of CD into adolescence; and/or (3) the manifestation of AD/HD symptoms during adolescence remains unclear. Further, it is unknown how this risk is affected by level of cognitive function. Data will be presented from an ongoing longitudinal study of youth who were evaluated and diagnosed with ADHD combined type, when they were seven to 11 years old. These patients, along with controls, are being re-evaluated at age 16 to 21 years. Preliminary analyses indicate that adolescent substance use in ADHD is best accounted for by an interaction between early CD and Full Scale IQ. Among patients with ADHD + CD, those with high IQ scores were most likely to use drugs and alcohol. In contrast, among those without early CD, increased adolescent substance use was associated with low IQ scores. Analyses will be expanded to assess the impact of persistence of CD and ADHD symptoms/subtype during adolescence, thus allowing for a better understanding of which children are at greatest risk for adolescent substance use.

No. 55F
LONG-TERM FOLLOW-UP OF CHILDHOOD ADHD: DEVELOPMENT OF ADULT SUBSTANCE ABUSE

F. Xavier Castellanos, M.D., *Department of Psychiatry, New York University Child Study Center, 577 First Avenue, CSC 204, New York, NY 10016;* Rachel G. Klein, Ph.D., Sal Mannuzza, Ph.D., John L. Moulton, Ph.D.

SUMMARY:

From 1970 to 1977, 226 cross-situationally hyperactive children were enrolled in a long-term follow-up after undergoing standardized treatment with methylphenidate. Based on data available for 171 male probands and 178 male contemporaneously recruited comparisons, we observed significantly greater rates of substance abuse in probands, along with a significant relationship between age of first treatment with stimulants and the lifetime prevalence of drug abuse disorders (OR=2.3; p=.01). Younger age at first treatment predicted lower risk, independently of potential confounds such as severity of hyperactivity, social class, or intelligence. In an independent sample of children and adolescents with ADHD who had longitudinal anatomic MRI scans, we observed strikingly low white matter volumes in previously untreated ADHD children, and an apparent increase in white matter volume in those children once they began stimulant treatment. These results are consistent with basic science studies suggesting that low doses of methylphenidate may have enduring effects, which are greatest in younger individuals. A study of brain anatomy during adulthood in these prospectively studied patients and comparison subjects is under way.

REFERENCES:

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SYMPOSIUM 56—ALCOHOLICS ANONYMOUS AND SPIRITUALLY ORIENTED RECOVERY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe objectively-derived observations on the role of spirituality in Twelve Step and related programs, and have a better understanding of the application of these programs in addiction treatment.

No. 56A
RESEARCH ON SPIRITUALITY'S ROLE IN RECOVERY

Marc Galanter, M.D., *Department of Psychiatry, New York University School of Medicine, 550 First Avenue, New York, NY 10016*

SUMMARY:

Alcoholics Anonymous, as well as other spiritually oriented approaches, have utility in moving patients toward remission from substance dependence. This has been found when AA is applied either singly or in combination with professional care. Additionally, in a multisite study, Twelve Step Facilitation was itself demonstrated to have effectiveness comparable to that of other manualized treatment. Clinicians, however, are sometimes reluctant to refer patients to AA and similar spiritually-oriented programs. In part this is because of a lack of understanding of the concept of spirituality that members of Twelve Step programs deem central to their fellowship's impact. This symposium is designed to provide an empirical basis for understanding the nature of the spiritual orientation in Twelve Step programs. It will thereby help clinicians employ these programs more effectively in clinical practice. Additionally, the symposium will present findings, both from controlled studies and clinical settings, which will facilitate an understanding of the research literature describing the relationship between spirituality and AA, and addiction treatment. The papers presented will deal with the following: spirituality as a mediator of addiction recovery; empirical studies on AA outcome; AA and character disorder; and integration of AA into psychotherapy.

No. 56B
THE EFFECTIVENESS OF AA: EMPIRICAL RESEARCH PERSPECTIVES

Barbara S. McCrady, Ph.D., *Department of Alcohol Study, Rutgers University, 607 Allison Road, Piscataway, NJ 08854-8001*

SUMMARY:

Although Alcoholics Anonymous (AA) is ubiquitous and widely respected as an approach to recovery, research on the effectiveness of AA has lagged behind its popularity. This talk will review recent empirical research on AA. Several research methods have examined the effectiveness of AA, treatments based on AA, patient-treatment matching factors, and mediators of program effectiveness. Epidemiological and ethnographic studies demonstrate the broad dissemination of AA, with variability in the expression of AA in different cultures, demonstrating the flexibility of the program. Controlled outcome studies of AA itself are limited, with few data suggesting the superiority of AA over other approaches to recovery. Non-randomized comparison group studies suggest that the programs based on 12-step principles are somewhat more successful than other treatment models in facilitating post-treatment abstinence. Randomized controlled trials do not find overall superiority of AA over other treatment approaches, but patient-treatment matching studies suggest that AA is particularly effective for those low in other psychopathology, or with social networks that strongly support continued drinking. Studies of mediators of the effectiveness suggest that AA enhances commitment to abstinence, social support for abstinence, and self-efficacy for abstinence. Studies have not supported enhanced spirituality as a major mechanism by which AA is effective.

No. 56C
THE INTERACTION BETWEEN AA AND PERSONALITY DISORDER

Edgar Nace, M.D., *7777 Forest Lane, Suite B413, Dallas, TX 75230*

SUMMARY:

Constructive personality dynamics and ego maturation are potentially realized through working the steps of Alcoholics Anonymous. The clinician can facilitate this process by appreciating the impact of AA on pathological narcissism and the ego-strengthening processes related to abstinence from alcohol; recognition, regulation and tolerance of affect: and the improved self-esteem that can be expected to develop as a destructive process is overcome.

No. 56D
INTEGRATING AA AND PSYCHOTHERAPY

Richard K. Ries, M.D., *Department of Psychiatry, University of Washington, Harborview Medical Center, 325 9th Avenue, Seattle, WA 98104*

SUMMARY:

When working with patients who have co-occurring psychiatric and addictions disorders, addiction psychiatrists, as well as other medical and non-medical mental health therapists often work with patients who either already attend AA, or whom the therapists wish would attend AA. In either case, in order to maximize both attendance and benefit of attending AA, therapists need to have a model of how their therapies, medications, etc., work either with or against some of the care concepts of AA. This presentation will not only examine how therapists can productively use the material in 12-Step Facilitation to increase addiction recovery benefits, but also how to integrate and utilize this material psychotherapeutically in the treatment of mood and anxiety disorders.

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3. Nace EP: Achievement in Addiction: A Guide to the Treatment of Professionals. Brunner/Mazel New York, 1995.
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SYMPOSIUM 57—AN UPDATE ON PARKINSON'S DISEASE AND ITS PSYCHIATRIC COMPLICATIONS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize and treat depression, psychosis, dementia, anxiety, and sleep disorders in patients with PD.

No. 57A
PARKINSON'S DISEASE: UPDATE ON TREATMENT, ETIOLOGY, AND PATHOGENESIS

Margery Mark, M.D., *Department of Neurology, Robert Wood Johnson Medical School, 97 Patterson Street, Room 210, New Brunswick, NJ 08901*

SUMMARY:

In the last ten years, enormous strides have been made in understanding and treating Parkinson's disease (PD). PD is now recognized as more than just a disorder of the nigrostriatal dopamine system, with significant involvement of cognition, behavior, and mood. For bradykinesia, rigidity, and tremor, however, levodopa remains the most efficacious treatment, but recent trends have turned to initial therapy with direct-acting dopamine agonists in younger patients; further, some studies suggest a possible neuroprotective effect of agonists. Peripheral inhibition of catechol-*O*-methyltransferase (COMT inhibitors) allowing prolongation of levodopa action, is another therapeutic alternative added in the last decade. An old drug, amantadine, has found new life in reducing dyskinesias, possibly through its mechanism as an NMDA-receptor antagonist. New drugs in clinical trials aim at improving both parkinsonism and dyskinesia (adenosine A_{2a} antagonists) as well as potentially slowing disease progression (mixed kinase inhibitors). Ultimately, knowing why the cells degenerate will allow targeted drug therapy and interrupt the process. Progress in understanding the disease process itself has been made possible by the identification of genes causing PD (mutations in alpha-synuclein, parkin, and ubiquitin carboxy-terminal hydrolase L1) and the implications for synuclein aggregation and impairment of the ubiquitin/proteasome pathway in cell death.

No. 57B
DEPRESSION IN PARKINSON'S DISEASE

Jeffrey L. Cummings, M.D., *Department of Neurology, UCLA/Reed Neurosciences Center, 710 Westwood Plaza, Los Angeles, CA 90095*

SUMMARY:

Depression is a common finding in patients with Parkinson's disease (PD). Depressive symptoms are present in 40% of patients and approximately 10% meet criteria for a major depressive episode. Depression may precede the onset of motoric abnormalities in PD occur in concert with the onset of extrapyramidal symptoms, or evolve later in the course of the disease. Depression is more common in patients with evidence of cognitive impairment and in those with psychotic phenomena. Motor abnormalities account for a small amount of the variance of depression severity and the occurrence of depression cannot be attributed solely to physical and cognitive disability. Selective D3-dopamine receptor agonists may decrease the emergence of depression in PD or reduce the severity of depressive symptoms present when the agent is introduced. Selective serotonin reuptake inhibitors are most commonly used for the treatment of depression in PD; patients should be monitored for exacerbation of rigidity and bradykinesia. Tricyclic antidepressants and monoamine oxidase inhibitor are therapeutic alternatives. Electroconvulsive therapy improves both motor symptoms and depression in PD. Motoric symptoms improve earlier in the clinical course and relapse within several weeks. Deep brain stimulation has exacerbated or precipitated depression in some patients with PD treated with this therapeutic modality. Depression in PD provides insight into the central nervous system mediation of mood disturbances.

No. 57C
PSYCHOSIS IN PARKINSON'S DISEASE

Laura Marsh, M.D., *Department of Psychiatry, Johns Hopkins, 600 North Wolfe Street, Phipps 300C, Baltimore, MD 21287*

SUMMARY:

Parkinson's disease (PD) is frequently complicated by psychosis. The psychotic phenomena range from benign visual hallucinations to states of extreme agitation with delusions and hallucinations. Because of complex relationships between motor, cognitive, and psychiatric phenomena and the treatments for each of these aspects of PD, PD-related psychosis is one of the most challenging conditions confronting the geriatric psychiatrist. This presentation will review the role of dopaminergic medications and other risk factors for the development of psychosis. The assessment, differential diagnosis, and comorbidities of psychosis in PD will be overviewed and basic pharmacologic guidelines will be discussed. Newer treatments such as the use of cholinesterase inhibitors will also be discussed. The relationship of Parkinson's disease to Lewy body disease will be addressed, with an emphasis on special issues in pharmacologic management. Following this presentation, the participant will be familiar with the diagnosis and pharmacologic strategies involved in the management of psychosis in Parkinson's disease.

No. 57D
COGNITIVE IMPAIRMENT, DEMENTIA, AND PARKINSON'S DISEASE

Iracema Leroi, M.D., *Department of Psychiatry, North Manchester General Hospital, Park House, Delaunays Road, Crumpsall/Manchest M85RB, United Kingdom*

SUMMARY:

Parkinson's disease (PD) is frequently complicated by both cognitive and psychiatric disturbances. Formal neuropsychological testing reveals selective deficits in virtually all patients, which include deficits in memory, executive, and visuospatial functioning. About 20% to 30% of those with PD develop dementia, and this increases in prevalence to over 50% with advancing age, disease duration, and overall disease.

The treatment of cognitive impairment in PD has been limited to date. However, in a randomized, placebo-controlled trial (RCT), we evaluated the safety and efficacy of donepezil in the treatment of specific components of cognitive impairment in patients with PD (Leroi et al, in press). Our results revealed that patients on donepezil showed selective and significant ($p<.05$) improvement on the mem-

ory subscale of the Dementia Rating Scale (DRS). There was also a pattern of selective improvement on a measure of psychomotor speed and attention. From this trial, we concluded that cholinesterase inhibitors may have a beneficial effect on memory and may improve other cognitive deficits in patients with PD and cognitive impairment. There is a need for further, more extensive RCTs to evaluate the question of pharmacologic treatment of cognitive impairment and dementia in PD.

No. 57E
ANXIETY, FATIGUE, AND SLEEP IN PATIENTS WITH PARKINSON'S DISEASE

Matthew A. Menza, M.D., *Department of Psychiatry, Robert Wood Johnson Medical School, D207A, 671 Hoes Lane, Piscataway, NJ 08854*

SUMMARY:

Sleep difficulties, anxiety, and fatigue are all common nonmotor problems in patients with Parkinson's disease (PD). While these symptoms are common in geriatric patients, they are particularly problematic for patients with PD. This talk will review the prevalence, etiology, and treatment of these symptoms. Sleep problems include insomnia, parasomnias, REM behavior disorder, excessive daytime sleepiness, and sleep attacks. Anxiety may involve a variety of diagnostic entities as well as subsyndromal anxiety. Fatigue is frequently significant and is described by patients as the second most troubling aspect of this illness. Etiology frequently involves an overlap of symptoms related to age, symptoms related to medications, symptoms that are core to the pathophysiology of PD, and symptoms related to psychiatric illnesses. Keys to recognition of these symptoms will be reviewed and there will be a discussion of treatment approaches. Treatment may involve behavioral approaches, a variety of medications, and in some cases, surgical approaches. Participants should learn to recognize these symptoms and disorders as well as recognize their importance. In addition, participants should become familiar with a variety of treatment approaches.

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2. Aarsland D, Larsen JP, Lim NH, Janvin C, Karlsen K, Tandberg E, Cummings JL: Range of neuropsychiatric disturbances in patients with Parkinson's disease. J Neurol Neurosurg Psychiatry 1999; 67:492–496.
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SYMPOSIUM 58—UNIPOLAR MDD: INTERNATIONAL UPDATE
APA Council on Global Psychiatry

EDUCATIONAL OBJECTIVES:

Participants will have a detailed sense of the following: the natural course of illness of unipolar MDD, current ideas of etiology, the international public health importance; and current psychopharmacological and psychosocial treatments. Equally important, the audience will have the opportunity to interact and question a superb panel of international experts in depression.

No. 58A
MDD: A NEW PARADIGM OF UNDERSTANDING AND TREATMENT

Lewis L. Judd, M.D., *Department of Psychiatry, University of California at San Diego, 9500 Gilman Drive, MC 0603, La Jolla, CA 92093-0603*

SUMMARY:

The long-term symptomatic structure of MDD for diagnostic purposes is a categorical illness, but its symptomatic expression longitudinally is expressed as a dimensional illness. It has now been established that MDD is primarily a chronic illness. Patients commonly experience relapse and recurrence of MDEs and are symptomatic from this illness 60% of the time during their life course. The longitudinal course of MDD is as a dimensional continuum. MDD's course is very dynamic and changeable and patients commonly alternate between experiencing syndromal MDEs, and inter-episode minor depressive, dysthymic, and subsyndromal depressive symptoms. These symptomatic periods are interspersed with periods when the MDD is quiescent and patients are asymptomatic. Over time, MDD patients experience minor and subsyndromal depressive symptoms, which are three times more common than major depressive symptoms. Relapse and reucrrence of MDEs as well as course chronicity can be significantly reduced if psychiatric clinicians ensure that their MDD patients are completly recovered from MDEs by eliminating all ongoing residual subsyndromal depressive symptoms, which are often present during MDE recovery periods and place the patient at high risk for future relapse and a more chronic course.

No. 58B
A PSYCHOBIOLOGICAL MODEL OF DEPRESSION: IMPLICATIONS FOR TREATMENT

Hagop S. Akiskal, M.D., *Mood Center, University of California at San Diego, 3350 La Jolla Village Drive, San Diego, CA 92161*

SUMMARY:

In 1973, together with McKinnery, we formulated a multi-factorial model of depression where genetic, developmental, demographic, and proximate stressors of a biological or social nature interacted in the genesis of limbicdiencephalic dysfunction, which was clinically manifested in affective illness. In a current reformulation, temperament has been proposed by the author as an intermediary between distal and proximal factors. New data indicate that experiencing life events depends on a familial diathesis for depression, and that temperament increases the reactivity to life events. Other new data indicate that variations in the serotonin transporter increase the risk of responding to life events with depression. Even social support, a factor that mitigates the depressant effect of life events, appears dependant on familial factors. Finally, a positive family history of depression seems to involve the amygdala. Response to aversive stimuli also appears to be processed through this limbic structure, and neuroticism is a mediating variable. These new data extend our original hypothesis for a truly integrative psychobiologic understanding of depressive illness.

No. 58C
PREDICTIVE FACTORS IN RESISTANT DEPRESSION: NEW EUROPEAN DATA

Julien Mendlewicz, M.D., *Department of Psychiatry, Free University, Route de Lennik 808, Brussels 1070, Belgium*

SUMMARY:

One of the major developments during the decade of the brain was in the introduction of different classes of antidepressants with different mechanisms of action. These agents have better tolerability profiles than the classic tricyclic and MAOI agents, and they have helped in taking the message of the treatability of depression to the primary care medical sector. It is particularly important that these agents are effective for all varieties of depression, including those without endogenous features, and are unlikely to result in fatal outcome in overdose. Thus, these new agents provide enhanced real world efficacy, while balancing health care costs in long-term treatment (reducing morbidity and possibly mortality). These developments have been paralleled with evidence-based psychosocial therapists, particularly those with interpersonal and congnitive-behavioral focus, which can be used in monotherapy in mild depressions, and should be used to enhance effectiveness of antidepressants in moderate to severe depressions (i.e. combined treatment). In brief, the psychiatrist and the general medical practitioner now have very effective tools to clinically manage depressive illnesses. Since these illnesses are often lifelong, choosing agents that are particularly tailored to a given patient wit respect to tolerability acquires particular significance.

No. 58D
A NEW PUBLIC HEALTH AGENDA FOR DEPRESSION

Norman Sartorius, M.D., *World Health Organization, 14 Chemin Collandon, Geneva 1211, Switzerland*

SUMMARY:

Depression strikes one in five women and one in ten men over a lifetime. Untreated, 15% commite suicide. It is a heterogeneous group of disorders, and is currently divided into at least three categories: unipolar depressive, bipolar II, and bipolar I. Although traditionally bipolar disorders have been estimated to occur in about 1% of the population, current data indicate that the actual rate may be as high as 6% (largely due to bipolar II disorder). The World Health Organization rates depression to be among the most disabling medical conditions. Its incidence, was once believed to be highest in the reproductive age, where it is highly comorbid with anxiety disorders, now includes increasing rates of "non-major" depression in the elderly often in association with physical illnesses and leading to the highest peak in completed suicides. Given the high prevalence of depression, and its common presentation with somatic symptoms, it is a common concern for all physicians. The fact that its negative impact is not limited only to the personal, social, and occupational spheres, but also involves aggravation of the prognosis of coexisting physical illness, further reinforces the public health significance of depression. Conquering this illness requires worldwide collaboration.

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2. Akiskal HS, McKinney WT: Depressive disorders: toward a unified hypothesis. Science 1973; 182:20–29.
3. Stahl SM: Essential Psychopharmacology. Cambridge University Press, Cambridge, Uk, 2000.
4. Murray CJL, Lopz AD: The Global Burden of Disease. Harvard Press, Boston, Mass, 1996.

WEDNESDAY, MAY 5, 2003

SYMPOSIUM 59—WHAT YOU NEED TO KNOW ABOUT TREATMENT OF HIV-RELATED DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) understand psychopharmacologic interventions associated with HIV-related disorders: mood disorders, anxiety, psychosis, sleep, pain; and (2) identify tools for working with special populations.

No. 59A
TREATING MOOD DISORDERS

Warren M. Liang, M.D., *Department of Psychiatry, University of Cincinnati, PO Box 670559, Cincinnati, OH 45267*

SUMMARY:

Mood disorders in HIV are common. Depression appears to be the most common psychiatric disorder found among HIV-infected patients. In fact, cross-sectional and prospective studies in both HIV+ and at-risk HIV populations estimate lifetime prevalence of depression disorders to range from 22.1% to 61.0%. It may be difficult to diagnose depression in HIV-infected patients. Multiple effective therapeutic strategies are available to manage the psychiatric complications of HIV-related mood disorders. This session will provide diagnostic evaluation and pharmacologic treatment knowledge for psychiatrists working with HIV/AIDS patients.

No. 59B
TREATING ANXIETY

Antoine B. Douaihy, M.D., *University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

It may be difficult to diagnose and treat patients with HIV-related anxiety disorder. This session will review the psychopharmacological management of anxiety with a discussion of psychotropic-antiretroviral drug interactions. Multiple effective therapeutic strategies are available to manage the psychiatric complications of HIV-related anxiety. Conventional and novel approaches that are also safe and effective in treating HIV-related anxiety will be provided. A clinical vignette will be presented as well as relevant information on managing special populations.

No. 59C
TREATING PSYCHOSIS

Shahrad Rod Amiri, M.D., *Department of Psychiatry, University of California, Los Angeles, 2301 Ocean Avenue, #204, Los Angeles, CA 90405*

SUMMARY:

It may be difficult to diagnose and treat patients with HIV-related psychosis. HIV-related psychosis may greatly affect quality of life and successful treatment by compromising medication adherence. This session will review the psychopharmacological management of psychosis with a discussion of psychotropic-antiretroviral drug

interactions Multiple effective therapeutic strategies are available to manage the psychiatric complications of HIV-related psychosis. Conventional and novel approaches that are also safe and effective in treating HIV-related psychosis will be provided. A clinical vignette will be presented along with relevant information on managing special populations.

No. 59D
TREATING SLEEP

Marshall Forstein, M.D., *Department of Psychiatry, Harvard University, 24 Olmstead Street, Jamaica Plain, MA 02130*

SUMMARY:

Significant numbers of HIV/AIDS patients complain of sleep difficulties. Sleep problems in HIV/AIDS are often associated with comorbidity. This session will review the psychopharmacological management of sleep with a discussion of psychotropic-antiretroviral drug interactions Multiple effective therapeutic strategies are available to manage the psychiatric complications of HIV-related sleep disturbance. Conventional and novel approaches that are also safe and effective in treating HIV-related sleep disturbance will be provided. A clinical vignette will be presented as well as useful information on managing and working with special populations.

No. 59E
TREATING PAIN

Philip A. Bialer, M.D., *Department of Psychiatry, Beth Israel Medical Center, 1st Ave. & 16th Street, 5F09 New York, NY 10003-2992*

SUMMARY:

Pain is a common problem encountered in HIV-1 infection and AIDS. It is often associated with significant psychological symptoms. In every case, it is a treatable problem that is all too often undertreated by physicians. Pain perception in patients is influenced by a number of cognitive-behavioral factors as well as sociocultural issues. This session will review the psychopharmacological management of sleep with a discussion of psychotropic-antiretroviral drug interactions Multiple effective therapeutic strategies are available to manage the psychiatric complications of HIV-related pain problems. Conventional and novel approaches that are also safe and effective in treating HIV-related pain problems will be provided. A clinical vignette will be presented as well as useful information on managing and working with special populations.

REFERENCES:

1. Gonzales FJ: HIV and depression: context and care. UCSF AIDS Health Project, San Francisco, 2001.
2. Postic B, et al: Antiviral treatment of human immunodeficiency virus infection; update for 2003. JSC Med Assoc 2003; 99(6):148–53.
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4. Sciolla A: Sleep disturbance and HIV disease. Focus 1995; 10(11):1–4.
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SYMPOSIUM 60—CHOOSING THE BEST TREATMENT FOR SUBSTANCE ABUSE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize, diagnose, and treat substance abuse; know the best methods, both pharmacologic and behavioral, for treating the major addictions to illicit drugs and prescription opioids. In addition, the participant will have an understanding of phenomenology of substance-induced addictions.

No. 60A
CHOOSING THE RIGHT TREATMENT FOR OPIOID DEPENDENCE

Herbert D. Kleber, M.D., *Department of Substance Abuse, Columbia University, 1051 Riverside Drive, Unit 66, New York, NY 10032*

SUMMARY:

The number of heroin addicts is estimated at one million and prescription opioid abusers double that with relatively few in treatment. The agonists methadone and LAAM decrease opiate use and improve psychosocial outcome, but present problems such as high rates of concurrent alcohol and cocaine abuse, need for frequent clinic visits, major difficulty in withdrawal, and, with LAAM, increased risk of Torsade de Pointes. The antagonist naltrexone, while blocking opiate use and decreasing alcohol abuse, has low rates of acceptance and high dropout rates. The partial agonist buprenorphine may have the advantages of these three agents but with easier withdrawal, a ceiling effect on respiratory depression, protection against diversion because of the combination with naloxone and, as compared with methadone, office-based prescribing. This opens the possibility of mainstreaming addiction treatment and attracting individuals who have not sought help. Agents in development include an injectable form of naltrexone, which can block heroin for up to five weeks, and an implant, which may block for three to 12 months. New approaches to opiate detoxification, including lofexidine, rapid detoxification, especially using buprenorphine and naltrexone, and the use of NMDA antagonists hold out hope for less discomfort and higher completion rates. The use of available medications in office-based settings will be discussed including patient selection, treatment, and safety issues.

No. 60B
CHOOSING THE BEST TREATMENT FOR COCAINE DEPENDENCE

Adam M. Bisaga, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 120, NYSPI, New York, NY 10032*

SUMMARY:

Cocaine abuse and dependence remain severe health problems, with treatment difficult and few successful controlled trials. A combination of pharmacological and behavioral interventions will likely be required for these patients to achieve and maintain abstinence. Antidepressants, with desipramine most studied, have yielded inconsistent results. Medications that affect dopaminergic neurotransmission, including dopamine receptor agonists, dopamine transporter inhibitors, dopamine receptor blockers, and stimulants have also not been consistently successful. Recently studied medications, including disulfiram, bupropion, modafinil, and topiramate, are more promising. Current areas of research interest include the use of medication that affect the excitatory and inhibitory amino acids neurotransmission, the HPA axis function, and strategies to prevent cocaine from entering the brain as in the active immunization approach. A new approach in cocaine treatment trials involves the induction of initial abstinence using the behavioral methods and the use of medication that may extend abstinence and prevent relapse. Despite the absence of reliable pharmacotherapy, there are several effective psychosocial treatment approaches that should be a part of every treatment effort. Although no single treatment is currently suggested, a variety of

treatment approaches will be discussed and will include the presentation of case studies.

No. 60C
CHOOSING THE BEST TREATMENT: MARIJUANA AND CLUB DRUGS

David M. McDowell, M.D., *315 West 57th Street, #19A, New York, NY 10019*

SUMMARY:

Marijuana is the most commonly used illicit substance in the United States. In addition, the use of club drugs, in particular MDMA, ketamine, and GHB, are increasing. Contrary to public perception, club drugs cause real and substantial morbidity and mortality. Heavy and chronic use of marijuana carries with it substantial morbidity as well as the risk of dependence and withdrawal. These issues have far reaching implications for substance abuse treatment and psychiatric treatment in the future. Pharmacological interventions for marijuana dependence have included mood stabilizers and medication focused on withdrawal symptoms. Treatment strategies for these conditions have focused on prevention measures and psychosocial interventions. These conditions are not as well studied as other substance abuse conditions. In recent years a great deal of work has been completed concerning the basic mechanisms of actions, pharmacology, and neurophysiology of marijuana and its endogenous ligand, anandamide. Given the increasing knowledge about marijuana, new and potential treatments are being studied and even more can be theorized. Especially promising are various pharmacological interventions for marijuana as well as for comorbid conditions. This portion of the seminar will focus on the latest developments in the study of marijuana and club drugs as well as treatment strategies. New and potential pharmacological treatments will be emphasized.

No. 60D
TREATMENT OF COMORBID CONDITIONS

Frances R. Levin, M.D., *Department of Psychiatry, Columbia University, State Psychiatric Inst., 722 West 168th Street, Unit 66, New York, NY 10032;* Suzette M. Evans, Ph.D., Herbert D. Kleber, M.D.

SUMMARY:

Evidence for a link between psychiatric and substance use disorders is strong and converging. Epidemiologic studies have demonstrated that substance abuse is over-represented among individuals with psychiatric conditions. Similarly, numerous prevalence studies among substance abusers seeking treatment have found that the majority of patients have at least one comorbid psychiatric disorder. These psychiatric disorders may include major depression, bipolar disorder, anxiety disorders, attention deficit-hyperactivity disorder, and schizophrenia/schizo-affective illness. Although there are established pharmacologic and nonpharmacologic approaches for each of these psychiatric conditions in non-substance abusing patients, the efficacy of these approaches in substance-abusing patients is not well established. Several questions will be addressed in this presentation: (1) What are the appropriate pharmacologic treatment approaches for specific dually disordered patients? (2) Should medications with abuse potential be avoided? (3) Is substance use reduced if the psychiatric comorbid condition is treated? (4) What are some possible modifications of currently available nonpharmacologic strategies that might be used for various diagnosed groups? Although there are no definite answers, clinical guidelines will be offered.

No. 60E
CHOOSING THE BEST TREATMENT FOR PSYCHOSOCIAL INTERVENTIONS

Jami Rothenberg, Ph.D., *Department of Psychiatry, Columbia University, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 120, New York, NY 10032*

SUMMARY:

Finding and improving effective treatments for substance abusers is imperative. Psychotherapeutic interventions, specifically cognitive-behavioral skill-building approaches, have received much empirical attention both independently and in conjunction with pharmacological interventions. Such interventions have served as a means of achieving abstinence, encouraging lifestyle change, and promoting compliance with medications. The best studied of these methods include Relapse Prevention Therapy, Contingency Management, Motivational Enhancement Therapy, and 12-Step Facilitation. Despite encouraging findings in treatment outcome research with the delivery of these manual driven approaches, many challenges remain. The behavioral interventions are not consistent in securing longer-term abstinence and commitment to change and even when known to have promising effect, transferring and integrating such treatment models from research to community treatment settings remains complex. An overview of these models will be provided as well as their known efficacy in working with different substances of choice. Obstacles encountered in the delivery of these approaches, the clinical implication of integrating such models, and the efforts thus far to generalize research findings to community settings will also be addressed.

REFERENCES:

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2. Kosten T: Pathophysiology and treatment of cocaine dependence, in Neuropsychopharmacology - The Fifth Generation of Progress. Edited by Davis KL, Charney D, Coyle JT, Nemeroff C. Lippincott Williams & Wilkins, pp 1461–74, 2002.
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SYMPOSIUM 61—PRACTICAL TECHNIQUES IN THE ASSESSMENT AND TREATMENT OF TOBACCO DEPENDENCE

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to assess tobacco dependence in the mental health or addictions treatment setting and understand how to provide psychosocial and pharmacological treatments. Participants will participate in a discussion of how program and system changes can support tobacco dependence treatment.

No. 61A
ASSESSMENT OF TOBACCO DEPENDENCE

Jonathan Foulds, Ph.D., *UMDNJ, Tobacco Dependence Program, 317 George Street, Suite 210, New Brunswick, NJ 08901*

SUMMARY:

This session aims to provide psychiatrists with guidance on the assessment of tobacco use. The three main issues to be addressed in assessing a patient's tobacco use are (1) severity of tobacco dependence (i.e. addiction), (2) strength of motivation to quit, and (3) other background factors that may influence a quit attempt. Assessment of dependence is important, as more dependent tobacco users are likely to experience more severe withdrawal symtpoms and have greater difficulty in quitting in future quit attempts. A range of simple techniques exist to more precisely assess dependence and motivation, and to assist the patient in making the first steps toward behavior change. The most commonly used biochemical measure of tobacco use, expired carbon monoxide, will be reviewed. Important environmental factors and social support will also be discussed. Smokers find it harder to quit when they live and work alongside other smokers, have a high current stress level, or have a history of psychiatric comorbidity. It is worth inquiring about these issues and working with the patient to try to resolve any problems. Treatment guidelines make clear that it is no longer acceptable for tobacco use to be ignored in any patient population, including those with mental health and/or other substance abuse problems and psychiatrists should learn to conduct a basic assessment of tobacco dependence in all identified tobacco users.

No. 61B
MOTIVATIONAL ASSESSMENT AND ENHANCEMENT STRATEGIES IN TOBACCO TREATMENT

Jonathan Krejci, Ph.D., *Department of Psychiatry, UMDNJ, Robert Wood Johnson Medical School, 671 Hoes Lane, D337, Piscataway, NJ 08854*

SUMMARY:

This session will be an overview of motivational assessment and interventions in tobacco dependence treatment. Participants will learn about the stages of change (precontemplation, contemplation, preparation, action, and maintenance); methods for assessing stages of change (URICA and motivational algorithms); and a simple method for assessing importance, confidence, and readiness for change. The treatment needs of patients at each stage of change will be reviewed, and these needs will be discussed in terms of Motivational Interviewing (MI), a client-centered brief treatment that has been shown to be effective with many different areas of behavior change. Basic principles of MI will be reviewed. These include techniques such as rolling with resistance, expressing empathy, developing discrepancy, and supporting self-efficacy. Specific topics include ways to maximize internal motivation to quit and to capitalize on existing client strengths. MI treatment strategies (open-ended questions, affirmations, reflective listening, summaries, and using assessment feedback as a motivational tool) will be reviewed. Specific applications of a motivational approach to tobacco dependence treatment will be discussed, including a computerized tool for providing feedback assessment.

No. 61C
PHARMACOTHERAPY TREATMENTS FOR TOBACCO DEPENDENCE

Jill Williams, M.D., *Department of Psychiatry, UMDNJ-Robert Wood Johnson Medical School, 671 Hoes Lane, D339, Piscataway, NJ 08854*

SUMMARY:

Pharmacotherapy is a recognized first-line treatment for tobacco dependence, although it is underutilized in behavioral health care settings. There are currently six FDA-approved treatments for tobacco dependence with established safety and efficacy, which will be reviewed in this session. Five are different types of nicotine replacement therapies (NRT) and include nicotine gum, nicotine patch, nicotine inhaler, nicotine nasal spray, and nicotine lozenge, and one is an antidepressant, bupropion SR. Psychiatrists should use pharmacotherapy to treat tobacco dependence in their patients and we will review how to choose and dose these medications. Issues such as price, ease of use, availability (OTC versus prescription), insurance coverage, and patient preference can influence the choice of medication used. Combinations of medications will also be discussed as a strategy that has become more popular. In addition to specific treatments for tobacco dependence, we will review general considerations of importance including the effects of tobacco on the hepatic metabolism of psychiatric medications and the role of atypical antipsychotics.

No. 61D
PSYCHOSOCIAL TREATMENT OF TOBACCO DEPENDENCE IN MENTAL HEALTH SETTINGS

Marc L. Steinberg, Ph.D., *Department of Psychiatry, UMDNJ, Robert Wood Johnson Medical School, 671 Hoes Lane, D337, Piscataway, NJ 08854*

SUMMARY:

Individuals with mental illness are more likely to smoke cigarettes than those in the general population. Unfortunately, mental health practitioners often ignore smoking in their psychiatric populations due to unfounded fears that smoking cessation will exacerbate psychiatric symptoms, or beliefs that their patients are incapable of quitting. Other reasons for not addressing tobacco include limitations on time or knowledge of tobacco dependence treatments. This talk will describe how to integrate tobacco dependence treatment within existing mental health treatment systems. Psychiatrists will be taught how to help smokers motivated to quit smoking, including specific relapse prevention and motivational techniques. Additional issues to be discussed include picking a quit date, dealing with smoking cues commonly encountered in mental health settings, increasing patients' external social support for quitting, and dealing with slips and relapses to smoking. Data will be presented to support clinical information and demonstrate a model intervention for seriously mentally ill smokers.

No. 61E
ADDRESSING TOBACCO THROUGH PROGRAM AND SYSTEM CHANGES

Douglas M. Ziedonis, M.D., *Department of Psychiatry, UMDNJ, Robert Wood Johnson Medical School, 675 Hoes Lane, Room D349, Piscataway, NJ 08854*

SUMMARY:

Addressing tobacco in mental health and addiction treatment settings requires program and broader system change, including staff training, new policy development and implementation, and integration of motivation-based tobacco dependence treatment into existing services. This will require that mental health and addiction treatment programs take ownership of nicotine dependence as a treatable DSM-IV diagnosis and begin to address tobacco in all patients they treat. Program changes must occur at all levels of care and in all types of mental health and addiction treatment programs. The changes may be limited or expansive, including the range from brief (including

tobacco in the assessment and treatment plan with brief advice to quit smoking), to comprehensive ones that provide a range of treatment services and place limits on staff and patient smoking in order to establish entirely tobacco-free buildings and grounds. Providing treatment will pose challenges, as this is a new issue for most treatment programs. For change to occur, we must change our programs from within and create a clear vision of how to make those changes. Model programs for addressing tobacco have integrated evidence-based tobacco dependence treatment into their practices after helping treatment staff to accept the importance of addressing the problem.

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5. Ziedonis DM, Williams JM: Managemnt of Smoking in people with psychiatric disorders. Current Opinion Psychiatry 2003; 16:305–315.

SYMPOSIUM 62—TREATMENT-RESISTANT DEPRESSION

EDUCATIONAL OBJECTIVES:

These presentations will summarize previously unavailable data to practitioners concerning the nature and treatment of refractory depression.

No. 62A
INTRODUCTION TO TREATMENT-RESISTANT DEPRESSION

Charles B. Nemeroff, M.D., *Department of Psychiatry, Emory University School of Medicine, 1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

A brief review of the definition and prevalence of treatment-refractory depression will be described. The results of both pharmacological and psychotherapy treatment trials in refractory patients will be presented. Results of augmentation strategies, combining antidepressants with another agent that is not inherently antidepressant, e.g., lithium, T3, buspirone, pindolol, and atypical antipsychotics, will be presented. Combination therapies with two antidepressants, usually of different mechanisms of action, or combination psychotherapy-pharmacotherapy, have also been studied. Switch strategies involve tapering and discontinuing the currently prescribed antidepressant and beginning treatment with a novel antidepressant of another class. The results of such switch studies will be presented. Remarkably, there are few controlled treatment studies of treatment-refractory depression and even fewer of refractory bipolar or psychotic depression. The implications of these findings and suggestions for future study directions will be discussed.

No. 62B
LONG-TERM OUTCOMES IN TREATMENT-RESISTANT DEPRESSION

A. John Rush, M.D., *Department of Psychiatry, University of Texas, SW Medical Center, 5323 Harry Hines Boulevard, MC9086, Dallas, TX 75390-9086*

SUMMARY:

Estimates suggest that at least up to 20% of patients with major depression do not achieve remission after three antidepressant treatment trials. These so-called treatment-resistant depressions may ultimately respond to more complex medication regimens or somatic treatments. This presentation reports on two one-year, naturalistic follow-up studies, one from the Texas Medication Algorithm Project (TMAP) and another following about 100 outpatients with TRD. Response and remission rates, as well as sustained response and remission rates, indicate that less than 25% achieve a response and far fewer achieve sustained response. Baseline clinical and demographic features predictive of a better outcome include younger age, shorter length of illness, and full-time employment at baseline. The implications of these findings for the development of effective long-term treatments and for the clinical management of these patients will be discussed.

No. 62C
INTRODUCTION TO A TREATMENT-RESISTANT DEPRESSION PATIENT REGISTRY

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

SUMMARY:

This presentation will review the conceptualization, creation, and first available data on the course and outcome on a novel long-term, naturalistic, multicenter patient outcome registry that collects data on treatment modalities in patients with pharmaco-resistant depression. This registry will collect long-term clinical, quality-of-life issues, health care utilization, demographics (to include history of depression medications, history of abuse as children, comorbidities, and other demographics), and patient safety. Hypothesized clinical predictor variables will be included based on studies of patients with TRD. These items are chosen with the hypothesis that they will help in the future to determine what is the patient population that responds best to VNS, ECT, or to pharmacotherapy. A major aim is to evaluate clinical and statistical significances between treatment modalities in patients with TRD and to access the quality of life, patient satisfaction, and cost utilization in patients who are debilitated by pharmaco-resistant depression. A format derived from the LIFE will be used for asking and recording of data on psychopathology, treatment, psychosocial functioning, and demographics. Each patient will be followed for a minimum of 36 months. Longitudinal methods of data analysis will be utilized.

No. 62D
LONG-TERM TREATMENT AND OUTCOMES IN TREATMENT-RESISTANT DEPRESSION WITH PHARMACOTHERAPY, ECT, REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION, MST, AND VNS THERAPY

Thomas E. Schlaepfer, M.D., *Department of Psychiatry, University Hospital, Sigmund-Freud-Strasse 25, Bonn 53105, Germany*

SUMMARY:

Affective disorders are associated with a high incidence and prevalence and result in a major decrease of life quality for the individual

and significant socioeconomic losses for society. A combination of psychotherapy and pharmacotherapy is often successful in treating the disease, which has in chronic patients a mortality rate of 20% due to suicide and disease-induced somatic complications.

However, there is a significant group of 20% to 30% of patients suffering from treatment-resistant depression (TRD) that do not respond to ordinary antidepressant medication. They need long-term pharmacotherapy with a combination of different drugs. This presentation will review current knowledge on the outcome of such therapies.

Other options for TRD are brain stimulation therapies such as electroconvulsive therapy (ECT), repetitive transcranial stimulation (rTMS), magnetic seizure therapy (MST), and vagus nerve stimulation (VNS). While ECT has been used clinically for a long time and has been researched extensively, the other methods have not yet been approved for clinical use. This presentation will review these therapies beyond their research application and discuss their clinical potential.

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SYMPOSIUM 63—PSYCHOTIC DEPRESSION IN 2004: THE NIMH COLLABORATIVE SEVERE DEPRESSION STUDY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, individuals who attend this symposium will become knowledgeable about the phenomenology, course, and treatment of psychotic (delusional) depression.

No. 63A
CHALLENGES IN THE DIAGNOSIS OF PSYCHOTIC DEPRESSION: ASSESSMENT, EPIDEMIOLOGY, AND BIOLOGY

Anthony J. Rothschild, M.D., *Department of Psychiatry, University of Massachusetts Medical Center, 361 Plantation Street, Worcester, MA 01605;* Michael A. Bell, M.D., Jayendra K. Patel, M.D., David P. Morin, M.D., Dorothy Sit, M.D., Colby Calkins, B.S., Denette Guerin, M.S.

SUMMARY:

Major depression with psychotic features (MDpsy)—a disorder with considerable morbidity and mortality—is more common than is generally realized and is a most difficult form of depression to treat. Varying diagnostic methods have found rates of MDpsy of 19% to 49% among mixed-aged inpatients with major depression. Higher rates approximating 45% have been reported in elderly inpatients. In some studies, subjects 65 and older had a significantly increased frequency of psychosis than the younger cohort (35.5% versus 27.5%). The presence of delusions as a distinguishing feature of psychotic depression has led to the suggestion that MDpsy should be considered as a single distinct diagnostic entity. Patients with MDpsy exhibit more frequent relapses and recurrences and have increased use of services, greater disability, and a poorer clinical course when compared with nonpsychotically depressed patients. In older patients with MDpsy, the prognosis is particularly poor. Patients with MDpsy demonstrate distinct biological abnormalities in studies of the hypothalamic-adrenal (HPA) axis, dopaminergic activity, enzyme studies, brain imaging, EEG sleep profiles, and measures of serotonergic function when compared with nonpsychotic depression. The social and occupational impairment in MDpsy has been hypothesized to be secondary to subtle cognitive deficits caused by the higher cortisol levels frequently observed in MDpsy patients. The implications of these studies for the accurate diagnosis and assessment of the MDpsy patient will be discussed.

Supported by NIMII grant no: MH62624-01

No. 63B
PHARMACOTHERAPY OF UNIPOLAR MAJOR DEPRESSION: WHAT IS THE EVIDENCE?

Benoit H. Mulsant, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Room 3-809, Pittsburgh, PA 15213-2593;* Robert H. Howland, M.D., Michael E. Thase, M.D., Mary C. McShea, M.S., Taafoi S. Kamara, B.A.

SUMMARY:

Up to 20% of patients hospitalized in the U.S. for the treatment of a major depressive disorder present with psychotic features, i.e., they suffer from psychotic depression. Psychotic depression is one of the most difficult forms of depression to treat. ECT is often the treatment of choice. For the pharmacotherapy of psychotic depression, treatment guidelines and expert consensus opinion recommend the use of a combination of an antidepressant medication and an antipsychotic medication, with both being given at high doses. Newer antidepressants and atypical antipsychotics are favored. This presentation will review the evidence supporting these treatment guidelines and expert recommendations. Studies conducted in younger and older patients will be discussed and contrasted. The potential role of novel pharmacotherapies and recommendations for acute and long-term treatment, will also be discussed.

Supported in part by PHS grants: K01 MH01613, U01 MH62565, P30 MH52247.

No. 63C
NIMH SEVERE DEPRESSION TRIAL: BACKGROUND AND DESIGN CHOICES

Barnett S. Meyers, M.D., *Department of Geriatric Psychiatry, New York Presbyterian Hospital, 21 Bloomingdale Road, White Plains, NY 10605;* Sibel Klimstra, M.D., Catherine Peasley-Miklus, Ph.D., Michelle Gabriele, M.S.W., Judith English, B.S.C., MoonSeong Heo, Ph.D., Melissa Carroll, Ph.D.

SUMMARY:

The history of this intervention study, from being an arm in the CATIE contract into its current form as a collaborative UO1, is discussed. Background studies are reviewed, with emphasis given to the public health significance of identifying an effective acute and prophylactic pharmacotherapy for late-life PD. Modifications in the design, which were selected in response to changes in the funding mechanism and to suggestions made by grant reviewers, are described. Arguments for and against important design choices, including whether to have an SSRI monotherapy and whether to study

augmentation for patients who achieve only a partial remission, are discussed. Methods that were applied to facilitate the inclusion of vulnerable subjects, who represent patients at both the greatest risk for poor outcomes and who would receive the greatest benefit from the identification of an effective pharmacological treatment, are described. Important risk versus benefit design choices, including whether to include outpatients, individuals at suicide risk, and patients with significant medical comorbidity are discussed. Preliminary data are reported that describe the subjects included thus far, including their risk factors for poor outcomes, and relationships between these factors and the initial course during the trial.

This work was supported by NIMH grant MH62518.

No. 63D
CHALLENGES IN CONDUCTING A PHARMACOTHERAPY STUDY IN PSYCHOTIC DEPRESSION

Alastair J. Flint, M.B., *Department of Psychiatry, Toronto General Hospital, 200 Elizabeth Street, 8 EN-238, Toronto, ON M5G 2C4, Canada*

SUMMARY:

The NIMH-funded Severe Depression Collaborative Study investigates the efficacy and safety of the pharmacologic treatment of psychotic (delusional) depression. One of the goals of this study is to compare treatment outcome in younger and older persons; thus, half of the study group will be aged 60 years or older. By virtue of the severity of their depression, most subjects start the study as hospital inpatients. A significant proportion of subjects have had a suicide attempt in the context of the index episode of depression. This presentation will highlight the challenges and, in some instances, resulting opportunities in conducting a randomized, controlled treatment study in this severely ill group of patients. Specifically, the following issues will be addressed and pertinent data presented: (1) evaluation of subjects' capacity to consent to participate in the study and use of the MacArthur Competence Assessment Tool in this process, (2) recruitment of subjects from minority groups and those with English as a second language; (3) balancing the need to recruit a representative sample of subjects yet minimize the risk of attempted suicide or suicide among study participants, and (4) maximizing retention of subjects in the study, especially older persons with severe functional impairment.

Funded by NIMH (MH62446).

No. 63E
REAL-LIFE OUTCOMES IN REAL-LIFE PATIENTS: DISCUSSION

Barry D. Lebowitz, Ph.D., *Interventions Department, National Institute of Mental Health, 6001 Executive Boulevard, Room 7160, MSC 9635, Bethesda, MD 20892-9635*

SUMMARY:

Experience with NIMH-supported, large-scale, public-health-oriented trials has identified a number of needs in the field. Several of these needs, specifically addressing the need to upgrade the operational capacity of the field are identified and the need for appropriate risk-management strategies is highlighted.

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SYMPOSIUM 64—SEPTEMBER 11TH: AFTER TWO-AND-A-HALF YEARS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe how city, state, and voluntary organizations and agencies worked together after the World Trade Center attack, what was special about this disaster, and what has been learned to ameliorate future terrorist assaults.

No. 64A
THE FIRST TWO WEEKS ONSITE

Antonio Abad, M.D., *Department of Psychiatry, New York University Medical School, 550 First Avenue, New York, NY 10016-6481;*

SUMMARY:

During the first two weeks after September 11, the mental health *ad hoc* team performed a large number of clinical interventions involving the majority of rescue, security, and support personnel working at Ground Zero. These activities included handing out more than 10,000 psychoeducational documents. The team also directly provided supportive interventions or debriefed more than 1,500 individuals, facilitated the evacuation of hundreds in urgent need for treatment and rest, and referred many more to mental health facilities citywide.

However, in spite of the presence and assistance of all the relevant disaster relief agencies, there was a delayed and limited deployment of organized mental health services at Ground Zero by federal agencies and nongovernmental disaster relief organizations. Therefore, it seems that it is imperative to create a contingency plan capable to deal with the mental health needs generated at the "Ground Zero" of any possible major catastrophe in the City of New York, ensuring the effective integration of the available mental health resources. This plan requires the appointment of official mental health teams ready to deploy immediately after a catastrophe of this magnitude and the availability of contingency plans applicable to a disaster area even larger than Ground Zero's 16 acres.

No. 64B
NEW YORK STATE OFFICE OF MENTAL HEALTH RESPONSE

William M. Tucker, M.D., *New York State Office of Mental Health, 44 Holland Avenue, Albany, NY 12224*

SUMMARY:

Federal disaster aid goes to the states and New York State was the conduit for such funds as well as providing funds of its own. The Office of Mental Health (OMH) was the official state agency involved in dealing with what was acknowledged from the start to be a disaster with a major mental health component. OMH worked with a wide variety of organizations and individuals to ensure that the media would carry compassionate, accurate messages. It helped organize and fund emergency services. It cleared space for casualties.

Although state efforts have operated in a variety of ways and venues, it was recognized that services had to be provided through outreach efforts that did not medicalize, pathologize, or stigmatize the problems people were experiencing. Project Liberty, the main outreach program, was developed and funded very rapidly. Celebrities were recruited to describe grief and other reactions as understandable and nudge listeners to consider how they were reacting and not to hesitate to seek help. More local efforts were conducted through churches, voluntary organizations, and community groups. Services were contracted through different types of providers. Statistics as of April 2004 will be presented, with an assessment of what worked and what did not.

No. 64C
NEW YORK CITY HEALTH AND MENTAL HEALTH: FIRST RESPONDERS

Neal L. Cohen, M.D., *Center of Biodefense, New York, NY 10020*

SUMMARY:

The Guiliani Administration was working toward a de facto integration of the departments of health and mental health by having a single psychiatrist directing both. This was an advantage as the World Trade Center disaster involved one of the most severe tests of local government ever to occur, involving as it did the largest loss of life in a single day in United States history. It was both a health and mental health disaster, involving both high morbidity and mortality from physical causes and profound feelings of rage, despair, loss, grief, fear, anxiety, and suspiciousness. Officials had to cope with what had already occurred, including the unexpected loss of the twin towers without knowing what might happen next. As the situation stabilized, a wide variety of demands and resources had to be balanced. Security on the site was a prime concern, as it was a crime scene and potentially toxic, but the need for medical care was overriding. The easiest population to treat were those already away from the site. Over the following weeks, a prime concern was working with victims' families and identification of the dead. Within months the emphasis had shifted to training and preparedness.

No. 64D
DISASTER PSYCHIATRY OUTREACH: SERVICE AND TRAINING

Craig L. Katz, M.D., *Department of Psychiatry, Disaster Psychiatry Outreach, 141 Fifth Avenue, 3rd Floor, New York, NY 10010*

SUMMARY:

Disaster Psychiatry Outreach (DPO) had been formed before the World Trade Center disaster but had worked primarily with airplane disasters. This had helped it to develop expertise, training curricula, and a core group of providers. It was designated the prime mental health service provider for September 11 victims and their families. The first few days were highly problematical, with confused communications and transportation, family members looking for their loved ones, wild rumors, and fears. The first site of operations, the armory at Lexington Avenue and 24th Street, could not be reached easily. Eventually, a pier was taken over and easily reached by all. DPO was deliberately placed among city agencies set up to meet housing and other support needs. Volunteer psychiatrists appeared in great numbers and allowed for round-the-clock staffing. Work continued for weeks and ebbed only slowly. DPO provided training to numerous agencies, while conducting screenings, brief counseling, and some referrals. Families both received service and were mobilized for outreach and support. Funding continued for some time and other funds were obtained that allowed for permanent staffing. An annual conference has helped develop the knowledge base and continue a high level of interest, despite the lack of recent disasters.

No. 64E
MEDICAL AND PSYCHIATRIC ORGANIZATIONS AND FINDINGS

Zebulon C. Taintor, M.D., *Department of Psychiatry, New York University School of Medicine, 19 East 93rd Street, New York, NY 10128*

SUMMARY:

More than 6,000 physicians and comparable numbers of other medial personnel volunteered within a few hours of the World Trade Center attack. Yet relatively few have come for bioterrorism training. Despite the emphasis on mental health in the media at the time of the attack, subsequent training has not included mental health, and it does not figure significantly in disaster planning. Smallpox, a highly speculative risk, has received more attention. Yet the mental health of the population is a prime target of terrorists. The September 11 attacks inflicted great damage and posed challenges that were met well, albeit with problems of access to Ground Zero. The six-month mark is when some previously well individuals can be expected to need help, even while the bulk of the initially distressed are recovering. Although government and the care system coped well, future plans should consider defined responsibility for disaster sites, including how to provide the most access for prequalified response teams. Charity and government support issues should be worked out in advance. Training those who are interested in being prepared for future attacks will provide a ready reserve of professionals for the future.

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SYMPOSIUM 65—NEUROIMAGING AND EMOTIONAL DYSREGULATION IN BPD

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the applied behavioral and neuroimaging strategies currently being employed to appreciate better the dysregulation of emotion and behavior that is found in patients with borderline personality disorder.

No. 65A
BRAIN IMAGING OF IMPULSIVITY AND AFFECTIVE INSTABILITY IN BPD

Larry J. Siever, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, One Gustave Levy Place. Box 1230, New York, NY*

10029; Antonia S. New, M.D., Monte S. Buchsbaum, M.D., W. Gordon Frankle, M.D., Harold W. Koenigsberg, M.D., Isak Prohovnik, Ph.D., Marc Laruelle, M.D.

SUMMARY:

Brain imaging provides a powerful tool to identify brain circuitry abnormalities in borderline personality disorder. Neurobiologic substrates have been identified for both impulsivity and affective instability and the more specific nature of these abnormalities can be identified through brain imaging mechanisms using neurochemical imaging, FDG PET, and fMRI. Reduced serotonergic activity has been linked to a failure of cortical inhibition of emergence of aggression. FDG PET studies of responses to m-CPP point to the anterior cingulate as a site of reduced metabolic activation after the serotonergic (5-HT_2) agonist m-CPP, with lack of expected correlation between frontal cortical and amygdalar activity in impulsive patients with borderline personality disorder. Initial studies suggest reduced 5-HT transporter activity in the anterior cingulate and enhanced cortical 5-HT_{2A} receptor number. fMRI studies suggest enhanced amygdalar activity in response to emotionally provocative stimuli. These studies cumulatively suggest that enhanced limbic, particularly amygdalar reactivity, in conjunction with reduced serotonergic facilitation of prefrontal cortical inhibition, may converge to provide the neurobiologic substrates for many of the impulsive and affectively unstable core criteria for borderline personality disorder.

No. 65B
AFFECT REGULATION AND BPD: FMRI AND DAILY EXPERIENCE OF MOOD

Katherine M. Putnam, Ph.D., *Department of Psychology, VAMC - Boston, 150 South Huntington Avenue, Boston, MA 02130*

SUMMARY:

Although the role of affective dysregulation is emphasized as a core symptom of BPD, there are few studies that have measured affective dysregulation symptoms in individuals with BPD with the use of measures gleaned from emotion theory and affective neuroscience. The current study examines affective dysregulation, specifically the inability to regulate negative affect, by using *f*MRI during an affective regulation paradigm designed to interrogate neural structures that are implicated in affective reappraisal and regulation. It is predicted that structures associated with regulation of affect, such as the prefrontal cortex and the anterior cingulate cortex, will be less activated in individuals with BPD, in contrast to a healthy control group, during an affective regulation task. Additionally, this study investigates the presence and effectiveness of affective regulation skills (e.g. reappraisal) in the daily lives of individuals with BPD with the use of Ecological Momentary Assessment, i.e., repeated, longitudinal measures of psychological phenomena (e.g. mood). It is predicted that the BPD group, in contrast to a healthy control group, will exhibit impaired affective regulation skills. Specifically, BPD subjects will report a longer duration of negative affect in response to a negative environmental event, and that the negative affect will increase over time. The data will be updated at the time of presentation.

No. 65C
EMOTIONAL PROCESSING OF PSYCHOSOCIAL STIMULI IN BPD

Jill M. Hooley, D.Phil., *Department of Psychology, Harvard University, 33 Kirkland Street, Cambridge, MA 02138;* Deborah Yurgelun-Todd, Ph.D., Staci A. Gruber, Ph.D.

SUMMARY:

Borderline personality disorder (BPD) is characterized by marked problems with affective regulation. People with BPD are also highly reactive to interpersonal stimuli. Despite this, little is known about how people with BPD process emotional events. This presentation will describe current work that is applying *f*MRI to explore the functional neuroanatomy of emotion in patients with BPD. This research uses an innovative psychosocial challenge paradigm to learn how patients with BPD process critical remarks, statements reflecting high levels of warmth, and statements that reflect high levels of emotional overinvolvement. High levels of emotional overinvolvement (EOI) in the family have been empirically linked to poor clinical outcomes in patients with schizophrenia and mood disorder but *better* clinical outcomes in patients with BPD. The study that will be described and presented is the first to explore the neural correlates of this protective emotional stimulus in people with borderline personality disorder.

No. 65D
INVESTIGATION OF PAIN PROCESSING IN BPD

Christian G. Schmahl, M.D., *Central Institute of Mental Health, 7 5, Mannheim 68159, Germany;* Martin Bohus, M.D.

SUMMARY:

Reduced pain perception is one of the core features of borderline personality disorder (BPD) and is often associated with self-injurious behavior (SIB). Several studies have demonstrated elevated pain thresholds in patients with BPD. Our findings from a study using laser-evoked pain potentials suggest that sensory-discriminative pain components seem to be unaffected in this patient population (BPD) and affective-motivational or cognitive-evaluational pain components may be altered in BPD. Functional MRI (*f*MRI) and heat pain stimulation were used to localize alterations in pain processing in seven patients with BPD and seven healthy age-matched female controls. The results of group comparison revealed more deactivation in perigenual cingulate as well as more activation in dorsolateral prefrontal cortex in patients with BPD. There was less activation in posterior parietal cortex in BPD subjects when compared with controls. Current studies that aim to define subgroups of BPD (patients with SIB reporting no pain, patients with SIB reporting pain, and patients without SIB) using laser pain thresholds will be presented and updated with new data. We employ *f*MRI before and after treatment to test the sensitivity of the functional abnormalities in pain processing to psychotherapeutic interventions.

No. 65E
A PET STUDY OF U-OPIOID NEUROTRANSMISSION AND AFFECTIVE LABILITY IN BPD

Kenneth R. Silk, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, F6234 MCHC, Ann Arbor, MI 48109-0295;* Jon-Kar Zubieta, M.D., Robert Koeppe, Ph.D.

SUMMARY:

Affective instability is a hallmark of BPD. The μ-opioid system has been implicated in regulation of affective responses to emotional and stressful stimuli, and BPD may result from dysregulation in affective processing and responses to such stimuli. Thus, understanding μ-opioid neurotransmission in these patients may reveal information about the biological bases of their affective lability. This study examines μ-opioid neurotransmission function via positron emission tomography (PET) in female patients diagnosed with borderline personality disorder (BPD) and matched controls $\geq$ 18 y.o. Subjects are

given a diagnostic evaluation and symptom rating scales. All subjects undergo two PET studies and one high-resolution structural MRI. PET studies employ 10–15 mCi [^{11}C]carfentanil (CFN), a selective μ-opioid receptor radioligand. Self-induced (subject-induced) neutral and sadness states are elicited at 10 minutes and 45 minutes post-tracer administration. Scan order (neutral or sustained sadness) is randomized and counterbalanced between subjects. Volume of Interest Analysis and Statistical Parametric Mapping are completed with the PET data. Data in healthy controls demonstrate dynamic changes in μ-opioid neurotransmission. The induction of a negative affective state was associated with a deactivation of this neurotransmitter system. These reductions in endogenous opioid release further correlated with affect ratings. The data suggest that the endogenous opioid system and μ-opioid receptors are involved in the regulation of affective states. These data will be updated with data from BPD patients to determine if alterations in this neurotransmitter system maybe implicated in the pathophysiology of BPD.

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SYMPOSIUM 66—DIAGNOSING AND MANAGING AGGRESSIVE MOOD-DYSREGULATED YOUTH

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will learn about evidence for the validity of the syndrome of severe mood dysregulation in conduct-disordered youth and its association with mood disorders. They will also understand the family-genetic data that support the existence of this subgroup and will learn pharmacological and psychosocial treatment methods for clinical practice.

No. 66A
PARSING THE ASSOCIATION BETWEEN BIPOLAR, CONDUCT, AND SUBSTANCE USE DISORDERS

Joseph Biederman, M.D., *Department of Pediatric Psychiatry, Massachusetts General Hospital, 15 Parkman Street, ACC-725, Boston, MA 02114;* Stephen V. Faraone, Ph.D., Janet Wozniak, M.D., Micheal Monuteaux, Sc.D.

SUMMARY:

Objectives: Bipolar disorder (BPD) has emerged as a risk factor for substance-use disorders in youth; however, the association between BPD and substance-use disorders is complicated by comorbidity with conduct disorder. We used familial risk analysis to disentangle the association between the three disorders.

Methods: Through structured interviews, we compared relatives of four proband groups: (1) conduct disorder + bipolar disorder, (2) bipolar disorder without conduct disorder, (3) conduct disorder without bipolar disorder, and (4) control subjects without bipolar disorder or conduct disorder. To analyze substance use disorders, Cox proportional hazard survival models were utilized to compare age-at-onset distributions.

Results: BPD in probands was a risk factor for both drug and alcohol addiction in relatives, independent of conduct disorder in probands, which was a risk factor for alcohol dependence in relatives independent of BPD in probands, but not for drug dependence. The effects of BPD and conduct disorder in probands combined additively to predict the risk for substance-use disorders in relatives.

Conclusions: The combination of conduct disorder + BPD in youth predicts especially high rates of substance-use disorders in relatives. This supports previous results documenting that when BPD and conduct disorder occur comorbidly, both are validly diagnosed.

No. 66B
A FAMILY GENETIC PERSPECTIVE ON CHILDHOOD MANIA

Stephen V. Faraone, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkway Street, Boston, MA 02114*

SUMMARY:

Family, twin, and adoption studies have consistently shown bipolar disorder to be a highly heritable condition. We review the extant genetic literature about early-onset bipolar disorder from two perspectives. We show that many studies show early-onset bipolar disorder to be more highly heritable than later-onset bipolar disorder. We also show that onset in childhood confers a greater risk to relatives than onset in adolescence. In addition, early-onset bipolar disorder is known to show substantial comorbidity with attention deficit/hyperactivity disorder and conduct disorder. We review the literature on this topic and show how it supports the idea that early-onset bipolar disorder with these comorbidities may be a developmental subtype of bipolar disorder. In addition, new data are presented on a genome-wide scan of 538 people in 97 families with bipolar disorder. We found that the age at onset of bipolar disorder had significant heritability (40%, p=.004). Three chromosomal regions yielded multipoint LOD scores greater than 2.5: markers DLS1292, GATA31B, and GATA153 on chromosomes 12, 14, and 15, respectively. We also describe the clinical correlates of age at onset of bipolar disorder and discuss how these concur with prior work in the areas.

No. 66C
RISPERIDONE TREATMENT OF AFFECTIVE SYMPTOMS IN MENTALLY RETARDED YOUTH WITH CONDUCT DISORDER

Eric Mick, Sc.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 725, Boston, MA 02114;* Joseph Biederman, M.D., Georges Gharabawi, M.D., Stephen V. Faraone, Ph.D., Gahan J. Pandina, Ph.D.

SUMMARY:

Objective: To examine the effect of risperidone on affective symptoms in children with disruptive behavior disorders (DBD).

Method: Children with DBD (n=118; mean age 8.4 years; 97 males) and subaverage IQ were randomized to placebo or risperidone in a six-week, double-blind study. Patient assessments included the Nisonger Child Behavior Rating Form (N-CBRF) and other mea-

sures. Secondary analyses were performed on N-CBRF clusters consisting of items indicative of depression or mania. Change scores from baseline to endpoint were measured.

Results: The risperidone group (mean dose at endpoint: 0.034±0.002 mg/kg/day) showed robust and significant improvements on N-CBRF depression and mania clusters (42.1% change, $p<0.0001$ and 34.9% change, $p<0.0001$, respectively). Although the placebo group also showed improvement over baseline (25.4% change, $p<0.0001$ and 15.8% change, $p=0.0003$, respectively), the improvement was much smaller than that observed on risperidone. Furthermore, the risperidone group showed significantly greater improvement than the placebo group on both the depression and mania clusters ($p=0.014$ and $p=0.001$, respectively) and children receiving risperidone improved on more individual mood items than placebo.

Conclusions: Risperidone appears to be effective for the management of manic and depressive symptoms frequently found in children with DBD.

No. 66D
CLINICAL TRIALS OF A MOOD STABILIZER FOR AGGRESSIVE, MOOD-DYSREGULATED YOUTH

Janet Wozniak, M.D., *Psychiatry, Harvard Medical School, 55 Fruit Street, Boston, MA 02114*

SUMMARY:

A growing literature of child and adolescent psychiatry research findings suggests that aggressive, mood, and conduct-disordered youth suffer from bipolar and bipolar spectrum disorder. As few studies have addressed the pharmacological treatment of conduct disorder or aggression directly, the recognition that these children suffer from bipolar disorder offers the option of treatment with mood stabilizer medication. This presentation will focus on data from ongoing open-label trials of mood stabilizer medications for bipolar and bipolar spectrum-disordered youth, with a focus on the treatment of aggression as a part of this clinical picture. Children and adolescents will be described, including high levels of comorbidity with attention deficit/hyperactivity disorder, conduct disorder, and oppositional defiant disorder. Data will be presented from trials of risperidone, olanzapine, olanzapine plus topiramate, as well as omega-3 fatty acids, all of which have demonstrated efficacy in treating the symptoms of bipolar disorder, especially in reducing levels of aggression. The effects of mood stabilizer medications on comorbid conditions and symptoms will be addressed.

No. 66E
COLLABORATIVE PROBLEM-SOLVING THERAPY FOR AGGRESSIVE YOUTH

Ross W. Greene, Ph.D., *Department of Psychiatry, Collaborative Problem Solving Institute, 313 Washington Street Suite 402, Newton, MA 02458*

SUMMARY:

Diverse psychosocial treatment approaches have been applied to aggressive youth. A cognitive-behavioral model of intervention known as Collaborative Problem Solving (CPS) differs from many parent training programs in its emphasis on facilitating adult-child problem solving. In the current study, CPS was compared with parent training (PT) in "affectively dysregulated" youth meeting DSM-IV diagnostic criteria for oppositional defiant disorder (ODD).

The 50 children with ODD between the ages of four and 12 years who began treatment were randomly assigned (using a 3:2 randomization scheme) to CPS or PT; 28 children completed treatment in the CPS condition, 19 in the PT condition. All children met full diagnostic criteria for ODD, and had at least subthreshold features of either bipolar disorder or major depression.

The CPS condition produced significant improvement from pre-treatment to post-treatment and from pre-treatment to four-month follow-up in parent ratings of their child's oppositional behavior. From pre-treatment to four-month follow-up, a large effect size was found for CPS (1.19) and a moderate effect size for PT (0.48). The CPS condition also produced significant improvement from pre-treatment to post-treatment in parenting stress and parent-child interactions.

No. 66F
ANTICONVULSANTS IN THE MANAGEMENT OF AGGRESSION IN YOUTH

Joseph M. Gonzalez-Heydrich, M.D., *Fegan 8, Children's Hospital, 300 Longwood Avenue, Boston, MA 02115*

SUMMARY:

Objective: To review the literature relevant to anticonvulsant treatment of aggression in youth and provide clinical recommendations.

Method: We searched for reports relevant to the use of a variety of anticonvulsants for treatment of aggression in youth.

Results: There are few controlled trials of anticonvulsants for treatment of aggression in pediatric populations. Divalproex has shown efficacy in placebo-controlled and open trials. Carbamazepine has shown efficacy in open-controlled but not in placebo-controlled trials. A placebo-controlled trial of the addition of quetiapine to divalproex supports some additional benefits from the combined pharmacotherapy. The evidence for efficacy of other anticonvulsants comes almost exclusively from adult studies and case reports. In adults, lamotrigine has demonstrated efficacy in bipolar depression, but can worsen aggression. Open reports suggesting the usefulness of gabapentin and topiramate in bipolar disorder have not been replicated in placebo controlled trials. Zonisamide, oxcarbazepine, and levetiracetam deserve further investigation, but tiagabine does not appear to be useful for acute treatment of aggression due to bipolar disorder.

Conclusion: Divalproex and carbamazepine have some empirical evidence of moderate efficacy for treatment of aggression in youth. Several of the newer anticonvulsants show promise but have yet to be studied for this indication.

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SYMPOSIUM 67—RESIDUAL SYMPTOMS IN DEPRESSION: RECOGNITION AND TREATMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize and treat residual symptoms remaining after treatment of a depressive disorder.

No. 67A
AN OVERVIEW OF RESIDUAL SYMPTOMS IN DEPRESSION

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

SUMMARY:

Antidepressant response, remission, and residual symptoms are all relevant outcomes for the treatment of depression. Response to antidepressants is defined as ≥50% reduction in baseline depression scale scores. Clinical trials have shown that about 70% of depressed patients respond to antidepressants and it is this well-established finding that is the foundation of antidepressant treatment in clinical practice. Response, however, frequently leaves patients with residual symptoms and dysfunction. The field has moved to require that patients reach full remission, usually defined as having a post-treatment depression scale score that is within the normal range. Remission usually occurs within a minority of patients at rates ranging from 35% to 50% in acute antidepressant trials. But even those who remit can have residual symptoms that impair full functioning. These residual symptoms can include the subtle persistence of classic depressive symptoms (e.g. decreased mood, decreased interest, fatigue), over reactions and decreased resiliency to stress, pessimism, and the lack of psychological well-being. Long-term studies consistently find that residual symptoms after acute treatment are associated with a worse functioning and a higher risk of depressive relapse and recurrence.

No. 67B
SLEEP DISTURBANCE AS A RESIDUAL SYMPTOM IN DEPRESSION

Matthew A. Menza, M.D., *Department of Psychiatry, Robert Wood Johnson Medical School, D207A, 671 Hoes Lane, Piscataway, NJ 08854*

SUMMARY:

Disturbed sleep is a highly prevalent and clinically significant aspect of depression. Insomnia is among the most common presenting complaints in patients with depression and is associated with negative long-term outcomes in depressed patients, including chronic course, diminished quality of life, increased health care utilization, greater risk of relapse and recurrence, and increased suicide risk. Insomnia is also the single most frequent residual symptom after treatment with antidepressants.

Despite the clear relationship of depression with sleep difficulties, any assessment of residual sleep problems in depressed patients needs to include a review of primary sleep disorders and the effect of antidepressants on the patient's sleep. It is common clinical practice to use an adjunctive sleep medication in depressed patients, and the one available controlled trial with zolpidem supports the usefulness of this strategy. There are a number of other medications that could be used for residual sleep problems, each of which could plausibly improve long-term outcomes. While a number of treatment trials support the efficacy of psychological interventions for primary insomnia, few studies have specifically evaluated psychologically based treatments in depressed patients with residual insomnia. However, there are sufficient pilot data to recommend behavioral or cognitive-behavioral therapies for patients with depression and residual insomnia.

No. 67C
ANXIETY AS A RESIDUAL SYMPTOM IN DEPRESSION

Alexander Bystritsky, M.D., *Department of Psychiatry, University of California at Los Angeles, NPI, 300 UCLA Medical Plaza, #2335, Los Angeles, CA 90095*

SUMMARY:

Anxiety and depression, as symptoms and disorders, very frequently become intertwined during the course of treatment. When depression is treated, anxiety may stay as a residual symptom that is frequently not responsive to conventional treatment with antidepressants. Anxiety can be provoked by antidepressant treatment.

We will review strategies for identifying anxiety in depression during the course of treatment. We will also discuss the implication of anxiety on the functional status of the patients and their response to the treatment. We will review the strategies of management of anxiety during the treatment of depression, which may consist of altering a dose of an antidepressant or adding an adjunct treatment that may include a serotonergic agent, a mood stablizer, or a narcoleptic. Other strategies, including psychotherapy, may be employed.

No. 67D
RESIDUAL SEXUAL DYSFUNCTION ASSOCIATED WITH MDD AND SSRI TREATMENT

H. George Nurnberg, M.D., *Department of Psychiatry, University of New Mexico, 2400 Tucker NE, MSC 095030, Albuquerque, NM 87131*

SUMMARY:

The presence of residual ED/SD (RSD) in a patient treated for MDD with antidepressant medication presents significant considerations for the treating physician. For example, does RSD indicate (1) a medication-associated side effect? (2) only partial MDD response to AD treatment? (3) a preexisting and coincidental condition? (4) symptomatic relief of the depression component of a complex syndrome for which ED/SD are additional symptoms? (5) a forme-fruste for another latent condition(s) (CVD, DM, dyslipidemia, hypertension)? Adding to the complexity, none are mutually exclusive and all may apply in different clinical circumstances.

ED/SD is multi-determined and needs to be systematically and longitudinally evaluated by individual domains for pre-existing, disorder associated, treatment associated, and residual sexual dysfunction. Recent advances into ED/SD treatment with selective-phosphodiesterase inhibitors (PDE-5I) have established efficacy for a broad spectrum of etiologies including MDD associated ED/SD, SRI-AASD, residual/preexisting ED/SD in treated MDD, and in antidepressant associated ED. This report will review the polymorphism of depression associated SD, depression-treatment-associated SD, evidence-based data on management approaches, and current PDE-5i treatment data from six DBPC trials in MDD-SD, SRI-AASD,

SRI-AAED, ED with minor depression, and residual ED following AD treatment of MDD.

No. 67E
THE TREATMENT OF RESIDUAL FATIGUE IN DEPRESSION

Humberto Marin, M.D., *Psychiatry Department, UMDNJ, Robert W. Johnson Medical School, 671 Hoes Lane, Room D-321, Piscataway, NJ 08855-1392*

SUMMARY:

Fatigue, a common symptom in the community and primary care, is the second most common presenting symptom of depression after depressed mood. It is also a common residual symptom in treated depression, even in treatment responders. Residual fatigue causes significant suffering and disability and seems the stronger predictor of a chronic course. The mechanism of fatigue is likely complex, involving the endocrine system, immunologic messengers like cytokines, and serotonergic, adrenergic, or dopaminergic systems. Clinically, the most important differentiation of fatigue is excessive daytime sleepiness (EDS), and evaluation of patient's sleep is required. There are few controlled data on the treatment of residual fatigue in depression, and most information comes from studies in cancer, AIDS, CFS, FM, or MS. The literature suggests that stimulants, amantadine, modafinil, and possibly bupropion, could be useful. Some TCAs seem to improve fatigue, while the effect of various SSRIs is unclear. Other agents that may have a role include thyroid and adrenal hormones, as well as 5HT3 antagonists and aminopyridines. In addition, cognitive and behavioral interventions (including attribution, validation, rest planning, and graded exercise) may be useful options. The literature on these treatments will be reviewed.

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SYMPOSIUM 68—WOMEN'S MENTAL HEALTH REVISITED: CURRENT PERSPECTIVES, FUTURE TRENDS
Association of Women Psychiatrists

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize, diagnose, and treat current, pertinent, and common mental health women's issues across the life cycle.

No. 68A
DEPRESSION IN THE REPRODUCTIVE YEARS

Nada L. Stotland, M.D., *Department of Psychiatry, Rush Medical College, 5511 South Kenwood Avenue, Chicago, IL 60637*

SUMMARY:

The fact that the gender difference in depression incidence begins at puberty and ends at menopause raises fascinating questions about the relationships among hormones, gender roles, and mood. Two conditions, premenstrual and postpartum syndromes, are specific to women. After long neglect, each has fostered a blossoming literature in the last ten or 20 years, a literature that continues to grow. Several selective serotonin reuptake inhibitors have received FDA approval as treatments for premenstrual dysphoric disorder. We now recognize that much postpartum depression is a continuation of prepartum depression, and that the self-limited "baby blues" differs from postpartum depression. Despite the obvious temporal connection between hormonal changes and mood symptoms, exogenous hormones are by and large not effective treatments for mood symptoms. It is a good idea for all psychiatric patients to chart their moods and menstrual cycles prospectively. Treatments may have to be altered cyclically, because symptoms thought to be premenstrual are often not linked to the menstrual cycle at all, and are better explained by other diagnoses and by life circumstances. The identification of gender-based research questions, and the answers to those questions, will benefit both men and women.

No. 68B
DEPRESSION AND ANXIETY IN WOMEN IN LATE LIFE

Marion Z. Goldstein, M.D., *Department of Psychiatry, SUNY at Buffalo-ECMC, 462 Grider Street, Buffalo, NY 14215-3021*

SUMMARY:

Women in late life (1) are the fastest growing segment in our population and (2) depression and depression and anxiety as comorbidities occur approximately twice as often in women as in men throughout life. Older women with these mental health conditions are a severely underserviced and undertreated group. We know that to improve access and quality of clinical care, the entire health care system has to be overhauled, which requires an inordinate dedication to advocacy. However, I will focus here on how attention to (1) many of the risk factors for depression and anxiety in older women, and (2) many of the presenting symptoms that mask depression and anxiety can greatly improve detection in a timely fashion. Benefits of early detection and state-of-the-art treatments can prevent the dire consequences of suffering, dysfunction, prolonged illness, mortality, and suicide for patient, family, or other caregivers if needed. Need for multidisciplinary collaboration will be emphasized.

No. 68C
DOMESTIC VIOLENCE: ITS IMPACT ACROSS THE LIFE CYCLE

Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville, School of Medicine, 3006 Dunraven Drive, Louisville, KY 40202*

SUMMARY:

Domestic violence has been identified by anthropologists in skulls thousands of years old. Victims seek general medical treatment in emergency rooms where, too frequently, they may not be asked about the etiology of their injuries, or more likely, they lie for fear of repercussions from the batterer.

Police receive training in identifying domestic violence and too many are part of personal battering relationships. Furthermore, many health professionals themselves are involved in domestic violence and thus, as do the police and other public agencies, avoid asking about and confronting the issues in patients.

Children, from in utero to adulthood, continue to be victimized. The elderly are the most recently identified (1980s) victims, usually abused by family or caretakers.

Despite continued media exposure to domestic violence and increasing availability of shelters, primarily for women and children, this medical condition continues across all socioeconomic, educational, ethnic, racial, gender, sexual orientation, and faith backgrounds.

This presentation will include a broad, in-depth focus on issues and new programs presented at the August 2003, program sponsored by the FBI in which the author participated.

This presentation will offer recommendations for psychiatrists and other mental health professionals to follow to attempt to decrease the often deadly effects of this international health crisis.

No. 68D
PTSD IN WOMEN: CURRENT CONCEPTS AND TREATMENTS

Marian I. Butterfield, M.D., *Department of Psychiatry, Durham VA/ Duke University, 508 Fulton Street, Suite 116A, Durham, NC 27705*; Mary Becker, M.S., Christine E. Marx, M.D.

SUMMARY:

PTSD is a common, disabling anxiety disorder that is caused by one or more traumatic events and presents with a constellation of re-experiencing, avoidance, and arousal symptoms. The lifetime prevalence rate for women is twice that of men, likely related to high rates of interpersonal trauma observed in women. Life threatening traumas such as rape or physical injury are associated with a 8.5-fold increase in PTSD risk as compared with other types of trauma. Prevalence estimates of rape-induced PTSD range between 31% and 94%, which indicate that currently 1.3 million women in the U.S. have rape-induced PTSD. Drawing from research with women veterans, the prevalence of PTSD related to military sexual trauma will be discussed. An overview of the neurobiology of PTSD in women will follow. Evidence-based treatment strategies for PTSD in women will be reviewed, including pharmacotherapy and psychosocial treatments. Future research directions addressing PTSD in women will also be highlighted.

No. 68E
RACISM AND WOMEN'S MENTAL HEALTH: THE INTERSECTION OF RACE AND GENDER

Altha J. Stewart, M.D., *111 South Highland #180, Memphis, TN 38111*

SUMMARY:

Psychiatry, like society in general, is not immune to the deeply rooted, pervasive influence of racism. The scientific literature reveals that African-American women are at increased risk for psychological distress because of factors that disproportionately affect them, including lower incomes, greater poverty, poor physical health, and racism. While some myths about mental illness in African Americans in general have been dispelled, there continues to be limited understanding of the role of the dual negative status of being black and female with respect to prevalence and treatment of mental illness. To understand and appreciate the unique issues facing black women, we must learn more about culturally determined values, beliefs, and attitudes that contribute to their psychological development, and the combined impact of racism and sexism on the manifestations of psychiatric illness.

This presentation will review the literature on black women and mental illness and gender differences observed in accessing treatment and inclusion in research. In addition, a model for understanding the impact of American racism on women of African descent and proposed recommendations for future research will be discussed.

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SYMPOSIUM 69—SUPPORTIVE PSYCHOTHERAPY: AN UPDATE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the status of supportive psychotherapy in the treatment of patients and its status as part of psychiatric training programs.

No. 69A
HISTORY OF SUPPORTIVE PSYCHOTHERAPY

Stephen Rojcewicz, Jr., M.D., *13808 Old Columbia Pike, Silver Spring, MD 20904–4554*

SUMMARY:

Supportive psychotherapy dates to the ancient Greeks, who emphasized treating the mentally ill humanely, and pioneered overall support for persons in crisis. Plato, Aristotle, Hippocrates, and the Greek tragedians depict emotional catharsis, and the therapeutic role of verbal persuasion. Socrates, in Gorgias, concludes that the person who uses verbal methods to cure must also know medicine.

In early Roman times, Aretaeus the Cappadocian composed treatises on the cure of melancholy, on madness, and acute and chronic diseases, stressing realistic goals: "It is impossible, indeed, to make all the sick well, for a physician would thus be superior to a god; but the physician can produce respite from pain, intervals in diseases, and render them latent."

Medieval physician-philosophers, such as Avicenna, developed components of supportive psychotherapy. Poets, religious leaders, and indigenous healers added further, but in an unsystematic way.

The German psychiatrist Christian Reil (1803) was the first to organize the disparate principles into a systematic method. Benjamin Rush counseled direct advice, educational efforts, healthy employment or productive activities, and temperance: precursors to supportive psychotherapy.

Recent work by Rockland, Novalis et al., and Pinsky have made supportive psychotherapy a sophisticated, mature, and teachable discipline.

No. 69B
ROLE OF PSYCHOTHERAPY IN THE MANAGEMENT OF DEPRESSION

Michael E. Thase, M.D., *Department of Psychiatry, University of Pittsburgh Medical Center, 3811 O'Hara Street, Pittsburgh, PA 152132593*

SUMMARY:

This paper will describe the current status of supportive psychotherapy in the management of depressive disorders. When discussing differential therapeutics, the term supportive psychotherapy is generally used to describe interventions that are broader in scope than the clinical management component of pharmacotherapy, yet less specific in form and content than the procedurally specified forms of cognitive, behavioral, interpersonal, and psychodynamic psychotherapies that have been studied in clinical trials. Although seldom the focus of specific study, supportive psychotherapy is probably more representative of what psychiatrists do in day-to-day practice than are any of the aforementioned depression-focused psychotherapies. Results of studies that have attempted to examine the mechanisms of action of various pharmacologic and psychotherapeutic interventions support the conclusion that the magnitude of the so-called nonspecific elements of the helping relationship are at least two to three times greater than any specific actions. Moreover, much of the evidence that indicates that the depression-focused psychotherapies are more effective than supportive therapy control groups is contaminated by the so-called allegiance bias (i.e., it was clear that the latter intervention was "brand X"). It therefore is timely to recognize that supportive psychotherapy is both a public health relevant standard of comparison for other models of treatment, and a valid, useful, and ethical foundation upon which other therapeutic elements can be added and tested for utility.

No. 69C
USE OF SUPPORTIVE PSYCHOTHERAPY WITH BIPOLAR DISORDER

Karen L. Swartz, M.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Meyer 3-181, Baltimore, MD 21287-7381*

SUMMARY:

Supportive psychotherapy can have a major role in the psychiatric management of bipolar disorder. Such therapy addresses the need to comprehend the illness over time as the patient's capacity varies with stages of the illness, e.g., denial is common between exacerbations and insight can disappear as mania arises. The attractions of hypomania often are a therapeutic challenge. Mood charting can increase the patient's understanding of the illness, the impact of stress, the role of medication compliance, and clarify the preamble signs for patients. While some are attracted to a biological basis, others need support to accept that these psychological manifestations imply a "brain" disease, preferring to blame all symptoms on environmental factors.

Supportive psychotherapy includes clarifying what "treatment adherence" means, reviewing necessary lifestyle changes, regulating daily activities, and setting reasonable goals. Even during periods of euthymia, patients with bipolar disorder can have cognitive or interpersonal limitations that require treatment.

Supportive psychotherapy assists the patient in identifying the interpersonal, scholastic, occupational, or legal damage that follows an exacerbation. The strong emotions that follow exacerbations in themselves can be overwhelming if not recognized and supported. Lastly, bipolar disorders are often associated with other psychiatric disorders, which can also benefit from supportive psychotherapy.

No. 69D
ADAPTING SUPPORTIVE THERAPY FOR TREATMENT OF BPD

David J. Hellerstein, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 101, New York, NY 10032*; Ron B. Aviram, Ph.D., Jessica Gerson, Ph.D., Kimberly Kotov, Ph.D., Barbara H. Stanley, Ph.D.

SUMMARY:

We will discuss how supportive therapy (ST) can be adapted for an outpatient population of BPD patients with self-injurious behavior (SIB) and chronic suicidal ideation (SI). Whereas ST has traditionally been described as a treatment of last resort, in more recent years it has been defined as an active treatment approach that may be efficacious for a wide variety of patients. For instance, Pinsker emphasizes the mobilization of strengths to minimize deterioration, and to enhance self-esteem, and encourages the use of adaptive defenses, and positive coping skills. In addition, competency in performing ST has been recently added as a requirement for psychiatry residency training. However, unlike treatments like cognitive therapy or interpersonal therapy, ST has rarely been adapted for treatment of particular diagnostic groups. In an NIMH-funded study at New York State Psychiatric Institute, we have adapted ST specifically for the treatment of outpatients with borderline personality (BPD) who repeatedly self-injure and/or attempt suicide. Patients receive once-weekly ST for the period of one year. We believe that such an approach may be effective for many, though not all, patients with BPD. The specifics of this adapted approach will be discussed, including engaging and retaining BPD-SIB individuals in treatment, addressing core symptom areas, and managing crises.

Funding source: National Institute of Mental Health (BH Stanley, PhD, Principal Investigator) 1R01MH6017

No. 69E
DEVELOPMENT OF COMPETENCIES IN SUPPORTIVE THERAPY: PROCESS AND PROBLEMS

Lisa A. Mellman, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Psychiatry training programs must demonstrate that residents have achieved competency in supportive therapy. These regulations, issued in 2001 by the Psychiatry Residency Review Committee of the Accreditation Council of Graduate Medical Education, greatly impacted psychotherapy training. Although these regulations caused much consternation for residency training directors, they provided new-found leverage for gaining resources including dedicated teaching time for psychotherapy, expert faculty, and access to suitable patients.

The American Association of Psychiatry Residency Training Directors (AADPRT) developed a Task Force on Competency, which wrote sample competencies for the field, including supportive therapy competencies. The APA Commission on Psychotherapy by Psychiatrists (COPP), working with the APA Task Force on Competency, provided consultation to the AADPRT workgroups. Issues discussed included the composition of supportive therapy competencies, setting the competency bar, and the comprehensiveness of the competencies.

The role of supportive psychotherapy training in residency education is currently under discussion by psychiatric educators. Competencies common to several psychotherapy modalities are a core part of supportive therapy, distinguishing it from other more specialized therapies that residents may find more difficult to learn.

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SYMPOSIUM 70—ANXIETY DISORDERS IN YOUTH: CLINICAL AND RESEARCH UPDATES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) diagnose and assess anxiety disorders in youth using standardized and empirically-based instruments; (2) demonstrate knowledge of empirically-based treatments of childhood anxiety disorders including pharmacotherapy and cognitive behavioral therapy.

No. 70A
EVIDENCE-BASED ASSESSMENT INSTRUMENTS WITH CHILDREN AND ADOLESCENTS

Thomas H. Ollendick, Ph.D., *Department of Psychology, Virginia Tech, Blacksburg, VA 20461-0355*

SUMMARY:

Various diagnostic, self-report, parent-report, behavioral, and physiologic measures of anxiety exist for children and adolescents. Many of them are not psychometrically sound or developmentally grounded. As a result, we have not advanced our thinking in this area and we have not been able to show clear effects of treatment, whether psychosocial or pharmacologic. The need for empirically sound, developmentally based instruments for evidence-based practice is evident. The present paper will review extant instruments (via meta-analytic procedures), identify those that are sound instruments, and recommend those that are for clinical and research practice. The presentation will be based on work by Ollendick and Hersen, and their colleagues, and enlist both empirical and developmental principles.

No. 70B
PHARMACOLOGICAL TREATMENT OF ANXIETY DISORDER IN YOUTH

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

SUMMARY:

The treatment of anxiety disorders in youth has increasingly included the use of medications. Clinicians are often faced with the dilemma of when to initiate pharmacotherapy, which medication to use, and how to monitor for treatment response and/or side effects. Pharmacological treatment studies of childhood anxiety disorders provide empiric guidelines for the use of these medications in clinical practice. Selective serotonin reuptake inhibitors are the most widely studied and prescribed group of medications for childhood anxiety disorders, including obsessive-compulsive disorder, social phobia, generalized anxiety disorder, and separation anxiety disorder. There are fewer controlled investigations of other medications to treat anxiety disorders in youth, including tricyclic antidepressants, anxiolytics, adrenergic agents, and newer atypical antidepressants. This presentation will review studies investigating the safety and efficacy of medications in the treatment of anxious youth. Medication selection, treatment guidelines, and side-effect profiles will be discussed. The importance of the use of medications in conjunction with cognitive-behavioral and psychosocial treatments will be emphasized.

No. 70C
ANXIETY DISORDERS IN CHILDREN AND ADOLESCENTS: ARE WE READY TO MOVE BEYOND THE STUDY OF TREATMENT EFFICACY?

Anne Marie Albano, Ph.D., *New York University Child Study Center, 215 Lexington Avenue, 13th Floor, New York, NY 10016*

SUMMARY:

Empirical evidence suggests that anxiety disorders in youth can be successfully treated with either cognitive-behavioral therapy or pharmacotherapy in upwards of 65% of cases. In addition, the CBT literature has advanced to report maintenance of gains for responders as far as seven years post treatment. This presentation provides a critical review of the methodological strengths and limits of the extant literature and raises the question of whether efficacy has been demonstrated for either monotherapy. The rationale and design of a federally funded, ongoing, multimodal, multicenter trial will be presented with a focus on evaluating the merits of combined treatment, a modality as yet untested for anxious youth. Questions for future research, involving the evaluation of adequate dosing in CBT, component analysis, matching patients to treatment, and dissemination issues will be discussed.

No. 70D
A COGNITIVE NEUROSCIENCE PERSPECTIVE ON CHILDHOOD ANXIETY DISORDERS

Amy L. Krain, Ph.D., *New York University Child Study Center, 577 First Avenue, New York, NY 10016*

SUMMARY:

Despite significant advances made in the assessment and treatment of childhood anxiety disorders, less is known about the cognitive processes and associated neural systems underlying these disorders. The cognitive-motivational model, which suggests that anxiety-disordered individuals selectively attend to threat in their environment, has provided a framework for research in this area. Support for this model has emerged from studies of anxiety-disordered adults demonstrating faster responses to probes following threatening stimuli than to those following neutral stimuli. Similar biases have been shown in anxiety-disordered children, suggesting developmental continuity of these cognitive differences.

Neuroimaging findings lend further support to information-processing theories of anxiety, and the stability of cognitive biases across development. Adult research has implicated the amygdala as playing a primary role in the assessment of, and response to, threat. Similarly, anxiety-disordered children show an exaggerated right amygdala response to fearful faces as compared with neutral faces, which is greater than that of non-anxious children. A recent structural MRI study found significantly greater right and total amygdala volumes in children with generalized anxiety disorder than in those without anxiety. These studies will be reviewed critically and future directions for the field will be outlined.

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SYMPOSIUM 71—DSM-V CLASSIFICATION OF PERSONALITY DISORDERS: THE WHITE PAPER AND BEYOND

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should appreciate the limitations of the DSM-IV classification of personality and understand the new research directions being considered in advance of starting the DSM-V process, including dimensional approaches, spectrum illness, and the underlying neurobiology of personality traits such as impulsivity and aggression.

No. 71A
DIMENSIONAL MODELS OF PERSONALITY DISORDER

Thomas A. Widiger, Ph.D., *Department of Psychology, University of Kentucky, 115 Kastle Hall, Lexington, KY 40506-0044*

SUMMARY:

Personality disorders are currently diagnosed in DSM-IV as categorically distinct conditions. However, a substantial amount of research has questioned the validity and clinical utility of this categorical diagnosis, and different approaches to providing a more dimensional model of classification have been developed. Included within this paper will be a summary of the limitations of the categorical approach, alternative dimensional models, and suggestions for future research that will be most informative to the authors of DSM-V, including matters of developmental progression, longitudinal course, biological mechanisms, and clinical utility.

No. 71B
RELATIONSHIP OF PERSONALITY TRAITS AND DISORDERS TO AXIS I DISORDERS

M. Tracie Shea, Ph.D., *Department of Psychiatry, Brown University-Butler Hospital, 700 Butler Drive, Duncan Building, Box G-BH, Providence, RI 02906*

SUMMARY:

The very high rates of Axis I disorders in individuals with personality disorders, as well as the reverse—high rates of personality disorders in individuals with Axis I disorders—raises the question of whether the various diagnostic categories represent distinct disorders. Similarly, consistent findings of maladaptive personality traits associated with some of the Axis I disorders, particularly anxiety and depressive disorders, raise the question of the meaning of the associations. Different assumptions or models have characterized efforts to understand the personality trait/disorder—Axis I associations. Some of these models (vulnerability, pathoplasty, complication) assume that the personality trait/disorder and associated Axis I disorders are distinct conditions, with one increasing the risk for, or somehow altering the course, of the other. Other prominent models (common cause, spectrum) assume that the personality traits/disorders and Axis I disorders are not distinct, but rather share common etiological or pathological mechanisms. Empirical evidence for the different models, particularly with regard to the assumptions of distinctiveness, is critical for the optimal classification of personality disorders and Axis I disorders. This presentation will provide an overview of the existing research in this area, including some of the methodological issues that have hindered conclusions, and outline recommendations for research priorities.

No. 71C
AXIS I/AXIS II BOUNDARY: SPECTRUM DISEASES AND MOLECULAR NEUROSCIENCE

John H. Krystal, M.D., *Department of Psychiatry, Yale School of Medicine, VA Medical Center, 950 Campbell Avenue, West Haven, CT 06516;* Robert T. Malison, M.D., Jaakko A. Lappalainen, M.D., Joel Gelernter, M.D.

SUMMARY:

Psychiatric disorders are remarkably heterogeneous entities, despite the reasonably high level of diagnostic consistency. The molecular foundations of this heterogeneity are increasingly evident, yielding a growing appreciation that, within groups of people carrying a given diagnosis, the severity of dimensions of illness may vary across a spectrum from the normal range to highly pathalogical states. Possible sources of this heterogeneity will be reviewed briefly in this presentation including: (1) single gene vs. polygenic phenotypes and phenotypic concomitants of allelic and locus heterogeneity, (2) disease vs. disease-modifying genes, (3) epigenetic processes (DNA methylation, etc.), (4) partial penetrance, (5) epistatic effects, and (6) gene-environment interactions. Historically, psychiatric diagnostic schema introduced diagnostic boundaries based on a few target dimensions of illness, for example the presence or absence of psychosis in schizophrenia, and deemphasized the importance of heterogeneity within diagnostic groups. A consequence of the creation of Axis I and Axis II was the reification of diagnostic distinctions between groups of individuals who otherwise share many symptoms, functional impairments, pathophysiologic mechanisms, and genotypes. Consistent with a growing literature, this presentation will suggest that there is compelling evidence to link some Axis I and Axis II disorders within a single disease spectrum diagnosis. The example of schizophrenia spectrum disorders will be reviewed.

No. 71D
TEMPERAMENT, PERSONALITY, AND PERSONALITY DISORDER: THE EXTERNALIZING SPECTRUM MODEL

Robert F. Krueger, Ph.D., *Department of Psychology, Universty of Minnesota, 75 East River Road, Minneapolis, MN 55455*

SUMMARY:

Normal-range personality traits and temperamental styles, abnormal personality variation, and Axis I and II constructs from the DSM are richly intertwined. However, many conceptualizations of the relations among these constructs focus on specific pairings (e.g., the prevalence of a specific Axis I condition in a group with a specific Axis II diagnosis), and not on the larger network of relationships among these constructs. This presentation will focus on the author's

research directed at developing a broader, inter-related conceptualization of temperament, personality, and their links to mental disorder. Particular emphasis will be placed on empirical research delineating an externalizing spectrum of personality and psychopathology, a spectrum that encompasses Axis I conditions (e.g., substance dependence), Axis II conditions (e.g., antisocial personality disorder), and more "normal-range" temperament and personality constructs (e.g., impulsivity and aggression).

No. 71E
THE NEUROBIOLOGY OF PERSONALITY TRAITS: FOCUS ON AGGRESSION

Emil F. Coccaro, M.D., *Department of Psychiatry, University of Chicago, 5841 South Maryland Avenue, MC#3077, Chicago, IL 60637*

SUMMARY:

Objective: Data over the past two decades clearly point to a significant dimensional relationship between neurotransmitter-based function and personality traits in personality disorders. This presentation will review existing and new data regarding the neurobiology of personality traits, using impulsive aggression as a focus in patients with personality disorders.

Methods: Studies reviewed come from data related to pharmacologic challenge, CSF neurochemical, and imaging studies of personality disorder.

Results: Measures of impulsive aggression correlate with various measures of serotonin, norepinephrine, GABA, and vasopressin. Preliminary data also point to selected locations in the brain where potential abnormalities exist in subjects with prominent histories of impulsive aggression. These data suggest treatment strategies that have been shown to be effective in selected patients.

Conclusions: The biology, and clinical psychopharmacology of impulsive aggression is complex, but critical to understanding the nature of aggression in these types of patients. Insights from this continuing work will likely lead to new views in the classification of personality traits and personality disorders.

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SYMPOSIUM 72—GROUP THERAPY IN MEDICAL/PSYCHIATRIC CARE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should learn the methods and outcomes of group therapeutic treatments for stress related to medical and psychiatric illnesses.

No. 72A
GROUP THERAPY FOR BREAST CANCER: FEELING AND HEALING

David Spiegel, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 2325, Stanford, CA 94305-5718;* Janine Giese-Davis, Ph.D., Lisa D. Butler, Ph.D., Catherine Classen, Ph.D., Cheryl Koopman, Ph.D.

SUMMARY:

Supportive-expressive group psychotherapy has been extensively evaluated as a tool in helping breast cancer patients to manage existential anxiety, pain, and depression. The studies presented here provide evidence regarding effectiveness in reducing distress and improving coping. New data indicating that this effect is mediated by reduced suppression of emotion will be reviewed.

One hundred and twenty-five women with metastatic breast cancer were recruited and randomized. Intervention subjects were offered one year of weekly supportive-expressive group therapy and educational materials. Primary analyses based on all available data indicated that participants in the treatment condition showed a significantly greater decline in traumatic stress symptoms on the IES, (effect size = .25) compared with the control condition, but there was no difference in POMS total mood disturbance. However, when the final assessment occurring within a year of death was removed in a secondary analysis, there was a significantly greater decline in both total mood disturbance (effect size = .25) and traumatic stress symptoms (effect size = .33) for the treatment condition compared with the control condition.

Women in the treatment group showed a significant decrease in mean Courtauld Emotional Control Scale (CECS) scores (measuring emotional suppression) over 12 months when compared with the women in the control condition. Using ANOVA, we observed a significant relationship between decrease in suppression on the CECS and decrease in PTSD symptoms on the Impact of Event Scale (IES) [$t(3,93)=4.0$, $p<.0001$]. We also found that increasing emotional self-efficacy on the Stanford Self-Efficacy for Serious Illness Scale (SSESI) was associated with decreasing IES scores [$t(3,61)=4.08$, $p<.0001$]. These findings confirm earlier observations that suppression of emotion is associated with higher distress among cancer patients, despite their tendency to under-report their distress. Thus, emotional expression in a supportive group environment enhances the management of disease-related emotion, reduces distress, and enhances social support. Data on the relationship between loss of social support and loss of normal diurnal cortisol rhythms will also be presented that have implications for effects of stress and support on survival time.

Conclusions: These findings suggest that supportive-expressive therapy, with its emphasis on providing support and helping patients face and deal with their disease-related stress, can help reduce distress among metastatic breast cancer patients.

No. 72B
IMPACT OF GROUP THERAPY ON ANTICANCER TREATMENT ADHERENCE

David W. Kissane, M.D., *Department of Psychiatry, Memorial Sloan-Lettering Cancer Center, 1242 Second Avenue, New York, NY 10021;* David M. Clarke, Ph.D., Graeme C. Smith, M.D., Brenda Grabsch, B.S.W.

SUMMARY:

The clinical application of supportive-expressive group therapy (SEGT) will be discussed from the perspective of the therapists taking part in the Melbourne randomized controlled trial involving 237 women with advanced breast cancer. The structure and framework of therapy, key issues that develop in exploring its common

themes, and what constitutes a well functioning group will be explored. The mature group process transforms existential ambivalence into creative living, evidenced by humor, celebration, assertiveness, altruism, new creative pursuits, and, eventually, courageous acceptance of dying. Some challenges and pitfalls in the application of SEGT include mechanisms of avoidance, noncontainment of ambivalence, intolerance of difference, anti-group phenomena, and splitting. Groups move through identifiable developmental phases. Exploration of health beliefs about cancer, its treatment, how to cope with side effects, and how to assess the evidence for the efficacy of anti-cancer treatments is crucial. This "medicalization" of the group culture promotes compliance with anti-cancer treatments, including both the initiation of and perseverance with chemotherapy. Such a mechanism may prove to be an important pathway to improving survival.

No. 72C
MINDFULNESS-BASED STRESS-REDUCTION GROUPS

Susan E. Abbey, M.D., *Department of Psychiatry, Toronto Hospital, University Health, 200 Elizabeth Street, 8EN-212, Toronto, ON M5G 2C4, Canada*

SUMMARY:

Mindfulness-based stress-reduction (MBSR) groups are growing in popularity and are an increasingly widespread form of therapy despite the relative lack of research evaluating this modality. MBSR provides intensive training in meditative awareness complemented by psychoeducational and cognitive therapy perspectives to groups of 12 to 30 participants over a 9- to 10-week program. This paper will review the structure and function of MBSR groups and the indications and contraindications for its use. The ways in which MBSR groups are similar to and different from other group therapies will be described. Data will be presented from 400 participants treated in a hospital-based program in a universal health care system.

Methodology: Self-report ratings pre and post program using SCL-90, CES-D, SF-36, Medical Symptom Checklist, Illness Intrusiveness Rating Scale, and visual analogue scales were collected from participants and were compared using two-tailed tests with a Bonferroni correction for multiple comparisons and a significance level of $p < 0.001$.

Participants: 483 individuals requested information about the program, 334 attended introductory sessions, and 322 participated in classes. Women outnumbered men 3:1. Participants' ages ranged from 23 to 79 with a mean age of 48.6 (sd 11.8). The self-identified primary reason for program participation was coping with chronic major medical illness or pain in 26.6%, recurrent major depression in 14.4%, and chronic life stressors and anxiety in 59%.

Results: 96% of participants who come to an information session go on to take the program and 93% of those who begin the program complete it. Robust and clinically significant pre-post treatment improvements are shown in terms of decreased physical and emotional distress, improved quality of life, and greater sense of general well-being, optimism, and control. These differences are obtained for less than $300 per participant, which is less than the cost of three individual sessions of counseling or psychotherapy.

No. 72D
PSYCHIATRIST-LED GROUP PSYCHOTHERAPY FOR THE CHRONICALLY MENTALLY ILL

Leslie H. Gise, M.D., *Department of Psychiatry, University of Hawaii, 1035 Naalae Road, Kula, HI 96790;* Annette Crisanti, Ph.D., Robert Randall, Ph.D., Dana Kiyabu, R.N., Travis Ho, B.A.

SUMMARY:

Psychiatrist-led outpatient group psychotherapy for the chronically mentally ill has been underutilized and understudied. Group is non-threatening, allows more frequent visits, a better therapeutic alliance, and facilitates early intervention. It was hypothesized that group treatment would be associated with less psychiatric hospitalization.

A retrospective cohort study was conducted of all patients (n= 608) treated at a community mental health center over three years. Patients attending group were compared with patients receiving usual care. Mean age 41 ± 14; 54% female; 78% single; 44% Caucasian, 24% Asian, 17% Hawaiian and other Pacific Islander; 47% mood disorder, 43% schizophrenia. Group patients (n=101, 17%) did not differ from those receiving usual care with regard to age, gender, ethnicity, marital status, diagnosis, or severity of illness. Group patients had significantly (p=.001) longer duration of treatment (27 months) compared with controls (22 months), especially for those with schizophrenia. Group patients had significantly (p=.046) shorter duration of hospitalization (14 days per year) compared with controls (25 days per year), especially for those with mood disorders.

The association of retention in treatment and shorter hospitalization with group therapy should be further investigated with a randomized, controlled trial. A mediating factor is likely medication adherence.

No. 72E
GROUP THERAPY FOR SUBSTANCE ABUSE

David W. Brook, M.D., *Department of Community and Prevention Medici, Mt. Sinai School of Medicine, One Gustave Levy Place, Box 1044A, New York, NY 10029*

SUMMARY:

Group psychotherapeutic approaches form a major method of treatment for substance abusers and this topic is of critical importance for the treatment of people at risk for substance abuse. Theoretical and technical issues will be presented that are relevant to both the evaluation and treatment of substance abusers using a variety of group approaches.

Group approaches discussed will include multiple family therapy groups, cognitive-behavioral groups, network therapy, modified psychodynamic group therapy, relapse prevention groups, behavioral-educational groups, harm-reduction groups, and self-help groups. A broad overview of the current literature will be presented, and a developmental approach will be used to look at risk and protective factors and their relationship to group treatment approaches. Issues involving comorbidity will be addressed, as will the uses of group approaches in a variety of settings, including inpatient, outpatient, and partial hospitalization.

No. 72F
GROUP INTERVENTIONS FOR PSYCHOLOGICAL TRAUMA AND TERRORISM

Henry I. Spitz, M.D., *Department of Psychiatry, Columbia University, 1011 Central Park West, New York, NY 10023–4204*

SUMMARY:

Psychological trauma has always been a source of concern for the mental health field. Following the terrorist attacks on 9/11, a dramatic expansion in the use of diverse group models with specific trauma-exposed populations has developed.

Out of this work has come a better understanding of the timing, form, and focus of group interventions. Similarly, an appreciation of how groups might be deleterious is also being clarified. A body of evidence-based research has emerged differentiating among the possible forms of therapeutic and educational models in the group

setting and for whom these tecyhniques are most appropriate. The focus of this presentation will be to present a clinically centered overview of group work with trauma survivors with special emphasis on problems related to terrorist events. A brief review of the group trauma literature will be followed by a presentation of several representative group formats that have shown promise in studies to date.

Since trauma work in groups is stressful for group leaders as well as group members, issues related to burn-out, retraumatization, single/multiple leadership, and therapist self-care will be highlighted as well.

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SYMPOSIUM 73—DISSOCIATIVE DISORDERS: ISSUES OF CULTURE AND ISSUES OF TRUST

Association for the Advancement of Philosophy and Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize several culture-bound presentations of dissociative disorders, understand the cultural limitations in DSM-IV definitions of dissociative syndromes, and discuss the consequences of cultural attitudes on the development of trust in the doctor-patient relationship.

No. 73A
DIVERSITY IN PRESENTATION OF DISSOCIATIVE DISORDERS IN TURKEY

Vedat Sar, M.D., *Department of Psychiatry, Istanbul University, 1st Tip F. Psikiyatri Klinigi Capa, Istanbul 34390, Turkey*

SUMMARY:

Dissociative disorders can present within various clinical syndromes as the prominent reason for psychiatric admission. Chronic resistant depression, conversion disorder, "hysterical psychosis," and conditions mimicking borderline personality disorder are the most prevalent presentation forms in Turkey. A screening study among psychiatric outpatients in a Turkish university clinic demonstrated that two-thirds of cases who fit DSM-III-R borderline personality disorder criteria had a concurrent DSM-IV dissociative disorder on Axis I. A follow-up study in Turkey demonstrated that half of the outpatients with conversion disorder had a DSM-IV dissociative disorder. These subjects had higher overall psychiatric comorbidity, suicide attempts, self-mutilation, and history of childhood trauma. Despite the diversity of clinical phenomenology, dissociative subjects have the common feature of multiple self states, i.e., subjective experience of multiple realities. Thus, based on clinical experiences in Turkey, a new model of mind is proposed here: structural dissociation of the self. This model differentiates sociological self from psychological self, which are related to different sociological and psychological realities. Trauma and dissociation are correlated with enlargement of sociological self, whereas successful psychotherapy leads to a shift toward psychological self. Trust in psychotherapeutic relationship is strongly related to understanding of patient's subjective realities by the therapist.

No. 73B
DIFFERENCES BETWEEN WESTERN AND SOUTH AFRICAN MODELS OF DISSOCIATION

Christa Kruger, M.D., *Department of Psychiatry, University of Pretoria, PO Box 667, Pretoria 0001, South Africa*

SUMMARY:

If we assume that dissociation is a universal phenomenon, its study in multicultural South Africa presents a series of challenges. DSM-IV and Western models of mental illness rely mainly on description of symptoms. In contrast, African models rely mainly on explanation or etiology. For example, the culture-bound syndrome of *amafufunyana* refers to possession by evil spirits. In African models, subjective experiences are neglected, and observable behavioral changes can fit various DSM-IV categories including the dissociative disorders. Furthermore, existing scales of dissociation can only be used in South Africa where clients have developed sufficient familiarity with Western concepts such as depersonalization and identity fragmentation, and with Western language describing these concepts. The translation of existing scales into South African languages is also problematic. Although 11 languages have official status, the most common spoken language—representing various mixtures of languages, and identified as various "Township languages"—have no formal written equivalent for questionnaires. Moreover, some dissociative terms, e.g., "unreal," do not exist in some local languages. Such terms would require culturally appropriate interpretation, rather than straightforward translation. Developing descriptive psychiatry in South African languages and focusing more on explanatory theories of dissociation would facilitate cross-cultural negotiation of meaning.

No. 73C
DISSOCIATION, TRANCES, AND TRANSCENDENCE: CULTURAL VALUES AND THEIR EFFECTS ON TRUST

Nancy L. Potter, Ph.D., *Department of Philosophy, University of Louisville, Louisville, KY 40292*

SUMMARY:

Dissociation is described as a kind of "altered state," with symptoms that include trance states, perceptual distortions, and depersonalization. Dissociative reactions are characterized by splitting off from awareness aspects of self, experience, or memory, interrupting normal integrated awareness and identity. But research in medical anthropology suggests that altered states are desirable in some cultures. For example, indigenous tribal members may induce religious trances to commune with spirits and receive guidance; others use pharmaceuticals to enhance spiritual communion. Many followers of Eastern religions meditate to achieve transcendence that resembles dissociative states. In each case, the effects may look similar to

dissociative states. These data raise two central conceptual questions that this paper investigates: (1) Can the etiology of dissociation be separated from the classification of dissociation as a symptom of mental illness? Mental illness versus useful capacity? and (2) What is good about being "present" and "integrated" such that being in an altered state is, in certain contexts, disvalued? Cultural attitudes about the value or disvalue of altered states affect trust: in particular, American distrust of dissociative states impedes trust between clinicians and patients. I offer a set of questions clinicians can use to uncover underlying assumptions that impede trust.

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SYMPOSIUM 74—NEUROPSYCHIATRY OF TRAUMATIC BRAIN INJURY: CURRENT RESEARCH
American Neuropsychiatric Association

EDUCATIONAL OBJECTIVES:

This symposium will provide the attendee with current cutting-edge research in the neuropsychiatry of traumatic brain injury, which will result in improved ability to evaluate and to treat these individuals.

No. 74A
THE CHOLINERGIC HYPOTHESIS OF COGNITIVE IMPAIRMENT DUE TO TRAUMATIC BRAIN INJURY

David B. Arciniegas, M.D., *Department of Psychiatry, University of Colorado, 4200 East Ninth Avenue, C268-25, Denver, CO 80262*

SUMMARY:

Cognitive impairments are among the most common neuropsychiatric sequelae of TBI at all levels of severity. Cerebral cholinergic neurons and their ascending projections are particularly vulnerable to traumatically-mediated dysfunction, both acutely and chronically. In light of the important role of acetylcholine in arousal, attention, memory, and other aspects of cognition, cerebral cholinergic systems both contribute to and may also be a target for pharmacologic remediation among persons with posttraumatic cognitive impairments. This article will review the evidence in support of this hypothesis. Studies of cholinergic dysfunction in experimental injury models, including evidence of relatively selective damage to cholinergic injury, the development of persistent anticholinergic sensitivity, and the effects of cholinergic augmentation on memory performance, are presented first. Thereafter, neuropathological, electrophysiologic, and pharmacologic evidence of cholinergic dysfunction following TBI in humans is reviewed. Finally, future directions for investigation of the cholinergic hypothesis and possible clinical applications of this information are discussed.

No. 74B
CATECHOLAMINERGIC DYSFUNCTION AFTER TRAUMATIC BRAIN INJURY: IMPACT ON COGNITION

Thomas McAllister, M.D., *Department of Psychiatry, Dartmouth Medical School, One Medical Center Drive, Lebanon, NH 03756;* Laura Flashman, Ph.D., Brenna McDonald, Psy.D., Heather Wishart, Ph.D., Richard B. Ferrell, M.D., Andrew Saykin, Psy.D.

SUMMARY:

Problems with memory and attention are the most common complaints after TBI and result in significant disability. Understanding the neural circuitry and neurochemistry underlying these impairments will improve our ability to design appropriate treatment interventions.

Evidence from both animal models and human clinical findings suggest that catecholaminergic systems, particularly the dopaminergic (DA) and alpha-2 adrenergic (A2A) systems, play important roles in the activation and modulation of information processing speed, memory, and attention. This paper presents recent work that uses functional MRI (fMRI) to delineate the role of DA and A2A systems in the modulation of cognitive function after mild and moderate TBI (MTBI). Individuals with MTBI approximately one month after injury, and healthy controls receive a DA agonist, an A2A agonist, or placebo in a randomized, double-blind, crossover design, 2.5 hours before performing memory and attention testing while undergoing fMRI.

Individuals with MTBI show modest cognitive deficits at baseline, and respond differently to the DA and A2A agonists. Furthermore, they have a different pattern of brain activation relative to controls, suggesting that the MTBI group has subtle changes in catecholaminergic systems one month after injury that may have implications for pharmacological management.

No. 74C
TRAUMATIC BRAIN INJURY, GENE EXPRESSION, AND RISK FOR SCHIZOPHRENIA

Dolores Malaspina, M.D., *Department of Psychiatry, Columbia University-NY Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032;* Cheryl M. Corcoran, M.D., Jill Harkavy-Friedman, Ph.D., Raymond Goetz, Ph.D., David J. Printz, M.D., Roberto Gil, M.D.

SUMMARY:

While traumatic brain injury (TBI) has been observed to precede the onset of schizophrenia-like psychoses since the early 20th century, accumulating evidence shows TBI may play a greater role in causing schizophrenia in those who have genetic schizophrenia susceptibility. We found that TBI doubled illness risk in schizophrenia pedigree members without increasing risk in bipolar pedigree members. A statistical model of gene environment interaction best explained these data. Results from our large clinical series study of schizophrenia patients demonstrate that patients with and without TBI have similar symptoms and performance IQ, but the TBI group shows a higher verbal IQ and better performance on Wechsler memory verbal, visual, attention, and delayed scales (although still impaired). These results are only superficially paradoxical; because the TBI insult occurred later in life than a corresponding prenatal insult, greater information could be acquired and cognitive skills developed before disease onset in the TBI group. Elegant mouse models of TBI demonstrate that a progressive deterioration of learning capacity and ventricular enlargement following a discrete TBI-type lesion are accompanied by gene expression changes. These data are consistent with a primary role for TBI in the etiology of schizophrenia by modifying the expression of underlying genes.

No. 74D
BLAST INJURIES TO THE BRAIN: ARMED FORCES INJURED DURING OPERATION IRAQI FREEDOM

Deborah Lee Warden, M.D., *Department of Neurology, DVBIC WRAMC, PO Box 59181, Washington, DC 20012;* Louis M. French, Psy.D., Elisabeth Moy-Martin, R.N.C., Robert J. Labutta, M.D., James M. Ecklund, M.D.

SUMMARY:

Objective: To present information on soldiers who received blast injury to the head. With increasing terrorist incidents, both in Iraq and other parts of the world, more individuals will be seeking care after sustaining such a traumatic brain injury (TBI), though blast injuries are not well described in the literature.

Method: Description of overpressurization blast mechanism of injury and specific injuries received from land mines, rocket-propelled grenades, and other explosives. Injury data were obtained from referrals and screening interviews at the military tertiary care hospital receiving many of the war wounded. Approximately 100 active duty have received care at Walter Reed for injuries that include concussive or more severe brain injury.

Results: Injury data are currently being compiled.

Conclusion: Returning soldiers who have sustained blast injuries may require care for TBI. Injury from overpressurization waves, as encountered during blast injury, has not been previously well described. Implications for civilian disasters involving blast injury will be included.

No. 74E
MULTICENTER, PLACEBO-CONTROLLED TRIALS IN TRAUMATIC BRAIN INJURY: A WORK IN PROGRESS

Jonathan M. Silver, M.D., *Department of Psychiatry, Lenox Hill Hospital, 1430 2nd Avenue, Room 103, New York, NY 10021-3313*

SUMMARY:

Neuropsychiatric sequelae of traumatic brain injury, including cognitive and affective disorders and irritability are common, and are treated with a number of psychopharmacologic agents. There is a large literature that is comprised of case reports and uncontrolled trials. While the "gold-standard" of evidence for pharmacotherapy is the multicentered, double-blind, placebo-controlled trial, these have never been completed in this population. This presentation will review the problems with the current literature, and issues important in the design of studies of individuals with traumatic brain injury. This includes diversity of etiology, severity, and length of time since injury, comorbid conditions, as well as facility site and experience of investigators.

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SYMPOSIUM 75—PSYCHIATRY, ETHNICITY, AND CULTURE: AN UPDATE ON ETHNOPSYCHOPHARMACOLOGY, MOOD, AND ANXIETY DISORDERS IN MINORITY POPULATIONS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize the cross-cultural differences in the clinical presentation of mood and anxiety disorders and understand the differential treatment issues in minority populations.

No. 75A
ETHNOPSYCHOPHARMACOLOGY UPDATE

David C. Henderson, M.D., *Department of Psychiatry, Massachusetts General Hospital, 25 Staniford Street, Boston, MA 02114*

SUMMARY:

This presentation will provide an understanding of basic psychopharmacology principles and the impact of race, sex, and culture on metabolism, response, adverse events, medication interactions and medication compliance. Ethnopsychopharmacology examines biological and non-biological differences across race, ethnicity, sex, and culture and is critical for safe prescribing practices. A growing body of published evidence is documenting important inter- and intra-group differences in how patients from diverse racial and ethnic backgrounds experience health and illness; and is affected by pharmacologic treatment. Recommendations will be provided to improve compliance, reduce adverse events, and medication interactions, and to improve clinical outcomes. Depression and anxiety are among the most common medical/psychiatric disorders and occur across all populations, though symptom clusters may vary greatly. Pharmacologic interventions are critical in the treatment of depression. An expanded understanding of the interactions between psychopharmacological treatment and gender, ethnic and cultural diversity informs conceptualizations of psychopharmacological treatments of various populations. This paper will review principles of ethnopsychopharmacology and highlight issues influenced by race, gender, and culture in the pharmacologic treatment of depressive disorders and anxiety disorders.

No. 75B
TREATMENT OF ANXIETY AND DEPRESSION AMONG CHINESE AMERICANS

Albert Yeung, M.D., *Department of Psychiatry, Massachusetts General Hospital, 50 Standord Street, Suite 401, Boston, MA 02114*

SUMMARY:

Both culture and biological factors can have a strong impact on treatment of anxiety and depression. Culture influences illness beliefs and symptom presentation of Chinese Americans. They tend to view mental illnesses as an embarrassment, delay seeking psychiatric care, and express their problems in somatic terms. Many Chinese Ameri-

cans are slow metabolizers of specific antidepressant agents, and may show response at lower doses. Clinical experience and the small number of published studies suggest that Asian Americans tend to tolerate newer antidepressants well.

No. 75C
PSYCHIATRIC MANAGEMENT OF HISPANIC PATIENTS: CROSS-CULTURAL ISSUES AND ETHNOPSYCHOPHARMACOLOGY

David Mischoulon, M.D., *Department of Psychiatry, Massachusetts General Hospital, 50 Staniford Street Suite 401, Boston, MA 02114*

SUMMARY:

Increasing numbers of psychiatrists work with Hispanic patients, either on a regular basis through their outpatient clinic, or by serving as consultants to general internists who are called upon to manage psychiatric disorders in patients seen in the primary care setting. This session will review the demographics of the Hispanic-American population; discuss the different challenges and obstacles faced by clinicians who work with Hispanics, including the language barrier, cultural and interpersonal factors, gender roles, and differing beliefs and attitudes about mental health; review difficulties in diagnosis, including the impact of culture-bound syndromes (such as ataque de nervios, and susto) on assessment; and review different approaches to treatment, including relevant principles of ethnopsychopharmacology, and the role of natural remedies and folk healing. The topics covered should allow the clinician to effectively diagnose and treat psychiatric disorders in Hispanic patients and communicate more effectively with these patients in the clinical setting.

No. 75D
DEPRESSION AND ANXIETY IN WOMEN: AN UPDATE ON CROSS-CULTURAL ASPECTS AND PHARMACOLOGIC STRATEGIES

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

SUMMARY:

The impact of sex hormones on brain functioning has been frequently cited as one of the factors that strengthen gender differences observed in the prevalence, outcome, and response to treatment of mental disorders. Interestingly, such differences become more noticeable with the onset of puberty and physical maturation, when girls undergoing physical and hormonal changes frequently report higher levels of emotional distress and affective instability. Accumulating data suggest that periods of heightened hormonal variability (i.e., premenstrual periods, puerperium, and the menopausal transition) would increase the vulnerability to depression among subgroups of women. It is therefore intuitive that hormone aspects should be taken into account while planning treatment strategies for reproductive-related mood and anxiety disturbances. In addition to gender-related aspects of psychiatric disorders, it has been postulated that demographic characteristics, cultural factors, and habits may influence the occurrence and symptom profile of mood and anxiety in women.

This presentation will review in detail data from community-based and clinic-based studies on gender-related characteristics and cross-cultural aspects of mood and anxiety in women, with particular emphasis on premenstrual symptoms (or premenstrual worsening of underlying psychiatric conditions), as well as symptoms occurring during the transition to menopause.

No. 75E
CULTURAL DIFFERENCES IN THE DIAGNOSIS AND TREATMENT OF MOOD AND ANXIETY DISORDERS: CONSIDERATIONS IN THE ASIAN INDIAN POPULATION

Rajesh M. Parikh, M.D., *Department of Psychiatry, Jaslok Hospital Research Center, 15 Dr. G. Deshnukh Marg, Bombay 400026, India;* Shamsah B. Sonawalla, M.D.

SUMMARY:

Asian-Americans from the Indian subcontinent are a growing ethnic group in the U.S., representing about 8% of the population. This subgroup of individuals have their own set of cultural norms, family traditions, and religious belief systems, with diversity within subgroups. All these factors may influence manifestation of depression and impact treatment outcome. Mood and anxiety disorders are under-diagnosed and under-treated in this population, and mental illness is frequently viewed as an embarrassment or stigma. Young women often face unique pressures in the system, both from the family as well as from society. Family involvement is important in all stages of treatment of mental illness, including interactions with the treating physician and compliance with treatment. Herbal remedies and alternative treatments are widely used. Data on ethnopsychopharmacology, although limited, suggest differences in metabolism, dose requirements, and adverse-event profiles for antidepressant medications in this population. Understanding the complex cultural belief systems may allow clinicians to assess some of the cultural factors in treatment and potentially increase treatment acceptability and compliance, particularly with antidepressant medications. Suggested modifications for managing depression in the Indian population will be discussed. Findings from cross-cultural studies comparing depression in college students in India and the U.S. will be discussed.

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2. Kleinman A: Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry. University of California Press, Ltd. London, England, 1980.
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4. Lock M, Kaufert M: Menopause, local biologies, and cultures of aging. Am J Hum Biol 2000; 13:494–504.
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SYMPOSIUM 76—ADOPTING EVIDENCE-BASED PRACTICE IN THE TREATMENT OF MOOD DISORDERS: THE CANADIAN EXPERIENCE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the main challenges encountered in the Canadian experience with adopting evidence-based practice.

No. 76A
TREATING DEPRESSION EFFECTIVELY: APPLYING CLINICAL GUIDELINES

Sidney H. Kennedy, M.D., *Department of Psychiatry, University Health Network, 200 Elizabeth Street, 8-EN Suite 222, Toronto, ON M5G 2C4, Canada*

SUMMARY:

In 2001, Clinical Guidelines for the Treatment of Depressive Disorders, developed by the Canadian Network for Mood and Anxiety Treatments (CANMAT), were published by the Canadian Psychiatric Association. These and other evidence-based guidelines incorporate new developments, particularly in the diagnosis and treatment of depressive disorders, including advances in combination pharmacotherapies and psychotherapy with pharmacotherapy in treatment-resistant depression. Despite these and other advances, there is still a substantial gap in the transfer of knowledge to health care teams and implementation of optimal management strategies. Under-detection and under-treatment of mood disorders continue to be responsible for sizeable economic and health care burdens. This presentation will address the necessary conditions for a successful implementation of guidelines, drawing parallels from chronic medical disorders, such as diabetes and rheumatoid arthritis. Presentation of information that is practical, easy to access, and specific to target populations is essential for any guidelines initiative. Special issues in treating depression in women, children, and adolescents and in the elderly will be selected to illustrate the role of the guidelines. Attention to implementation projects and funded grants to adopt the evaluation of guidelines into standard practice are important components of a longitudinal strategy.

No. 76B
STRATEGIES TO ENHANCE MENTAL HEALTH CARE IN THE PRIMARY CARE SECTOR: WORKING WITH FAMILY PHYSICIANS

Sagar V. Parikh, M.D., *Department of Psychiatry, Toronto Western Hospital, 399 Bathurst Street, Toronto, ON M5T 2S8, Canada*

SUMMARY:

The majority of mental health disorders worldwide are seen and treated in primary care settings. Primary care physicians, mostly family physicians (FP), face multiple obstacles to providing evidence-based care. This paper will describe three different types of interventions: (1) shared care, where the psychiatrist visits the FP office; (2) a pilot program both to educate and support the FP, while providing time-limited care to the patient; and (3) a new World Health Organization education toolkit for FPs to assist them in delivering mental health care. Each of these programs has been designed and implemented in various Canadian settings, and outcome measures at the level of the FP and the patient are available. Since each of these programs requires a very different level of commitment to resources and staff, the participant will be able to identify a strategy for working with FPs that will be applicable to his or her own practice setting.

No. 76C
EVIDENCE-BASED PRACTICE LEADS TO IMPROVED EFFICIENCY IN THE WORK OF A SPECIALIZED MOOD-DISORDERS SERVICE

Roumen V. Milev, M.D., *Department of Psychiatry, PCC, Mental Health Services, 752 King Street West, PO Box 603, Kingston, ON K7L 4X3, Canada;* Gaby Abraham, M.D., Fia Voutsilakos, M.D.

SUMMARY:

Background: The Mood Disorders Service in Kingston is a regional provider of specialized services for treatment-resistant and/or chronic mood disorders with or without comorbidity. It serves a mixed urban and rural region with a population of approximately 800,000. It has over 30 staff and is fully affiliated with the academic department of psychiatry at Queen's University. It has an inpatient unit with 12 beds, an outpatient service with approximately 250 active outpatients, a day program with an average of 30 attendees, electro-convulsive therapy (ECT) and transcranial magnetic stimulation (TMS) facilities, and a community outreach component of the service. Staff are also active in teaching and research.

Results: Following an external review of the work, a number of changes were implemented, allowing for average length of stay to reduce from 96 to 58 days, bed occupancy increased from 60% to 96%, new referrals and consultations increased from five to 25 per month, and there was a significant increase in outreach and research activities.

Conclusion: Adopting evidence-based practice in a specialized mood disorders service is challenging, but leads to significant improvement in the efficiency and quality of the service.

No. 76D
TRANSLATING RESEARCH INTO PRACTICE: THE APPLICATION OF CLINICAL GUIDELINES IN MOOD DISORDERS

Valerie Taylor, M.D., *Department of Psychiatry, Mood Disorders Unit, St. Joseph's Heath Center, 100 West Fifth Street, Box 585, Hamilton, ON L8N 3K7, Canada;* Glenda M. MacQueen, M.D.

SUMMARY:

A number of clinical guidelines now exist for the treatment of major depression, including published guidelines. This presentation will examine several factors relevant to implementing such guidelines in tertiary and non-tertiary care settings. First, we will examine the evidence for whether implementing clinical guidelines is, in fact, associated with improved outcome in the treatment of depression. We will briefly review the available published guidelines for treatment of major depression. Then we will examine the concept and components of best practice. Using the experience of the mood disorders program in the department of psychiatry at McMaster University as a template, we will review some of the competing demands on clinicians' time when they try to either conduct research or implement research-based best practice guidelines. We will examine factors that appear to be necessary conditions for facilitating a programmatic move to research-based clinical work (implementing an innovation), including the importance of buy-in from all levels of staff, the role of change champions, and the role for evaluation of the innovation. Finally, we will discuss several practical strategies that may be useful for implementing and evaluating the utility of best practice guidelines in mood disorders clinics.

No. 76E
DEVELOPING A COMMUNITY-BASED STRATEGY FOR DEPRESSION: THE BRITISH COLUMBIA EXPERIENCE

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

SUMMARY:

Systemic change in community management of depression is notoriously difficult. Several large pragmatic community studies have shown how difficult it is to demonstrate changes in outcomes with

community and physician interventions. Many of these studies have been conducted in large health maintenance organizations in the United States, or in primary care clinics in the United Kingdom. However, these settings are very different from health care systems in other countries, so it is difficult to generalize findings from these studies into other practice settings. This presentation will describe the ongoing development and implementation of a provincial depression strategy in British Columbia, a Canadian province of 3.5 million people. The strategy involves a diverse number of participants, but is led by the university mental health services research and mood disorders units. The strategy is based on chronic disease management models, with elements including public education, clinical guidelines for primary care, "shared care," self-management, and telehealth. Resources and educational programs for clinicians will be discussed. Problems and (possible) solutions encountered by the project team may be helpful for those in other settings who are trying to implement community evidence-based management programs for depression.

REFERENCES:

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2. Kates N, Craven M Crustolo AM, Nikoloau L: Mental health services in the family physician's office: a Canadian experiment. Isr J Psychiatry Relat Sci 1998; 35(2):104–13.
3. Damodaran L, Wilson A: Developing a Research Centre Training Strategy: A Handbook for Professional Development. Loughborough University, 1995.
4. To A, Oetter H, Lam RW: Treatment of depression in primary care. Parts 1 and 2. British Columbia Medical Journal 2002; 44:471–482.

SYMPOSIUM 77—IMPACT OF TRAUMA AND LIFE STRESS IN BIPOLAR DISORDER

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will gain familiarity with the nature, prevalence, and features of trauma and psychosocial stress in bipolar patients, and their ramifications for clinical presentation, disease pathology, and treatment.

No. 77A
PSYCHOSOCIAL STRESS AND VULNERABILITY TO AFFECTIVE RELAPSE

Michael J. Gitlin, M.D., *Department of Psychiatry, UCLA, 300 UCLA Medical Plaza, #2200, Los Angeles, CA 90095*

SUMMARY:

Mood disorders, both manias and depressions, lead to poorer psychosocial function, as measured by either role function (e.g., work, school, taking care of children and home) or interpersonal (friendships, social networks, love relationships, family relationships) function. Conversely, psychosocial stress, whether measured by chronic stresses or by specific (usually negative) life events are associated with higher relapse risk in all patients with mood disorders, both bipolar and unipolar. Thus, the relationship between episodes and stresses is best conceptualized as circular, with episodes leading to functional disruption, and stressful lives and functional disruption leading to a greater likelihood in episodes. This conceptual scheme implies the possibility of therapeutic intervention—both somatic and psychological—at a number of different points to interrupt this vicious cycle. This presentation will discuss this issue in some depth. Additionally, functional recovery from affective episodes is markedly delayed compared with syndromal recovery. Potential reasons for this are many and will be discussed along with the implications for treatment.

No. 77B
CHILDHOOD TRAUMA AND OUTCOME IN BIPOLAR PATIENTS

Joseph F. Goldberg, M.D., *Department of Psychiatry, Zucker Hillside Hospital, 79–59 263rd Street, Glen Oaks, NY 11004;* Jessica L. Garno, Ph.D.

SUMMARY:

The deleterious effects of childhood trauma on the course of affective disorders has only recently become the focus of empirical study. Little is known about the prevalence and subtypes of childhood abuse among bipolar patients relative to other psychiatric disorders, or the impact of childhood traumas on varied dimensions of outcome.

This presentation will summarize current information about known clinical correlates of childhood abuse in bipolar patients as described from contemporary investigations. Particular attention will be paid to the role of sexual versus physical or emotional abuse and their impacts on relapse, cyclicity, suicidality, and comorbidity. New findings from the Cornell Bipolar Research Program indicate that severe childhood abuse histories are evident in about half of adult bipolar patients. Childhood abuse appears linked with the eventual development of comorbid substance use disorders as well as cluster B Axis II disorders. Formal posttraumatic stress disorder arose in about one-third of childhood abuse survivors, particularly following sexual abuse. Childhood sexual abuse survivors were more likely to experience adult sexual or physical assaults and to make multiple suicide attempts.

Clinical diagnostic and therapeutic implications of these findings will be discussed in light of possible mechanisms underlying disease progression for bipolar illness.

No. 77C
BIPOLAR DISORDER AND THE FAMILY ENVIRONMENT

David Miklowitz, Ph.D., *Department of Psychology, University of North Carolina, Davie Hall, CB#3270, Chapel Hill, NC 27599-3270*

SUMMARY:

There is increasing evidence that social-environmental factors affect the course of bipolar disorder. This presentation will discuss the impact of caregivers' "expressed emotion" (EE) attitudes on clinical outcome among adult and childhood-onset bipolar patients. Several studies indicate that, over one to two year periods of follow-up, patients from high EE households are more likely to relapse or show significant mood disorder symptoms than patients from low EE households. New data shed light on why some relatives are highly critical and others are not. For example, relatives who score high on EE criticism or hostility often express the belief that the patient could do more to control his or her negative behavior. Studies of family interaction indicate that high EE attitudes among relatives during an acute bipolar episode predict negative relative/patient interaction patterns during a post-episode period. Finally, new data will be presented from the STEP bipolar program indicating that a brief self-report questionnaire of family criticism can be used in clinical practice settings to predict the one-year course of adult bipolar disorder.

No. 77D
NEUROFUNCTIONAL CORRELATES OF AFFECTIVE STRESSORS IN BIPOLAR PATIENTS

Caleb M. Adler, M.D., *Department of Psychiatry, University of Cincinnati, 231 Albert Sabin Way, Cincinnati, OH 45267-0559;* Stephen M. Strakowski, M.D., Scott Holland, Ph.D., Melissa P. DelBello, M.D.

SUMMARY:

Several recent studies of cognitive function in patients with bipolar disorder have observed specific attention and memory deficits that persist into periods of euthymia. Some of these cognitive deficits appear to be associated with length of illness, particularly frequency and duration of affective symptomatology, suggesting that affective episodes in patients with bipolar disorder are associated with neuropathologic changes. Patients with bipolar disorder have been observed to demonstrate multiple central nervous system structural abnormalities, and several studies have observed an association between these structural changes and the number of previous affective episodes. Compared with first-episode patients, bipolar patients with a history of multiple manic and depressed episodes show increased lateral ventricle size, suggestive of volume loss, as well as volumetric changes in structures involved in cognitive performance and mood regulation. Studies including unipolar and mixed depression populations have also reported affective episode-related structural changes impacting overlapping and complementary regions. While data addressing effects of other acute stressors on neuronal integrity in patients with bipolar disorder have been limited, stress has been widely associated with volumetric decreases in similar regions.

While limited, neurofunctional studies have been consistent with these structural findings. Several studies utilizing functional magnetic resonance imaging (fMRI) have demonstrated changes in frontal and medial temporal activation in patients with bipolar disorder. At least one study has demonstrated a significant correlation between the number of previous depressive episodes and activation of some frontal areas, and an inverse correlation with medial temporal activation. Studies examining white matter integrity in patients with bipolar disorder have been mixed, but recent studies utilizing diffusion tensor imaging (DTI) demonstrate evidence of white matter pathology and loss of axonal bundling in these patients. Preliminary analysis of these data suggest that at least some of these white matter changes are similarly correlated with the number of previous affective episodes. Together, these studies suggest that stressful events, including affective episodes, are associated with neuronal morbidity and derangement leading to deficits in associated cognitive domains. We will discuss the implications of these findings on the clinical care of patients with bipolar disorder, with particular emphasis on the importance of aggressive treatment intervention.

No. 77E
IMPLICATIONS OF THE KINDLING MODEL FOR AFFECTIVE RELAPSE

Robert M. Post, M.D., *Biological Psychiatry, National Institute of Mental Health, 10 Center Drive MSC 1272, Bethesda, MD 20892-1272;* Gabriele S. Leverich, L.C.S.W., Andrew M. Speer, M.D.

SUMMARY:

The major tenets of the kindling/sensitization model are: (1) that early stressors may be vulnerability factors to illness onset and recurrence; (2) that each episode increases the likelihood of the next (i.e., a shorter well interval between successive episodes); and (3) with multiple stressors and episode recurrences, stressors become less necessary as precipants, i.e., episodes occur more autonomously, (although there is an increased reactivity to stressors).

These postulates have been largely validated in unipolar recurrent illness in the work of Kessing et al., and Kendler et al. New data indicate that extreme environmental adversity in childhood (i.e., a positive history of physical or sexual abuse) is associated with an earlier onset of bipolar illness, more comorbidities, more suicide attempts, and more time ill (both retrospectively recalled and prospectively documented). These data, together with Kessing's findings that the number of prior bipolar depressions predicts a shorter latency to relapse, support postulates (1) and (2) above. A history of earlier adversity was not only associated with more stressors at illness onset, but also at the most recent episode, suggesting a stress generation, as well as sensitization process. These findings reemphasize the necessity of earlier intervention in those at highest risk in an attempt to decrease the occurrence and impact of both stressors and affective episodes, and thus, hopefully, program a more benign course of bipolar illness.

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2. Leverich GS, McElroy SL, Suppes T, et al: Early physical and sexual abuse associated with an adverse course of bipolar illness. Biol Psychiatry 2002; 51:288–297.
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5. Leverich GS, Perez S, Luckenbaugh DA, Post RM: Early psychosocial stressors: relationship to suicidality and course of bipolar illness. Clin Neurosci Res 2002; 2:161–170.

SYMPOSIUM 78—GAY AND LESBIAN ORTHODOX JEWS: A PRIMER FOR CLINICIANS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize the psychosocial challenges facing Orthodox gay and lesbian Jews and their families from the perspective of clinicians who treat this population, rabbis who counsel them, and a filmmaker who has documented their struggles to integrate religious and sexual identities.

No. 78A
ORTHODOX JEWISH GAYS AND LESBIANS: THE FILMMAKER'S PERSPECTIVE

Sandi Dubowski, *3413 Kapayette Street, PMB 302, New York, NY 10012;*

SUMMARY:

This presentation focuses on the experience of the director of Trembling Before G-d, a feature documentary that touches upon the meaning of religious identity and tradition in a modern world. The film, challenging assumptions about faith, sexuality, and religious fundamentalism, presents intimately-told personal stories of Hasidic and Orthodox Jews who are gay or lesbian. These are a group of people who face a profound dilemma—how to reconcile their passionate love of Judaism and the Divine with Biblical prohibitions that forbid homosexuality. In the process of filming, a range of

complex individuals—some hidden, some out of the closet—were encountered. Among them were the world's first openly gay Orthodox rabbi; closeted, married Hasidic gays and lesbians; those abandoned by religious families; and Orthodox lesbian high-school sweethearts—all forced to question how they can pursue truth and faith in their lives. The presentation recounts both the experience of making the film as well as how the film has sparked a lively, public debate in Orthodox circles on the issue of what to do about their gay and lesbian members.

No. 78B
FAILED REPARATIVE THERAPY OF ORTHODOX JEWISH HOMOSEXUAL MEN AND WOMEN

Abba E. Borowich, M.D., *Department of Psychiatry, Mount Sinai School of Medicine, 166 Valley Road, New Rochelle, NY 10804-3744*

SUMMARY:

This paper presents the author's experience of treating homosexual men and women with traditional Orthodox Jewish beliefs over the course of a 36-year career. Having identified some patients who appeared to have changed their homosexual orientations while undergoing therapy for other problems, the author attempted to apply whatever had seemed to benefit these patients to a proactive re-orientation "therapy" of others. He reasoned that Orthodox Jews would make a highly motivated population for change, given the enormous difficulties they faced in reconciling their sexual identities with their Orthodox beliefs and practices.

The results obtained did not support the hypothesis that such patients would change. What seemed to "work" in some patients' lives had no demonstrable effect on others. In some instances, even after 15 years of apparent sexual re-orientation, homosexual drives re-emerged under stressful or other conditions, dominating patients' lives and sometimes wreaking havoc on entire families. Although problematic to draw conclusions from limited samples, this author's lifetime experience with a number of Orthodox Jewish homosexuals sustains the generally held belief that reparative therapy of such individuals is an uncertain enterprise that can have disastrous effects on the individual and his or her family.

No. 78C
IDENTITIES IN CONFLICT: TREATING GAY AND LESBIAN ORTHODOX JEWS

Naomi Mark, M.S.W., *915 West End Avenue, #7D, New York, NY 10025*

SUMMARY:

As gay men and lesbians find greater acceptance in American society, traditionally observant gay and lesbian Jews have begun a complex and sometimes frightening process of negotiating their sexuality and identities within their religious communities. The author of this paper has extensive clinical experience with this patient population. Through use of clinical case examples and vignettes, this paper will explore the psychodynamics of those attempting to construct what was, until recently, an oxymoronic Orthodox Jewish *and* gay and lesbian identity. She will focus on how Orthodox gays come to terms with the inherent tensions and internal contradictions posed when trying to balance a traditionally Orthodox lifestyle and one that affirms their sexual identity. The paper describes how they attempt to resolve the value conflicts and the factors that contribute to their decision to remain in this difficult position. Also explored is the impact that the coming out process has on Orthodox family members such as parents, children, and a straight spouse, as their responses are examined in light of communal norms and mores. A review of the literature and a description of the formal and informal support networks is included.

No. 78D
GAYNESS AND GOD: THE GAY ORTHODOX RABBI'S PERSPECTIVE

Steven Greenberg, *210 West 101st Street, #7C, New York City, NY 10025*

SUMMARY:

The author is the first openly gay Orthodox rabbi whose presentation will focus upon the conflict between homosexual sexual identity and Orthodox religious commitment from two vantage points. First, is a review of the common, traditional responses gay and lesbian Orthodox Jews receive when they turn to rabbis for spiritual counsel. Following that, the author will present an alternative array of options available to rabbis and pastoral counselors who struggle between their desire to care for individuals and fulfill their role as protectors of Orthodox traditions. The paper addresses the limits and the opportunities within the Orthodox tradition to responsibly confront the dilemma that they face and those faced by their gay and lesbian congregants and their families.

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1. Balka C, Rose A: Twice Blessed: On Being Lesbian or Gay and Jewish. Boston, MA, Beacon, 1989.
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3. Drescher J: Psychoanalytic Therapy and the Gay Man. Hillsdale, NJ, The Analytic Press, 1998.
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SYMPOSIUM 79—PERSONALITY, THERAPEUTIC ALLIANCE, AND OUTCOME IN BRIEF PSYCHOTHERAPY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the relative contributions of patient and therapist personality, the therapeutic alliance to treatment outcome in three brief psychotherapies.

No. 79A
PERSONALITY, THERAPEUTIC ALLIANCE, AND OUTCOME IN SHORT-TERM DYNAMIC AND COGNITIVE-BEHAVIORAL PSYCHOTHERAPIES

Sarah Aderholt, M.D., *Department of Psychology, Baylor College, Menniger Clinic, 2801 Gessner Drive, Houston, TX 77280;* Elena Bruck, M.D., J. Christopher Muran, Ph.D., Arnold Winston, M.D.

SUMMARY:

This study examined patient and therapist personality, therapeutic alliance, and treatment outcome in short-term dynamic and cognitive-behavioral psychotherapies. Participants included 46 patient-therapist dyads. Personality was assessed by the Relationship Questionnaire, a self-report measure of attachment style, and the INTREX, a self-report measure of introject style. Therapeutic alliance was assessed by patient-and therapist-rated post-session questionnaires, which included the Working Alliance Inventory and the Session

Evaluation Questionnaire (among other scales). Treatment outcome was determined by patient and therapist-rated measures of symptomatology and adaptive and interpersonal functioning. Results indicated that affiliative introject style had the greatest predictive validity with regard to quality of alliance, resolution of ruptures, depth of exploration, and overall outcome. The predictive validity of several personality matches were also explored, using the principle of interpersonal complementarity. Implications for training and practice will be discussed.

No. 79B
PERSONALITY, THERAPEUTIC ALLIANCE, AND OVERALL OUTCOME IN BRIEF RELATIONAL THERAPY

Regina Biscoglio, M.A., *Department of Psychology, State University of New York, 131 Locust Lane, Irvington, NY 10533;* J. Christopher Muran, Ph.D., Paul Watchel, Ph.D., Bernard S. Gorman, Ph.D.

SUMMARY:

This study examined patient and therapist contributions to therapeutic alliance and outcome in 30-session, brief psychotherapy treatment for personality-disordered patients. It attempted to identify the role of personality factors on alliance, ruptures and their resolution, as well as on overall therapeutic outcome in a brief relational therapy. Participants included 39 patient-therapist dyads. Personality was assessed by the Relationship Questionnaire, a self-report measure of attachment style, and the INTREX, a self-report measure of introject style. Therapeutic alliance was assessed by patient and therapist-rated post-session questionnaires, which included the Working Alliance Inventory and Session Evaluation Questionnaire (among other scales). Treatment outcome was determined by patient and therapist-rated measures of symptomatology and adaptive and interpersonal functioning. Preliminary analyses replicated findings from the Aderholt et al. study, indicating the affiliative introject was most predictive. Personality matches, based on the principle of interpersonal complementarity, were explored with regard to therapeutic alliance and overall treatment outcome. Differences in the findings from the two studies were explored. Implications for training and practice will be discussed.

No. 79C
PATIENT-RATED ALLIANCE AND OVERALL OUTCOME IN BRIEF PSYCHOTHERAPIES

Christopher Stevens, Ph.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th Street, New York, NY 10003;* J. Christopher Muran, Ph.D., Jeremy D. Safran, Ph.D., Bernard S. Gorman, Ph.D.

SUMMARY:

The research literature has well established the therapeutic alliance as a robust predictor of psychotherapy outcome. In this study, the impact of both level and pattern of therapeutic alliance development in 44 therapeutic dyads seen in three different manualized, 30-session treatment conditions, was examined by looking at patient ratings on the Working Alliance Inventory (WAI) completed after each session. It was hypothesized that high level, a linear increase in ratings, or a series of brief repair episodes would be found in successful treatments. More global high-low-high pattern predicted in the literature were not expected to be present. Higher WAI levels were found to predict improved outcome, as determined by patient and therapist report. A global high-low-high pattern was not found to be predictive. Local tear and repair patterns and statistically significant linear trends were found in more than 50% of the cases. No relationship was found between outcome and either pattern of alliance development on measures of symptom reduction and interpersonal functioning. The suitability of the WAI to measure within and between session shifts in the therapeutic relationship will be discussed.

No. 79D
THERAPIST-RATED ALLIANCE AND OVERALL OUTCOME IN BRIEF PSYCHOTHERAPIES

Kevin Gillett, *Department of Psychology, Rutgers University, 62 Park Terrace West #A66, New York, NY 10034;* J. Christopher Muran, Ph.D., Bernard S. Gorman, Ph.D., Karen Riggs-Skean, Ph.D.

SUMMARY:

The literature indicates that the quality of the alliance between patient and therapist in a therapy dyad is a predictor of psychotherapy outcome. Much of the research on this phenomenon focuses on patient ratings of therapeutic alliance; a smaller body of research examines the relationship between therapist alliance ratings and treatment outcome, and the findings in this area have been mixed. This study investigated the relationship between therapist ratings on the Working Alliance Inventory completed after each session, and treatment outcome, based on patient and therapist report. Participants included 48 therapy dyads that met for 30 sessions in three manualized treatment conditions. Statistical analyses followed procedures conducted in the Stevens et al. study, which examined levels and patterns of alliance development across the course of treatment, including high-low-high patterns and rupture-repair cycles. Preliminary analyses yielded comparable results, although there was some indication that therapists rate alliance with more sensitivity to therapeutic alliance ruptures. Differences in the findings from the two studies were explored.

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4. Martin DJ, Garske JP, Davis MK: Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. J Consulting Clinical Psychology 2000; 68:438–450.

SYMPOSIUM 80—CONSEQUENCES AND TREATMENT OF MARIJUANA ABUSE
Collaborative Session with the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will gain a broad perspective on how marijuana abuse impacts human cognition, development, and brain activity. They will also learn about current treatments available for marijuana dependence, as well as the potential for medications development based on our growing knowledge of the roles of the endogenous anabinoid system in the brain.

No. 80A
COGNITIVE TOXICITY OF CANNABIS: THE DEVIL IS IN THE CONFOUNDING VARIABLES

Harrison G. Pope, Jr., M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478;* Deborah Yurgelun-Todd, Ph.D.

SUMMARY:

Acute intoxication with cannabis clearly produces cognitive impairment, but there is much less consensus regarding the duration and severity of cognitive deficits after cannabis is stopped. The residual neuropsychological effects of long-term heavy cannabis use can be assessed only by field studies of actual users—and such studies are bedeviled by numerous methodological problems that make it difficult to determine whether observed cognitive deficits are attributable to toxic effects of cannabis itself, or simply to confounding factors associated with heavy cannabis use. At present, it appears reasonable to conclude that deficits in attention and memory persist for at least several days after discontinuing regular heavy cannabis use. It is less clear, however, whether heavy cannabis use can cause neurotoxicity that persists long after discontinuation of use, or whether cognitive deficits increase with increasing lifetime cannabis exposure. At present, the weight of evidence seems to suggest that such long-term effects, if they exist, are subtle and not clinically disabling—at least in the majority of cases.

No. 80B
COGNITIVE EFFECTS IN ADOLESCENTS EXPOSED PRENATALLY TO MARIJUANA OR CIGARETTES

Peter A. Fried, *Department of Psychology, Carleton University, 1125 Colonel By Drive, Ottawa, ON K1S5B6, Canada*

SUMMARY:

In spite of marijuana being the most widely used illegal drug among women of reproductive age, there is a relative paucity of literature dealing with the putative neurobehavioral impact in offspring, particularly the longer-term effects. In the present report, the consequences of prenatal exposure upon aspects of cognitive functioning and visual analysis/hypothesis testing in early and late adolescent offspring is described in a middle-class, low-risk sample who have been followed in a prospective fashion since birth. Results of prenatal marijuana exposure will be contrasted to the impact of prenatal cigarette exposure in the same sample. The consequences of fetal marijuana exposure are subtle and appear not to impact upon global intelligence but rather upon aspects of executive functioning (EF). EF is a nonunitary set of cognitive/behavioral abilities critical in effortful, nonroutine, goal-oriented situations primarily subserved by the prefrontal region of the brain. In contrast, in-utero exposure to cigarettes impacts upon overall intelligence with many aspects of verbal performance being particularly vulnerable. These findings will be discussed in terms of effects (or lack of effects) across different ages and the extant general marijuana and prefrontal literature.

No. 80C
EFFECTS OF CHRONIC MARIJUANA USE AND THC ON BRAIN FUNCTION IN HUMANS: A fMRI STUDY

Alan S. Bloom, Ph.D., *Department of Pharmacology, Medical College of Wisconsin, 8701 Watertown Plant Road, Milwaukee, WI 53226*

SUMMARY:

Marijuana and its primary psychoactive constituent, delta-9-tetrahydrocannabinol (THC), produce characteristic physiological and behavioral actions in humans, including impaired short-term memory and perceptual-motor function. However, THC's sites of action in the human brain and their involvement in the drug's actions are not well understood. We have now studied in frequent marijuana users, the effects of doses of THC (0.5 to 3 mg injected iv over 1 min) that produce subjective effects similar to those seen with marijuana use in a social situation, on regional brain activity using BOLD and arterial spin labeling (ASL) fMRI techniques. The research subjects either rated their subjective experiences or performed motor and cognitive tasks while being scanned. Significant findings include: (1) THC produces a dose-related increase in the activity of the nucleus accumbens, (2) THC administration decreases brain activation induced by the performance of both cognitive and motor tasks, and (3) global brain perfusion (blood flow) was greater in frequent marijuana users than non-drug using control subjects. Taken as a whole, our studies demonstrate that THC produces significant effects on brain activity and cognitive task-induced activation at doses that produce effects similar to those produced by marijuana in a social situation.

No. 80D
BEHAVIORAL AND TREATMENT RESEARCH ON MARIJUANA WITHDRAWAL AND DEPENDENCE

Alan J. Budney, Ph.D., *Department of Psychiatry, University of Vermont, 54 West Twin Oaks Terrace, Suite 12, South Burlington, VT 05403*

SUMMARY:

The past 15 years of clinical and basic research has produced strong evidence demonstrating that cannabis can and does produce dependence. Basic research has identified a neurobiological system specific to the actions of cannabinoids. Human and nonhuman findings have demonstrated a valid withdrawal syndrome that is relatively common among heavy marijuana users. Clinical and epidemiological studies indicate that cannabis dependence is a relatively common phenomenon with significant associated psychosocial impairment. Many adults and adolescents enroll in treatment with the primary diagnosis of marijuana abuse or dependence. Treatment outcome research evaluating treatments for cannabis dependence suggests that this disorder, like other substance dependence disorders, is responsive to intervention, but the majority of patients have much difficulty achieving and maintaining abstinence. This presentation will provide highlights of our clinical research on marijuana dependence, withdrawal, and treatment of adults and adolescents.

No. 80E
THE ENDOGENOUS CANNABINOIDS AND THE CONTROL OF DRUG CRAVING

Billy R. Martin, Ph.D., *Department of Pharmacology & Toxicology, Virginia Commonwealth University, Smith Building 746, Richmond, VA 22398*

SUMMARY:

Although the use of psychoactive drugs begins as a voluntary behavior, in addicted individuals it becomes as uncontrollable as the obsessive and ritualized acts that afflict obsessive compulsive disorder patients. The overpowering nature of drug addiction and its association with changes in brain structure and function have led to conceptualize this condition as a chronic disease of the CNS. Like other chronic brain diseases, drug addiction goes through recurrent cycles of remissions and relapses, which can be readily triggered

when abstinent addicts are confronted with reminders of their drug habit (conditioned cues) or with emotiona distress. The prevention of such relapses is thus one of the primary goals of addiction treatment. There is increasing evidence that CB_1-type cannabinoid receptors, the molecular target of marijuana, are involved in triggering drug craving during abstinence, and that antagonists for these receptors prevent relapse to drug use. CB_1 receptors are normally activated by a small group of natural lipids called endocannabinoids. Do these compounds participate in the regulation of drug craving and, if so, is this regulation part of the broader role in the control of rewarding mechanism? Can we take advantage of our understanding of the endocannabinoid system to design treatments for substance abuse and other psychiatric disorders? I will review new information that provides initial answers to these important questions.

REFERENCES:

1. Pope HG Jr, Gruber AJ, Hudson JI, Cohane G, Huestis MA, Yurgelun-Todd D: Early-onset cannabis use and cognitive deficits: what is the nature of the association? Drug Alcohol Depend 2003; 69:303–310.
2. Fried PA: Adolescents prenatally exposed to marijuana: examination of facets of complex behaviors and comparisons with the influence of cigarettes. Journal of Clinical Pharmacology, 2002; 42:975–1025.
3. Stein EA, Risinger R, Bloom AS: FMRI in pharmacology in Medical Radiology. Edited by Moonen C, Bandettini PA. Springer-Verlag, 1999, pp 525–538,
4. O'Brien CP: A range of research-based pharmacotherapies for addiction. Science 1997; 278:66–70.
5. McRae AL, Budney AJ, Brady KT: Treatment of marijuana dependence: a review of the literature. J Subst Abuse Treat 2003; 24:369–376.

SYMPOSIUM 81—PERSONALITY DISORDERS: MULTIPLE PERSPECTIVES IN THE UNDERSTANDING AND TREATMENT OF RESISTANCE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the various resistances that personality disorders present in outpatient and hospital settings, and increase clinical armamentaria through the use of effective cognitive, psychdynamic, systems, and psychopharmacological interventions.

No. 81A
RESISTANCE IN PERSONALITY DISORDERS FROM A PSYCHODYNAMIC PERSPECTIVE

R. Rao Gogineni, M.D., *Department of Psychiatry, Robert Wood Johnson Medical School, 118 One Bala Avenue, Balacynwyd, PA 19004*

SUMMARY:

Wilhelm Reich, in his 1933 classic Character Analysis, describes character armor, character resistance, and techniques for analyzing it. Prior to and since this classic, classical psychoanalytic, object relations, self psychological, and attachment theorists have contributed much to understand and treat character disorders. In particular, Otto Kernberg and Heinz Kohut's contributions to character analysis have advanced the treatment of borderline and narcissistic personalities. Understanding of shame, sadomasochism, and attachment dynamics, advanced the treatment of personality disorders.

Personality disorders manifest extreme ambivalence, excessive attention seeking, acting out, self-injurious behaviors, intense anger, hopelessness, intense anxiety, extreme entitlement, excessive hatred of self and others, sadomasochism, avoidance, denial, externalization, and intellectualization as major defenses. They also manifest pathological forms of self and self-esteem and affect regulation. The presentation will address these defenses and behaviors and suggest techniques to handle and treat these dysfunctional patterns.

No. 81B
RESISTANCE IN BPD: COGNITIVE-BEHAVIORAL STRATEGIES THAT FACILITATE CHANGE

Donna M. Sudak, M.D., *Department of Psychiatry, Drexel College of Medicine, 3200 Henry Avenue, EPPI, Philadelphia, PA 19129*

SUMMARY:

Borderline personality disorder remains a consistently challenging clinical problem. Resistance in this group of patients often leads to therapist frustration, and can lead to disruption of the therapeutic alliance. Specific cognitive-behavioral interventions, and staging and prioritizing treatment targets can effectively manage resistant behaviors and prevent therapy from drifting from crisis to crisis. Validation and therapist support are key elements to avoid stalemates in therapy. Techniques derived from cognitive-behavioral therapy for this disorder will be presented. The therapeutic relationship, managing countertransference, and finding effective sources of support for therapists will be explored.

No. 81C
FAMILY THERAPY WITH PERSONALITY DISORDERS

G. Pirooz Sholevar, M.D., *Department of Psychiatry, DLFAPA, Robert Wood Johnson Medical School, 222 Righters Mill Road, Narberth, PA 19072-1315*

SUMMARY:

Personality is the major tool of social adaptation that is reflected in the selection of and interaction with peers and marital partners. There is a close relationship between both personality and *neurotic* disorders and dysfunctional family relationships. Such families generally represent a midrange level of dysfunction and become symptomatic only when excessive internal and external pressures are placed on them. The nucleus for the development of a personality and its disorders is formed within the families of origin. The continued relationship with the extended family tends to maintain and consolidate the personality disturbances. The personality and neurotic types of interactions are further perpetuated by the choice of a mate, who overtly or covertly supports the rigidities in the personality of the spouse. The developmental failures initiated in childhood serve as the basis for the creation of marital disorders, and intensified relational problems further impede developmental progression and intimacy, giving rise to the phenomenon of *interlocking neurotic marriage.*

Interventions based on the above concepts will be described.

No. 81D
CLINICAL PRACTICES THAT LEAD TO TREATMENT RESISTANCE

William R. Dubin, M.D., *Department of Psychiatry, Temple University Hospital, 100 East Lehigh Avenue, Philadelphia, PA 19125*

SUMMARY:

Depending on the illness, as many as 50% of psychiatric patients do not respond or only partially respond to treatment. These patients

are labeled as non-responders or treatment-resistant patients and not infrequently are pejoratively labeled as noncompliant. In some cases the term *treatment resistant* has a negative connotation and implies that the patient is not cooperating with treatment. The issue of treatment resistance has led to the development of treatment algorithms and consensus guidelines that provide a systematic treatment approach to such patients. However, rarely is there a discussion as to the system issues that impact treatment in a way that fosters the appearance of treatment resistance and encourages psychiatrists to practice in a manner that induces treatment resistance.

This presentation will address these issues, which includes:

- The undermining effect of the 15-minute medication visit
- The failure to consider the impact of time on a patient's response to medication, with the subsequent rush to polypharmacy
- The treatment of symptoms rather than diagnosis with resulting polypharmacy
- The failure to consider the impact of polypharmacy on medication noncompliance
- Failure to recognize comorbid disorders, especially Axis II disorders
- The devaluation of psychotherapy techniques with psychotic disorders
- The continuing misdiagnosis of schizophrenia in African-American patients.
- The concept of inpatient treatment as crisis intervention rather than definitive treatment

REFERENCES:

1. Lax R: Essential Papers on Character Neurosis and Treatment. New York, NY University Press, 1989.
2. Linehan ML: Cognitive Behavioral Treatment of Borderline Personality Disorder. New York, Guilford Press, 1993.
3. Sholevar GP: Family therapy with personality disorders, in Textbook of Family and Couples Therapy. Edited by Sholevar GP. APPI Press, pp 2003, 715–723.
4. Walkup JT, McAlpine DD, Olfson M et al: Patients with schizophrenia at risk for excessive antipsychotic dosing. J Clin Psych 2000; 61:344–348.

SYMPOSIUM 82—CLINICAL CONTROVERSIES IN ECT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the controversies within psychiatry concerning ECT electrode placement, stimulus dosing, physiological monitoring, and institutional policy, including a variety of views on risks, benefits, and their balances.

No. 82A
CONTROVERSIES IN ECT: ELECTRODE PLACEMENT

Conrad M. Swartz, M.D., *Department of Psychiatry, SIU School of Medicine, P O Box 19642, 901 West Jefferson, Springfield, IL 62794-9642*

SUMMARY:

Patients should respond better to ECT with individually selected electrode placement, yet most practitioners uniformly use one placement. Outside bitemporal vs. unilateral ECT, there are no decisive comparisons. In the absence of decisive data, clinical practice operates from professional experience. For example, differences among the half dozen tricyclic antidepressants are appreciated through clinical experience; likewise with SSRIs. Similarly, ECT clinicians should obtain first-hand experience with all four current electrode placements, for clinical perspective. Neurobiological differences among tricyclics correspond to their clinical differences; neurobiology in electrode placement is similarly relevant.

Bitemporal ECT is most widely generalized over the brain, so logically has the greatest efficacy but also most side effects, which can temporarily increase need for supportive care. Other bilateral placements reportedly have high efficacy with low disorientation; these are bifrontal and left anterior right temporal (LART). This is apparently because the left electrode is anterior to the temporal lobe, more so with LART. The asymmetry of LART presumably facilitates compensation by the opposite hemisphere. Unilateral ECT at moderate stimulus dose has lower efficacy than bitemporal ECT and frequent relapse within two months, but should suffice in patients who develop vigorous seizures at low stimulus dose, usually young patients.

No. 82B
CONTROVERSIES IN ECT: STIMULUS DOSING

W. Vaughn McCall, M.D., *Department of Psychiatry, Wake Forest University, Medical Center Boulevard, Winston-Salem, NC 27157*

SUMMARY:

The field of electroconvulsive therapy (ECT) remains divided regarding the proper selection of the stimulus dose. The controversy is largely related to two themes: first, the uncertainty regarding the relative memory and mood effects of bilateral (BL) versus right unilateral (RUL) electrode placement, and second, the uncertainty in how to best balance the desire for maximizing antidepressant efficacy while minimizing cognitive side effects. Clinical trials have established that the antidepressant efficacy of RUL ECT is related to the magnitude of the stimulus dose above the individual patient's seizure threshold, while BL ECT is near-maximally effective at a dose just barely above threshold. When RUL is dosed such that efficacy is good, then it is no longer clear that RUL has a superior side-effect profile compared with BL. The concern over minimizing cognitive side effects is also in some doubt since it is difficult to establish that the cognitive side effects of ECT impact greatly on patients' quality of life (QOL). Function and QOL of the patient are more closely related to efficacy of ECT rather than the extent of side effects. The finding suggests that stimulus dose should maximize efficacy, with lesser concern about cognitive side effects.

No. 82C
CONTROVERSIES IN ECT: PHYSIOLOGICAL MONITORING

Charles H. Kellner, M.D., *Department of Psychiatry, UMDMJ New Jersey Medical School, 183 South Orange Avenue, Suite F1439, Newark, NJ 07103*

SUMMARY:

Modern ECT technique includes monitoring of EEG, ECG, and motor manifestations of the seizure. While there is no controversy about the need to monitor these parameters to provide safe, standard-of-care ECT, the interpretation of more complex physiological indices as measures of seizure or treatment adequacy is still controversial. Contemporary ECT devices provide the opportunity to calculate sophisticated measures of seizure intensity. Preliminary research indicates that such measures, particularly those of ictal and postictal EEG, may be useful indicators of the therapeutic "adequacy" of an individual ECT treatment and may have bearing on clinical decision making for the entire course of ECT. They may also be useful guides to the practitioner to help determine optimal stimulus

dosing. In this presentation, several of the available indices will be reviewed in the context of current thinking about seizure adequacy. Discussion will highlight the ongoing debate over whether these technologically sophisticated markers are ready for use in everyday patient care decision making.

No. 82D
DENYING PATIENTS TREATMENTS THAT WORK

William H. Reid, M.D., *PO Box 4015, Horseshoe Bay, TX 78657*

SUMMARY:

Although very safe and highly effective when clinically indicated, electroconvulsive therapy (ECT) is among the most underused treatments in medicine. This presentation will briefly review several controlled studies of its safety and efficacy and compare those data with similar studies of pharmaceutical treatments for severe depression, bipolar disorder, and psychosis. The social and political context of ECT availability in various states, communities, and mental health care organizations (public and private) will be discussed, with emphasis on decreased patient access to ECT and the resulting potential for clinical deterioration, suicide, and psychiatrists' exposure to malpractice liability. The author's experience with over 40 cases of ECT administered to colleagues, their family members, and his own family members will be presented as well.

REFERENCES:

1. Swartz CM, Evans CM: Beyond bitemporal and right unilateral electrode placements. Psychiatric Annals 1996; 26:705–708.
2. McCall WV, Dunn A, Rosenquist PB, Hughes D: Markedly suprathreshold right unilateral ECT versus minimally suprathreshold bilateral ECT: antidepressant and memory effects. J ECT 2002; 3:126–129.
3. Abrams R: Electroconvulsive Therapy, 4th Edition. New York, Oxford University Press, 2002.
4. Reid WH: Electroconvulsive therapy (ECT) in psychiatrists and their families. The Journal of ECT 1999; 15(3):207–212

SYMPOSIUM 83—TOXIC LOVE ON FILM: ROMANTIC LOVE, FROM NORMAL TO PATHOLOGIC

EDUCATIONAL OBJECTIVES:

At the end of this symposium, the participant should be able to (1) conceptualize romantic love as a spectrum that spans "normality" and pathology, (2) use film as a teaching tool in discussing psychiatric concepts that abut the concept of romantic love, (3) recognize the need to view issues of romantic love within a multidisciplinary perspective, (4) improve his/her practice by appreciating the nuances of human relationships using the narrative strategies of film.

No. 83A
OBSESSIVE LOVE AND THE LOSS OF SELF IN FILM

Anton C. Trinidad, M.D., *Department of Psychiatry, Washington Hospital Center, 110 Irving Street, NW, Washington, DC 20010*

SUMMARY:

That a love relationship can endanger humans is a fact illustrated by such phenomena as stalking, suicide, and other forms that may be loosely termed as "clinical." The fragmentation of the boundaries of the self may be seen as underlying these phenomena and films such as Lyne's *Fatal Attraction* and Almodovar's *Talk To Her* highlight the vulnerability of humans to such fragmentation. In this part of the symposium, we will explore the ways by which personal narratives that unravel during the process of falling in love are unique in every person and that in films (as it is may be in real life,) the normal may easily ease itself into the abnormal. Other films such as Wilder's *Sunset Boulevard* more starkly narrate the descent of characters into forms of recognizable psychopathology. We hope to survey the wide array of characters, pathologic and otherwise, on film and come out with a greater appreciation of the subtlety of the spectrum from normality to pathology.

No. 83B
THE TEACHING OF WHAT IS NORMAL AND ABNORMAL IN ROMANTIC LOVE

Robert J. Boland, M.D., *Department of Psychiatry, The Miriam Hospital/Brown University, 164 Summit Avenue, Box G-MH, Providence, RI 02906-2853*

SUMMARY:

Psychopathology as it subsumes the love relationship or the love experience can be difficult to teach in the classroom or in the clinics. Actual cases may be difficult to find, not only because of confidentiality concerns but also because young physicians may not be able to relate immediately to actual cases but may easily relate to characters in films. In this part of the symposium, we will demonstrate the issue of the "caseness" of a romantic love in Adrian Lyne's *Lolita* among other films and how the teaching of psychopathology and character may be approached among medical students and residents. It will also demonstrate how we conceptualize clinical problems in love experiences that oftentimes transcend categorical diagnostic systems.

No. 83C
THE *FEMME FATALE* AND ITS ALLUSIONS

Harvey Ray Greenberg, M.D., *320 West 86th Street, New York, NY 10024-3139*

SUMMARY:

We will discuss the idea of the *femme fatale* through history, and the changing visions of the vamp from Theda Bara to Glenn Close. Context will be placed within the historical period of a particular film, its national origins, and the time period in which it was produced. Films to be discussed are *Amour Fou* and some of Michael Douglas' films that interpret the idea of the predatory female.

No. 83D
LOVE: WHAT IS NORMAL?

Anton C. Trinidad, M.D., *Department of Psychiatry, Washington Hospital Center, 110 Irving Street, NW, Washington, DC 20010*

SUMMARY:

The contemporary idea of romantic love historically evolved throughout the course of Western civilization, an idea that in the past subsumed filial love and courtly love. Now, it may be said that Hollywood's version of the ideal romantic love, which may represent the average person's idea of it as well, is distilled in the enduring genre of the romantic comedy like Reiner's *When Harry Met Sally* and Ephron's *Sleepless in Seattle.* But as popular as these movies have been, do we agree that what these films represent are our own idea of what love should be? And do our patients have this same idea? If so, does it create problems in the navigation of real love relationships? These are the questions we hope to ask and answer in this part of the symposium. The presenters will moderate a discussion

among the audiences who will be asked to actively answer these questions and at the end, hopefully come up with a clearer idea of how we define normality in love relationships as psychiatrists.

REFERENCES:

1. Gabbard GO, Gabbard K: Psychiatry and the Cinema, 2nd Edition. Washington, DC, American Psychiatric Press, 1998.
2. Monaco J: How to Read a Film: The World of Movies, Media and Multimedia Language, History and Theory. Oxford, Oxford University Press, 1991.
3. Trosman H: Contemporary Psychoanalysis and Masterworks of Art and Film. New York, NYU Press, 1996.
4. Lynden J: Film and Religion, Myths, Morals and Rituals. New York, NYU Press, 2003.

SYMPOSIUM 84—MOVING THE TARGETS: THE NEUROBIOLOGY OF ADDICTION Collaborative Session with the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant will gain an appreciation of the scope of dysregulation in the brain circuitry that underlies addictive processes, and how elements of that circuitry can be modified by the physiological changes that occur as a result of drug use.

No. 84A
NEUROADAPTATION IN ADDICTION: THE EXTENDED AMYGDALA AND BRAIN-REWARD SYSTEM

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

SUMMARY:

A conceptual structure for drug addiction focused on allostatic changes in reward function that lead to excessive drug intake provides a heuristic framework with which to identify the neurobiologic and neuroadaptive mechanisms involved in the development of drug addiction. Decreases in reward are associated with withdrawal from chronic drugs of abuse and escalation in drug intake. The brain reward system implicated in the development of addiction is comprised of key elements of a basal forebrain macrostructure termed the extended amygdala and its connections. Neuropharmacologic studies in animal models of addiction have provided evidence for the dysregulation of specific neurochemical mechanisms, not only in specific brain reward systems in the extended amygdala (opioid peptides, gamma-aminobutyric acid, glutamate and dopamine). There also is recruitment of brain stress systems (corticotropin-releasing factor and norepinephrine) and dysregulation of brain anti-stress systems (neuropeptide Y) that provide the negative motivational state associated with drug abstinence. The changes in the reward and stress systems are hypothesized to maintain hedonic stability in an allostatic state, as opposed to a homeostatic state, and as such convey the vulnerability for development of dependence and relapse in addiction.

No. 84B
NEURAL CIRCUITRY OF RELAPSE

Peter W. Kalivas, Ph.D., *Department of Physiology, Medical University of South Carolina, 173 Ashly Avenue, Charleston, SC 25067*

SUMMARY:

The neural circuitry mediating relapse was examined in the rodent reinstatement model of relapse. In this model, rats are trained to self-administer cocaine and following a period of withdrawal the animals are primed to reinstate lever pressing for saline with a cocaine injection or an environmental stress (footshock). Prior to the priming stimulus, different brain nuclei were inactivated by administering a local injection of GABA agonists. It was discovered that the glutamatergic projection from the prefrontal cortex to the nucleus accumbens was a neural substrate shared between drug and stress primers. Using microdialysis to examine changes in glutamate release, either a cocaine or stress prime released glutamate in the accumbens. It was subsequently discovered that the increase resulted from alterations in presynaptic regulation of glutamate release caused by a deficit in cystine glutamate exchange, and the reinstatement of drug seeking in animals trained to self administer cocaine was abolished by reactivating the cystine-glutamate exchanger with a systemic injection of N-acetylcysteine. This drug is currently used clinically to restore glutathione levels and a clinical trial has begun to determine the effectiveness of N-acetylcysteine in preventing cue-primed craving in cocaine addicts.

No. 84C
DRUGS, NEUROPLASTICITY, AND ADDICTION

Terry E. Robinson, Ph.D., *Department of Psychology, University of Michigan, Biopsychology 525 East University, Ann Arbor, MI 48109*

SUMMARY:

A fundamental question in addiction research concerns why some susceptible individuals undergo a transition from drug use to addiction. Recent studies suggest that the transition to addiction is due in part to a drug-induced reorganization of brain systems involved in incentive motivational processes (such as the nucleus accumbens) and brain systems involved in decision making and judgment that usually exert inhibitory control over behavior (such as the prefrontal cortex). This lecture will focus on some of the long-term neurobehavioral consequences of repeated exposure to drugs of abuse, conditions that promote or retard drug-induced neuroplasticity and the effects of drug-induced changes in mesolimbocortical circuitry for behavior and psychological function.

No. 84D
HOW DO DRUGS OF ABUSE REWIRE THE MOTIVATIONAL CIRCUITRY?

Marina E. Wolf, Ph.D., *Department of Neuroscience, Chicago Medical School, 3333 Green Bay Road, North Chicago, IL 60064-3095*

SUMMARY:

Glutamate is a key neurotransmitter for neuroplasticity and learning. Recent work has established that addiction can be viewed as a maladaptive form of learning, which uses the same glutamate-dependent cellular mechanisms important for "normal" forms of neuroplasticity. Through rewiring of motivational circuits, chronic drug exposure facilitates the formation of new habits centered around drug-seeking behavior, usually at the expense of more appropriate behaviors. A current focus is to understand how drugs like cocaine and amphetamine, which initially target dopamine systems, influence glutamate-dependent neuroplasticity. Long-term potentiation (LTP) is the leading candidate for mediating neuronal plasticity, so we focused on identifying mechanisms through which dopamine-releasing drugs can directly influence LTP. During LTP, glutamate synapses are strengthened by phosphorylation of AMPA-type glutamate receptors and by insertion of new AMPA receptors into synapses. Using primary neuronal cultures prepared from nucleus accumbens

or prefrontal cortex, important brain regions for addiction, we have shown that stimulation of D1 dopamine receptors produces rapid increases in AMPA receptor phosphorylation and externalization of AMPA receptors at extra-synaptic sites. This may promote LTP by increasing the AMPA receptor pool available for synaptic insertion. Understanding the plasticity that leads to addiction is key to developing effective strategies to reduce drug craving.

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1. Koob GF, Le Moal M: Drug addiction, dysregulation of reward, and allostasis, Neuropsychopharmacology 2001; 24:97–129.
2. Baker et al: Neuroadaptations in cystine-glutamate exchange underlie cocaine relapse. Nature Neuroscience 6: 743–749
3. Robinson TE, Berridge KC: Addiction Annual Review of Psychology 2003; 54:25–53.
4. Wolf ME: Addiction: making the connection between behavioral changes and neuronal plasticity in specific circuits. Molecular Interventions 2002; 2:146–157.

SYMPOSIUM 85—DRUG ABUSE TREATMENT ISSUES IN WOMEN Collaborative Session with the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should gain knowledge of the unique treatment and service needs of women; the relationship of violence, trauma, and the stress response to women's drug use, comorbidities, and implications for treatment; and, drug treatment issues for pregnant women including pharmacotherapy and behavioral interventions.

No. 85A
GENDER DIFFERENCES IN TREATMENT NEEDS, SERVICES, UTILIZATION, AND OUTCOMES

Karol A. Kaltenbach, Ph.D., *Department of Pediatrics, Jefferson Medical College, 1201 Chestnut Street, Suite 900, Philadelphia, PA 19107*

SUMMARY:

Women's special needs and the delineation of gender-specific treatment strategies have received attention over the past 25 years. These efforts have resulted in the development of gender-specific treatment models in order to address the addiction, medical, psychosocial, parenting, educational, and vocational needs of both women and their children. However, the availability of women-centered treatment is limited. Of treatment programs in the United States, only 15% of the residential programs are for women and only 3% of outpatient programs are women only. Moreover, across all modalities, both gender-specific and coed, approximately only 39% of women who need treatment receive it. A lack of attention to gender issues is also reflected in the literature identifying factors related to successful outcomes. This literature suggests a variety of conceptual frameworks such as patient matching, motivation to change, etc, but all are gender neutral. We know relatively little of the relationship between women's characteristics, treatment utilization, and treatment outcome. The data that are available indicate that there are no simple predictors of women's treatment outcomes, but rather multiple predictors that reflect complex factors related to medical issues; care-giving responsibilities, child and partner relationships, and victimization.

No. 85B
TREATMENT ISSUES IN DRUG-DEPENDENT WOMEN WITH COMORBID DEPRESSION

Rajita Sinha, *Department of Psychiatry, Yale University, 34 Park Street, Room S110, New Haven, CT 06519*

SUMMARY:

Major depression is known to increase the risk of development of drug abuse and also affect the chronic relapsing nature of addiction. This presentation summarizes findings on the effects of major depression, acute stress responses, and their effects on cocaine relapse. Treatment issues related to comorbid depression and drug abuse will be discussed. Data on cocaine-dependent men and women participating in inpatient treatment who were evaluated for psychiatric diagnoses, neurobiological responses to stress, and on measures of cocaine relapse during a 90-day period upon discharge from the inpatient unit will be presented. Findings indicate that while men and women were not different in rates of major depression, women with greater neurobiological reactivity to acute emotional stress in the laboratory are significantly more likely to relapse as compared with men. Associations between early trauma, depression symptomatology, and stress responsivity will also be presented. These data suggest that altered stress responding may underlie the comorbid association between depression and cocaine dependence and its effects on cocaine relapse in women. Pharmacological and psychosocial treatment implications for comorbid depression and drug abuse will be discussed with specific respect to treatments that target stress regulation in this comorbid group of drug-dependent women.

No. 85C
TRAUMA AND PTSD: ISSUES IN THE TREATMENT OF DRUG-DEPENDENT WOMEN

Denise Hien, Ph.D., *Social Intervention Group, Columbia University, 411 West 114th Street, #3B, New York, NY 10025*

SUMMARY:

Research findings consistently demonstrate that the majority of treatment-seeking women presenting to addictions and psychiatric settings have a history of chronic complex trauma and multiple associated impairments captured by the diagnosis of PTSD and other psychiatric disorders. This presentation will review the main cognitive-behavioral therapy (CBT) approaches that have been empirically examined to treat women with trauma. It will focus upon the findings of one randomized clinical trial comparing two active CBT treatments with a non-randomized comparison treatment as usual (TAU) condition in a population of urban women with chronic histories of emotional, physical, and sexual abuse, dually diagnosed with PTSD and SUD. A total of 108 participants, predominantly minority women of lower SES, were recruited from substance treatment programs and newspaper advertisements in the New York metropolitan area. Women were assessed pre- and post-treatment, and at six and nine months post baseline on a variety of measures. Outcomes revealed statistically significant improvements on an primary outcome measures for both active treatments compared with the community control group.

No. 85D
DRUG-DEPENDENT WOMEN WITH PARTNER VIOLENCE: TREATMENT ISSUES

Brenda A. Miller, Ph.D., *Prevention Research Center, 1995 University Avenue, Suite 450, Berkeley, CA 94708;* Linda P. King, Ph.D., Eugene Maguin, Ph.D., Nancy J. Smyth, Ph.D.

SUMMARY:

Women's drug/alcohol use is related to partner violence and to other mental health disorders, including depression, anxiety, and PTSD symptoms. Yet the interaction between these problems has not been well understood. This presentation will provide an overview of some of the mechanisms by which these comorbid disorders are related to partner violence and the evidencc for the bi-directional relationships. Recent findings from a study based on women (N= 499) recruitcd from three sources (treatment programs for drug/ alcohol problems, communities with and without high levels of drug/ alcohol use) measured partner violence, depression and anxiety, and drug and alcohol use. High prevalence of partner violence, other forms of victimization, and depression and anxiety are found among women substance users. Of particular interest is evidence of how depression is related to partner violence both at six months and a year following the initial measurement of depression. Not only are relationships between comorbid disorders and partner violence important to consider for comprehensive treatment planning, they also are relevant for planning follow-up for women in treatment. Although there is much to be learned by further research on the connections between comorbid disorders and partner violence, these research findings can guide clinical protocols.

No. 85E
DRUG-TREATMENT ISSUES IN DRUG-DEPENDENT, PREGNANT WOMEN

Hendree Jones, Ph.D., *Johns Hopkins University, 4940 Eastern Avenue, #D3E, Baltimore, MD 21224*

SUMMARY:

Pregnancy can be a catalyst for pregnant, opioid-dependent women to spontaneously cease drug use. However, many women unable to cease their opioid use seek help for their illness. Methadone, the recommended standard of care for opioid-dependent pregnant women, improves maternal and neonatal outcomes when provided as a part of a comprehensive care model. However, methadone treatment during pregnancy remains controversial. This talk aims to dispel the myths and provide evidence-based recommendations for the appropriate use of methadone during pregnancy. Buprenorphine is the latest opioid pharmacotherapy to be approved for the treatment of opioid dependence in non-pregnant patients. Since it is expected to be widely used, pregnancies will obviously occur during treatment with this medication. Thus, information as to the safety and efficacy of burpenorphine during pregnancy is needed. This talk will provide the latest results from a double-blind, randomized controlled trial comparing methadone and buprenorphine in the treatment of opioid-dependent pregnant women and the effects of prenatal exposure to these medications on the neonate. Finally, the success of novel behavioral approaches examined in the context of methadone and comprehensive care will be reviewed.

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SYMPOSIUM 86—MANAGING HIPAA-RELATED TENSIONS IN CLINICAL PRACTICE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand (1) the sources of HIPAA, (2) its benefits and detriments in both outpatient and inpatient psychiatric practice, (3) how it transgresses the limits of optimum constraint, (4) clinician guidelines for implementing HIPAA, (5) roadblocks to confronting over-regulation, and (6) societal issues at play.

No. 86A
INTENDED AND ACTUAL EFFECTS OF HIPAA ON CLINICAL PRACTICE

Claudette H. Beahrs, M.S.W., *Department of Psychiatry, Oregon Health and Science University, 3318 NE Hancock Street, Portland, OR 97212*

SUMMARY:

The HIPAA privacy rule was designed to improve clinical practice by protecting patients from growing threats to their privacy, and strengthening recognition of their autonomy. Paradoxically, in psychotherapy with individuals, families, and groups, this comprehensive and expensive legislation creates as many problems as solutions for therapists and their patients. It inadvertently empowers patients' regressive strivings, weakens their support systems, and undermines clinicians' leverage as effective agents of therapeutic change, running the risk of producing a pseudo- rather than integrated autonomy. Case examples will illustrate dilemmas HIPAA presents to clinicians, along with opportunities for clarified clinical thinking and problem solving. Dynamics are interpreted in developmental terms, object relations, and family systems theory. Concepts from transactional analysis are particularly useful in understanding and working with the complex interpersonal issues at play.

No. 86B
THE IMPACT OF HIPAA ON PSYCHIATRIC HOSPITAL CARE: THE GOOD, THE BAD, AND THE UGLY

Steven S. Sharfstein, M.D., *Sheppard Pratt Health System, 6501 North Charles Street, Baltimore, MD 21204;* Robert P. Roca, M.D., Angela Niparko, Erin Scally

SUMMARY:

Protecting a patient's privacy is both an ethical obligation and a critical component of the quality of care. In hospital psychiatry, it is a challenge to safeguard confidentiality in the medical marketplace, which demands the sharing of information among clinicians, insurers, utilization reviewers, and regulators. The impact of the federal law, HIPAA, may be summarized as follows: The Good: Clinicians and clerical staff are more aware than ever of the need to protect privacy. Patients are more aware than ever of their right to privacy and of the process to follow if they feel that their rights have been breeched. Their pursuit of the process, in turn, further heightens staff awareness of privacy rights. The Bad: The doctor-patient relationship becomes further bureaucratized and burdened by red tape; bewildered patients

receive legalistic notices of privacy policies (which they rarely read) and sign yet another form. The Ugly: Quality of care is compromised when clinicians do not realize that HIPAA almost always allows communication with colleagues for purposes of coordination of care without written consent.

In this paper, clinical vignettes will be presented that examine the impact of HIPAA since its implementation in April 2003.

No. 86C
REGULATION, HIPAA, AND THE QUEST FOR OPTIMUM CONSTRAINT

John O. Beahrs, M.D., *Department of Psychiatry, Oregon Health and Science University, V3MHC, Portland VA Medical Center, P.O Box 1035, Portland, OR 97207*

SUMMARY:

"Regulation" is information that specifies preferred behaviors enforced by social sanctions. It can protect, liberate, and empower; just as it can stifle or tyrannize. Like all information, "too much" is equivalent to "not enough." Hence, the question of optimum constraint becomes paramount. In health care, as in all human sociality, optimum regulation (1) limits specific harms, (2) promotes greater goods, (3) is "fair" by standards of reciprocity and balance, and (4) simplifies information management by highlighting the most relevant common principles. HIPAA is problematic at all these levels. New harms arise, and the original targets are limited insufficiently. Coupled with competing mandates, criminalizing privacy violations strikes terror in many practitioners, and the informational excess leaves many without a clear sense of how to walk the fine lines involved. In part, practicing clinicians can mitigate these problems through skilled contracting and informed consent. To truly re-optimize health care, however, will require societal intervention. To specify simplifying "presumptions" is one social strategy that can help practitioners balance opposing tensions within the limits of optimum constraint.

No. 86D
COMPLYING WITH HIPAA MADE LESS DIFFICULT

Jeffrey L. Metzner, M.D., *Department of Psychiatry, University of Colorado, 3300 East First Avenue, Suite 590, Denver, CO 80206-5808*

SUMMARY:

This presentation will review resource documents developed by several APA components that provide a structure for compliance with the HIPAA privacy rule. These documents address issues such as minimum necessary guidelines, policies and procedures, the notice of privacy practices requirement, and the psychotherapy notes provision.

This presentation will also address issues relevant to HIPAA and forensic psychiatry examinations.

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SYMPOSIUM 87—MEMORY IN THE U.S. AND FRANCE: VIVE LA DIFFERENCE

EDUCATIONAL OBJECTIVES:

At the end of this symposium, the participant should be able to understand the differences and similarities in France and the United States in the assessment of, research about, and treatment of memory problems as well as the transcultural issues involved in depression, PTSD, and the elderly.

No. 87A
WHAT CAN WE LEARN FROM THE FALSE-MEMORY WARS?

Paul R. McHugh, M.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Meyer 4-113, Baltimore, MD 21287-7413*

SUMMARY:

The false memory wars began in the mid 1980s when many therapists came to believe that they could help depressed and anxious patients by exploring their past for repressed or dissociated experiences of sexual abuse. This practice of essentially trolling for hidden sexual traumas unfortunately often provoked false memories and beliefs of mistreatment in the patients. In particular, the use of hypnosis and other suggestion-laden practices instead of standard modes of evaluation and therapy increased the false positive results. Eventually, many of the patients retracted their charges against their parents. Careful review of the evaluative misdirection has led to better understanding of memory as a mental faculty and to better knowledge of pitfalls in the assessment of patients. As well, experience with over 1,000 families has demonstrated the process of recovery from false memories, the stages followed, and how this recovery is facilitated.

No. 87B
PTSD: TOO MUCH OR TOO LITTLE MEMORY?

Anne-Marie F. Pezous, M.D., *Department of Psychiatry, Lariboisiere Hospital, 21 Rue Ambroise Pare, Paris 75010, France;* Barbara Cochet, Eric Guillem, M.D., Saena Bouchez, M.D., Jean-Pierre Lepine, Ph.D.

SUMMARY:

Most anxiety disorders show to a certain extent discrepancies between emotional and cognitive functioning. As there is a strong link between posttraumatic stress disorder (PTSD) and memory, the former is a good example to discuss such paradoxes in memory functioning.

Current data highlight the controversial aspects of memory in PTSD, as, for instance: the links between PTSD and traumatic brain injury (TBI) with impaired recollection of the trauma, and acute recollection of negative events with intrusive memories while traumatic reminders may impair memory performance.

In the light of the different conditions related to PTSD (i.e., personality disorders, substance abuse), the causal relationship between impaired neuropsychological tests and PTSD is also discussed. In both human and in animal models, the secretion of catecholamine and glucocorticoid during the stressful event, and their deregulation, is strongly related to vulnerability and development of PTSD. Catecholamines and glucocorticoids modulate emotional and cognitive components of memory in potentially opposite ways. Such discussions about PTSD and memory have major implications when treat-

ing patients, as evidenced by the different therapeutic approaches on both sides of the ocean.

No. 87C
THE NATURE OF TRAUMATIC MEMORY: IMPLICATIONS FOR TREATMENT

Bessel A. Van Der Kolk, M.D., *Department of Psychiatry, Boston University, 16 Braddock Park, Boston, MA 02116*

SUMMARY:

Current understanding of the way the mind processes traumatic experiences was first formulated by Pierre Janet in L'automatisme Psychologique, in 1889. Contemporary research, including neuroimaging studies, has provided robust evidence for Janet's notion that dissociative processes cause the traumatic experience to be imprinted in the form of sensory perceptions, emotional states, and behavioral repetitions. The underlying mechanisms are being elucidated in neuroimaging studies that have shown alterations in function on the level of the thalamus, amygdala, hippocampus, and the medial and dorsal lateral prefrontal cortices. This presentation will review Janet's studies on traumatic memory and contemporary studies on traumatic memory, including neuroimaging studies, and discuss their treatment implications.

No. 87D
DEPRESSION AND DEMENTIA: LOOKING FOR SPECIFIC MEMORY IMPAIRMENTS

Eric Fakra, M.D., *Department of Psychiatry, Sainte-Marguerite, 270 Boulevard Sainte-Marguerite, Marseille 13007, France;* Bernard Michel, M.D., Jean-Michel Azorin, M.D.

SUMMARY:

Depressive disorders in the elderly can take a particular form and exhibit severe cognitive impairment. In these cases, memory loss due to depression may be hardly distinguishable from organic dementia; they are, therefore, labeled pseudodementia. Several prospective studies demonstrated that patients diagnosed as depressive pseudodementia show a higher risk of developing dementia during follow-up, thereby increasing the difficulty to distinguish pseudodementia from dementia.

The aim of this paper is to focus on memory impairments that can help differentiate these two diagnoses and can be of predictive value in the evolution of pseudodementia. Various measures will be scrutinized including recall and recognition, semantic encoding and retrieval, and naming and visuospatial tasks. None of these indices seems to be sufficiently specific to allow a secure diagnostic distinction at the individual case level. However, they could be helpful during the follow-up of depressed patients in order to identify subsequent neurological disorders.

Results of a study dealing with a four-year follow-up of depressive pseudodementia versus elderly depression without cognitive impairment will be presented.

These results are examined in the light of recent neuroimaging data, which emphasize the role of the hippocampus in both mood disorders and in the onset of dementia.

No. 87E
COGNITIVE IMPAIRMENT IN LATE-LIFE DEPRESSION

Charles F. Reynolds III, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213;* Meryl A. Butters, Ph.D.

SUMMARY:

Major depression in old age usually coexists with cognitive impairments, with approximately 50% to 60% of patients demonstrating impairment in one or more domains of cognition. In addition, there is a substantially increased risk for a progressive dementia after a depressive episode in old age. In a recently completed study at the Pittsburgh Intervention Research Center for Late Life Mood Disorders, we found that more than half of 100 elderly patients (mean age 70.8) performed below the tenth percentile of the control group, with impairments occurring most commonly in information processing speed, and visuospatial and executive abilities. Most of the neuropsychological impairments were mediated by slowed information processing speed. Education and ventricular atrophy explained additional, but modest variance in language performance. Medical and vascular disease burden, APOE allele type, and serum anticholinergic burden did not contribute significantly to variance in cognitive functioning. In other studies performed at Pittsburgh, treatment of late-life depression to remission was associated with improvement, but not normalization, of cognitive functioning. These data suggest the potential importance of subcortical/frontal lobe dysfunction in late-life depression and underscore the need for additional research into treatment of depression-associated cognitive impairment in old age.

No. 87F
DEPRESSION: REMEMBERING THE BAD THINGS

Natacha Fouilhoux, M.D., *Hospital Sainte Anne S17, 1 rue Cabanis, Paris 75674, France;* Francois C. Petitjean, M.D.

SUMMARY:

Patients suffering from depression show negative biases in perception and memory. Beck has described how such biases in information processing play a fundamental role in the maintenance of mood disorders: depressed patients make unrealistic negative judgments about themselves, their own actions, and the world. Recent studies (Harmer et al, 2003) indicate that antidepressants may directly affect the way in which emotional information is processed. This leads to a neuropsychological confirmation of Beck's theory and stresses the importance of an extensive clinical evaluation of these aspects in patients with depression. We present different clinical vignettes of patients at various stages of their treatment for depression, showing how negative biases in information processing may lead to self-destructive behaviors: by pervading their environment with their own negative ideas, by extending suicidal behaviors to their family, or through treatment interruptions.

A correct evaluation of negative cognitions in their various forms and degrees of severity is indispensable during the clinical evaluation of all depressed patients. Whether they affect memory, perception, or action, the negative biases have a decisive impact on treatment and prognosis.

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2. Bremner JD, Vythilingam M, Vermetten F, Southwick SM, McGlashan T, Staib LH, Soufer R, Charney DS: Neural correlates of declarative memory for emotionally valenced words in women with posttraumatic stress disorder related to early childhood sexual abuse. Biol Psychiatry 2003; 53(10):879–89.
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SYMPOSIUM 88—QUALITY OF CARE FOR CHILDREN: MULTIPLE PERSPECTIVES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should become familiar with multiple methodologies used to assess quality of psychiatric care.

No. 88A
QUALITY OF CARE FROM THE AGENCY'S PERSPECTIVE: ARE MEDICAID CLAIMS DATA VALID?

Penelope Knapp, M.D., *Department of Psychiatry, University of California, Sacramento, 2825 50th Street, Room 2321, Sacramento, CA 95817*; Bonnie T. Zima, M.D., Michael Hulburt, Ph.D., Lingqi Tang, Ph.D., Heather Ladd, M.S., Naihua Duan, Ph.D., Kenneth B. Wells, M.D.

SUMMARY:

Objective: This study examines discrepancies between Medicaid claims and medical record data for sociodemographic characteristics as well as diagnosis with provider indicators of the diagnosis, such as DSM-IV symptoms, clinical diagnosis, stimulant or antidepressant medication use, and probable diagnosis criteria as determined by an expert panel.

Methods: Using a multistage sampling strategy, 1,350 records of children identified as receiving care for ADHD, major depression, or conduct disorder in publicly funded outpatient mental health programs in California were abstracted.

Results: Slightly more than 20% of the children identified in the claims data were from a minority ethnic background. Caucasian youth were significantly more likely (2=160.90; p<.0001) to be over-reported in administrative data than those from minority backgrounds. Almost one-third (32.6%) of the children identified as having conduct disorder had three or more symptoms and at least one functional impairment documented in the record.

Conclusion: Children from minority backgrounds, particularly Latino children, and those with conduct disorder symptoms are under-reported in the Medicaid claims data. Standardized reporting procedures are needed to improve the utility of Medicaid claims data for federally mandated monitoring of quality of care.

No. 88B
QUALITY OF CARE FOR CHILDREN IN OUTPATIENT MENTAL HEALTH PROGRAMS

Bonnie T. Zima, M.D., *Department of Psychiatry, UCLA-NPI, 10920 Wilshire Boulevard, #300, Los Angeles, CA 90024*; Michael Hulburt, Ph.D., Penelope Knapp, M.D., Lingqi Tang, Ph.D., Heather Ladd, M.S., Naihua Duan, Ph.D., Kenneth B. Wells, M.D.

SUMMARY:

Objective: This study describes the clinical care processes for three major childhood psychiatric disorders among a statewide representative sample of children ages six to 17 years who received ongoing (≥3 visits within a 90-day period) outpatient specialty mental health care within a ten-month span in 1998–1999, and to examines how adherence to quality indicators varies by child sociodemographic factors, program contract status, and county poverty and population density, adjusting for clinical severity and psychosocial complexity.

Methods: A total of 114 quality-of-care indicators for the assessment and treatment of ADHD, major depression, and conduct disorder were developed using the RAND-UCLA modified Delphi method. Using a multistage sampling design, 813 records (weighted n=7560) from 62 outpatient mental health programs in 21 counties were abstracted.

Results: Documentation of care processes related to general assessment ranged from 78% to 96%, yet adherence to quality indicators related to safety, such as obtaining physical exam results (31.4%), screening for abuse (60.4%), and ≥1 recommended monitoring of a vital sign or laboratory study for children prescribed psychotropic medication (25.4%) was lower.

Conclusion: Quality improvement interventions for children served in publicly funded programs should target better documentation of safe clinical practices, particularly those related to use of psychotropic medication.

No. 88C
UNRAVELING VARIATIONS IN ACCESS TO ADHD CARE: DEDUCTIVE ANALYSIS FINDINGS

Regina Bussing, M.D., *Department of Psychiatry, University of Florida, PO Box 100234, Gainesville, FL 32610-0234*; Mirka K. Ljungberg, Ph.D., Cynthia Garvan, Ph.D., Dana Mason, B.S., Christine Leon, M.A.

SUMMARY:

Objective: Adequate access represents an important quality-of-care parameter. Gender and race differences in treatment rates for ADHD are well documented but poorly understood. This study seeks to identify access barriers for qualitative improvement efforts.

Methods: Parents of 258 students identified as high risk for ADHD completed diagnostic interviews and provided detailed accounts of help-seeking activities since they first became concerned about their child. Help-seeking steps (N=1592) were transcribed. Responses were coded based on a deductive application of Prescosolido's network episode model. Codes were developed to identify who the parent talked to, the intervention system parents used or were steered toward, and the specific network function of a given encounter. Coded data were subsequently merged with demographic and other participant characteristics, and subjected to standard family quantitative analysis techniques.

Results: African Americans sought more help from family; Caucasians sought more help from health professionals and teachers. Medical treatment was recommended more often to Caucasians than African Americans and more often to boys than girls. Parents of African-American girls were least likely to receive advice or referrals.

Conclusion: Quality improvement efforts need to include educational interventions addressing cultural stereotypes among families, teachers, and health professionals contributing to inequitable ADHD treatment access.

No. 88D
QUALITY IMPROVEMENT OF MENTAL HEALTH SERVICES FOR CHILDREN IN SPECIAL EDUCATION

Sheryl H. Kataoka, M.D., *Department of Psychiatry, University of California, Los Angeles, 10920 Wilshire Boulevard, #300, Los Angeles, CA 90024-6505*; Jeanne Miranda, Ph.D.

SUMMARY:

Objective: Children in special education are at high risk for psychiatric disorders, yet little is known about the quality of school counseling provided for these students. In an effort to improve the quality of services delivered to special education students who are receiving school counseling, this study uses quantitative and qualitative data to explore child and provider characteristics that can impact the types of services being provided.

Methods: We interviewed randomly selected clinicians from one school district to determine use of different treatment modalities, practice of evidence-based treatments, and school climate and culture. Parents and middle school students participated in a diagnostic assessment and open-ended questions about their experiences in receiving school-based care.

Results: Findings suggest that school clinicians primarily provide treatment in a group format and report some experience with evidence-based treatments, such as parent training and cognitive-behavioral therapy, but few use a specific treatment manual. More than half of the students receiving school counseling met diagnostic criteria for a major psychiatric disorder, yet counselors report that they make diagnoses in only a minority of their cases.

Conclusions: Improvement in identification of mental health problems in schools and training clinicians in evidence-based practices are needed.

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SYMPOSIUM 89—MEETING THE MENTAL HEALTH NEEDS OF LATINOS IN COMMUNITY AND PRIMARY CARE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should have increased awareness of mental health disparities faced by Latinos in community and primary care and will understand the challenges of detecting and managing common psychiatric conditions in this population.

No. 89A
PTSD IN LATINOS: REACTIONS IN PRIMARY CARE TO THE WORLD TRADE CENTER ATTACKS

Yuval Y. Neria, Ph.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 69, New York, NY 10032;* Amarendra Das, M.D., Rafael Lantigua, M.D., Marc J. Gameroff, Ph.D., Mark Olfson, M.D., Adriana Feder, M.D., Myrna M. Weissman, Ph.D.

SUMMARY:

Objective: We examined psychological reactions to the World Trade Center (WTC) attacks and the prevalence of PTSD symptoms in low-income, mostly Hispanic patients attending a primary care clinic in Manhattan.

Methods: A systematic sample of 993 adults (82.7% of Latino ethnicity) consented to complete a psychiatric screening, including the Posttraumatic Check List (PCL-S).

Results: Among patients who identified the WTC attacks as the most distressing event in the past month, 11.5% screened positive for PTSD based on the PCL-S. PTSD was more common in women and Hispanics. PTSD was significantly more likely to be present among patients who stated that a loved one or somebody close was in the WTC at the time of the attack or who knew somebody who was injured or killed by the disaster, or involved in the recovery efforts. The majority of the patients endorsed having increased worries about their personal or family safety. Nearly one-half had increased worries about staying in the U.S., and more than one-third of patients reported concerns about prejudice or discrimination.

Conclusions: The findings represent a detailed description in primary care of psychological reactions to WTC attacks and indicate a significant rate of posttraumatic symptoms among Hispanic primary care patients.

No. 89B
DEPRESSION AND DIABETES IN AN URBAN GENERAL MEDICINE CLINIC

Raz Gross, M.D., *Department of Epidemiology, Columbia University, 600 West 168th Street, Room 518, New York, NY 10032;* Mark Olfson, M.D., Marc J. Gameroff, Ph.D., Olveen Carrasquillo, M.D., Steven Shea, M.A., Rafael Lantigua, M.D., Myrna M. Weissman, Ph.D.

SUMMARY:

Objective: The primary aim of this research is to assess in a largely Latino primary care clinic population the association of major depression (MDD) with poor glycemic control (PGC), an outcome of diabetes management.

Method: Data from two consecutive, cross-sectional, mental health surveys in an urban general medicine clinic (N=2,163), cross linked to the hospital's computerized databases, will be presented. Current MDD was measured with the Patient Health Questionnaire (PHQ). PGC was defined as Hemoglobin A_{1c} [HbA_{1c}] ≥8%.

Results: In the first survey data, we identified 295 patients (mean age 57.2 ± 10.2 years; 71% Latinos) with recent ICD-9 codes for DM, and one or more HbA_{1c} tests. Prevalence of MDD was 28.5%. Probability for PGC steadily increased with severity of depression. Forty-six (54.8%) of the 84 patients with MDD had HbA_{1c}≥8%, compared with 63/145 (43.4%) in the minimal-mild depression group, and 25/66 (37.9%) in the no depression group (adjusted odds ratio: 2.52 [1.10–5.77], P=.03, for moderate or severe depression vs. no depression). Only 42.8% of the patients with MDD received past year mental health treatment.

Conclusions: Improving identification and treatment of depression in this high-risk population might have favorable effects on diabetic outcomes.

No. 89C
BIPOLAR SPECTRUM DISORDER IN HISPANIC PRIMARY CARE PATIENTS

Amarendra Das, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 24, New York, NY 10032;* Marc J. Gameroff, Ph.D., Rafael Lantigua, M.D., Steven Shea, M.A., Mark Olfson, M.D., Myrna M. Weissman, Ph.D.

SUMMARY:

Objective: To characterize bipolar spectrum disorder (BSD) in Hispanic primary care patients.

Methods: A systematic sampling and psychiatric screening of adult patients was undertaken at an urban general medicine clinic. The Mood Disorder Questionnaire (MDQ), a recently validated screen for lifetime hypomanic/manic symptoms, was used to assess a history of BSD. Among Latino patients, we examined demographic correlates, comorbid conditions, and treatment patterns of BSD.

Results: Of 1,147 patients, 941 were of Hispanic ethnicity. The prevalence of hypomanic/manic symptoms was 9.8%; 22.2% reported being diagnosed with BSD. Patients with BSD are more likely to be poor (household income less than $6,000) than those without BSD (13.2% vs. 7.0%, $P = 0.002$). Current major depression (48.9% vs. 18.4%, $P < 0.001$), suicidality (20.7% vs. 4.3%, $P < 0.001$), and alcohol use disorder (20.5% vs. 4.6%, $P < 0.001$) are more prevalent in patients with BSD. 39.8% took a psychotropic medication in the past month, and 57.1% of these patients were prescribed an antidepressant without concurrent mood stabilizer.

Conclusions: Nearly one out of ten Latinos presenting to primary care may have a bipolar spectrum disorder associated with current depression and suicidality. Few cases are recognized, and many receive inappropriate treatment.

No. 89D
DISPARITIES IN MENTAL HEALTH TREATMENT FOR LATINOS IN COMMUNITY CARE

William Vega, *151 Centennial Avenue, Piscataway, NJ 08854;* Shula Minsky, Ed.D., Michael Gara, Ph.D., Theresa M. Miskimen, M.D.

SUMMARY:

Objective: To examine rates and correlates of failure to present for therapeutic treatment appointments among Latinos compared with other groups.

Methods: Administrative data were used to contrast rates of failure to present for treatment among individuals who made an appointment for initial evaluation and among patients in treatment at University Behavioral Health Care, the largest mental health services provider serving north and central New Jersey.

Results: Latinos and African Americans were about 40% more likely to be no shows for treatment. Detailed analyses of ethnic patterns and correlates of failure to present are described.

Conclusions: As the Latino service population increases rapidly in size, significant no-show rates will become a serious cost and administrative burden to mental health providers. Issues of preparing Latinos for treatment to improve retention and quality of care need greater attention. Stigma, community and patient education, and cultural competence issues need to be addressed to overcome discontinuities of care.

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THURSDAY, MAY 6, 2004

SYMPOSIUM 90—NEW CLINICAL INDICATIONS FOR LIGHT TREATMENT: STATUS REPORT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) identify and discuss the important clinical factors for selecting between light and medication treatment for winter depression, (2) describe the use of light treatment and negative ions in antepartum and chronic depressive conditions, and (3) discuss the evidence base for light treatment of nonseasonal depression.

No. 90A
TREATMENT OF WINTER DEPRESSION: LIGHT OR DRUGS?

Raymond W. Lam, M.D., *Department of Psychiatry, University of British Columbia, 2255 Wesbrook Mall, Vancouver, BC V6T 2A1, Canada;* Anthony J. Levitt, M.D., Robert D. Levitan, M.D., Murray W. Enns, M.D., Rachel L. Morehouse, M.D.

SUMMARY:

Both light therapy and antidepressant medications have been studied in randomized, controlled trials (RCTs) in seasonal affective disorder (SAD), or winter depression. Studies have shown that efficacy and response rates for each type of treatment are similar. However, there is little evidence comparing light treatment and antidepressants within a single study, so the question of which treatment to recommend to patients is still unanswered. Factors identified in evidence-based clinical guidelines that may be important for selecting a treatment include side-effect profile, motivation for treatment, convenience, cost, severity, and, perhaps, symptom profile. In this presentation, studies that directly compare light and medication will be reviewed. New data from a recently completed Canadian multicenter RCT of light treatment versus fluoxetine will be highlighted.

No. 90B
LIGHT TREATMENT FOR ANTEPARTUM DEPRESSION

Katherine L. Wisner, M.D., *Department of Psychiatry, University of Pittsburgh, WPIC 3811 O'Hara Street, Pittsburgh, PA 15213;*

SUMMARY:

Objective: Two studies were conducted to evaluate light treatment for nonseasonal major depression in pregnant women.

Methods: (1) Seventeen subjects enrolled in a single-blind, open trial. Morning bright light that produced 10,000 lux was provided for five weeks. (2) In a randomized design, ten subjects received daily bright light for five weeks with either bright (7000 lux) or dim (500 lux) illumination. After five weeks, partial responders increased exposure to 75 minutes, and dim light nonresponders were treated with active light.

Results: (1) The mean SIGH-SAD score dropped by 42% from of 27 ± 5 to 15 ± 8 for patients who completed three weeks, and by about 50% to 14 ± 12 for subjects who completed five weeks. (2) Eight women completed the randomized trial; two subjects in the placebo group dropped out. The bright light- and placebo-treated groups showed a ten and five point symptom reduction at five weeks,

respectively. In a random effects regression analysis across ten weeks, a significant effect for the presence of bright light (effect size=0.43) was observed.

Conclusions: These findings provide evidence for an active effect of bright light for antepartum depression and compel an expanded RCT.

No. 90C
BRIGHT LIGHT AND NEGATIVE ION TREATMENT FOR CHRONIC DEPRESSION

Namni Goel, Ph.D., *Department of Psychology, Wesleyan University, 207 High Street, Judd Hall, Meddletown, CT 06459-0408;* Jiuan Su Terman, Ph.D., Michael Terman, Ph.D., Mela M. Macchi, Ph.D., Jonathan W. Stewart, M.D.

SUMMARY:

Objective: Bright light and high-density negative air ion exposure show treatment success for winter depression. These nonpharmacologic treatments also may benefit nonseasonally depressed patients who discontinue relapse, cannot tolerate, or lack response to medication.

Method: A total of 24 women and eight men, ages 22–65 with major depressive disorder (single episode chronic) were randomly assigned to bright light (10,000 lux; n=10), high-density negative ions (4.5×10^{14} ions/sec; n=12), or a low-density ion placebo (1.7×10^{11} ions/sec; n=10). Treatment was taken daily for five weeks (1 h, ≤10 min after waking). The Structured Interview Guide for the Hamilton Depression Rating Scale—Seasonal Affective Disorder Version (SIGH-SAD) assessed weekly response. Entry scores were ≥20; remission was a score reduction to ≤8.

Results: Baseline depression severity was similar across groups. All groups showed significant score improvement; however, improvement was far greater under light and high-density ions than under placebo. Remission rates also were similar for the two active treatments; both showed large effect sizes relative to placebo.

Conclusions: Bright light or high-density negative ions produced significantly greater clinical improvement than low-density ions in chronic depression. Success rate was similar to that seen for winter depression.

NIH MH42931 (MT; JST); Wesleyan Project Grant (NG).

No. 90D
A META-ANALYSIS OF LIGHT TREATMENT FOR NONSEASONAL DEPRESSION

Arja L. Tuunainen, M.D., *Department of Psychiatry, University of Helsinki, Lapinlahdentie 1 PO Box 320, HUS Helsinki FIN-00029, Finland;* Daniel F. Kripke, M.D., Takuro Endo, M.D.

SUMMARY:

The authors are completing a systematic review of light treatment of nonseasonal depression for the Cochrane Collaboration. The world literature was searched systematically through several indexes, and knowledgeable consultants were asked to identify all relevant studies. More than 20 controlled trials of bright light treatment for nonseasonal depression were identified, some published in several places, but not all could be included due to strict criteria regarding methods of randomization and choice of placebos or other control treatments. Treatment durations ranged from one hour on one day to two hours daily every four weeks. A great majority of trials randomized light treatment with placebo as an adjunct for inpatients who were also receiving antidepressants and milieu therapy, and about half of the trials had applied light with concomitant sleep deprivation. The majority of studies reported treatment benefits with bright light for nonseasonal depression. It is hoped that by the time of the meeting, the Cochrane Collaboration will have formally released the final results of this review.

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SYMPOSIUM 91—MOOD DISORDERS IN WOMEN THROUGHOUT THE LIFE CYCLE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize barriers to treating pregnant women with substance use disorders, to identify and treat postpartum psychosis and learn prevention strategies, to recognize features of premenstrual dysphoria and depression during perimenopause and menopause and their treatment.

No. 91A
PREGNANT ADDICTS DO NOT USE DRUGS

Leslie H. Gise, M.D., *Department of Psychiatry, University of Hawaii, 1035 Naalae Road, Kula, HI 96790*

SUMMARY:

Addiction in women differs from that in men. Most pregnant addicts make positive behavior changes in response to getting pregnant. Many stop using during pregnancy, which provides a window of opportunity for substance abuse treatment. Negative attitudes toward addicts are more toward women than for men and pregnant addicts have been criminally prosecuted. This punitive approach has been associated with less prenatal care and less substance abuse treatment. Collaboration between treatment providers and law enforcement is controversial but creative models of collaboration appear successful. Besides pregnancy, other gender differences in addiction relate to epidemiology, abuse and victimization, sexual dysfunction, psychiatric comorbidity, and relationships. Honoring culture in women's addiction treatment is a hallmark of a gender-specific substance abuse treatment program on Maui. This innovative community treatment program uses Hawaiian culture to improve access and outreach and includes psychiatric consultation. Women served are 46% native Hawaiian, predominantly single, unemployed mothers who have not completed high school. Seventy-nine percent used drugs before age 17 with "ice" (a unique form of smokeable crystal methamphetamine) being the drug of choice for 66%. Outreach in 2002 resulted in 48% entering treatment, 39% completing intensive outpatient treatment, and 36% completing residential treatment.

No. 91B
POSTPARTUM PSYCHOSIS: PHENOMENOLOGY, TREATMENT, AND PREVENTION

Margaret G. Spinelli, M.D., *Department of Psychiatry, Columbia Presbyterian Hospital, 1051 Riverside Drive, Suite 123, New York, NY 10032*

SUMMARY:

Postpartum psychiatric disorders are a major public health problem. Psychiatric hospital admissions increase seven times in the first three postpartum months compared with pregnancy. Postpartum psychosis is relatively rare at 1-2/1000 births. Psychiatrists unfamiliar with the perinatal literature have limited information on the symptoms, signs, prevention, and even the dire consequences of these illnesses. Clinicians may therefore be less cautious about the unpredictable nature of the psychosis and potential danger to the infant. Since gonadel steroids have multiple mood modulator effects, endocrine withdrawal has become a focus of etiology and represents a first step in the sequence of biological events that may trigger psychiatric symptoms. Psychiatry has failed to demonstrate a unique phenomenology to postpartum disorders, precluding a distinct diagnostic category in the DSM-IV. Yet in the 19th century. Marce described unique presentations including agitation, delirium, alternating mania and melancholy, and loss of memory. Contemporary experts describe the same organic picture associated with a delirium-like, impaired sensorium, cognition and a waxing and waning picture of mood lability and amnesia. Unusual psychotic symptoms, such as tactile, olfactory, and visual hallucinations present in a woman who looks well at one moment, but floridly psychotic in the next. The task for psychiatry is to identify phenomenology and neurocognitive impairment in order to promote education, early identification, treatment and prevention, and reduce the risk of maternal morbidity and infant mortality. Prevention strategies for women at risk will be central to the presentation. Case vignettes of mothers who killed infants will be presented.

No. 91C
CYCLIC MOODS AND ACYCLIC MOODS

Kimberly A. Yonkers, M.D., *Department of Psychiatry, Yale University School of Medicine, 142 Temple Street, Suite 301, New Haven, CT 06510*

SUMMARY:

Findings from epidemiological studies consistently show that women are at a higher lifetime risk for unipolar mood disorders. Although the underlying causes for this increased risk are unknown and likely multifactorial, it is thought that times associated with fluctuations in gonadal steroids confer a greater likelihood of mood instability. The quintessential example of an association between fluctuations in mood and changing hormonal levels is the perimenstrual phase of the ovarian cycle, but the perimenopause may also constitute such a time. For example, dysphoric symptoms typically commence during the menstrual cycle when progesterone levels have peaked and are descending and when estrogen has had a second maxima. Symptom severity worsens until the onset of menses, but the majority of women continue to have problematic symptoms into menses, when both progesterone and estrogen levels are at their nadir. The type of symptoms women experience are relatively stable although the duration of the symptomatic period is variable from one cycle to another. While mood symptoms are not more common in menopausal women, perimenopausal women experience lability in mood and dysphoria during the perimenopause, lending support to the notion that fluctuations in gonadal steroids have an impact on women's moods.

No. 91D
THE GREATEST EXPERIMENT EVER PERFORMED ON WOMEN

Barbara Seaman, Ph.D., *110 West End Avenue, New York, NY 10023*

SUMMARY:

While doctors have, for years, prescribed HRT and other estrogen drugs to treat and prevent a variety of ailments from heart disease and osteoporosis to Alzheimer's, my reader mail reveals that women themselves are motivated to take estrogen for very different reasons. The depression, mood swings, and fear of memory loss that can accompany the menopause transition are among the top reasons women say they take the drugs. Pharmaceutical companies have exploited these anxieties for years, painting menopausal women in ad campaigns as crazed shrews made sane only by the addition of a strict estrogen regimen. Given the recent Women's Health Initiative confirmation of HRT's long suspected complications, such as elevated risk of heart disease, stroke, and cancer, it is necessary that women think carefully before resorting to HRT to treat menopausal depression. This is particularly true given that only 15% of women suffer mood symptoms severe enough that they are willing to take drugs. While we wait for more hard scientific evidence regarding the relationship of estrogen and mood to emerge, it is important for women to put menopausal depression and cognitive problems in their context. Like puberty before it, menopause is a profound biological transition that can, along the way, wreak temporary havoc on the body. But it is a natural life process that has a beginning, and, despite what drug companies would have women believe, an end.

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SYMPOSIUM 92—OVERCOMING BARRIERS TO LONG-TERM-CARE AND TREATMENT OF THE ELDERLY
APA Corresponding Committee on Long-Term Care and Treatment for the Elderly

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) appreciate the array and complexity of geriatric psychiatric conditions in diverse long-term care settings, (2) understand how various biological, psychosocial, ethno-cultural, systemic, and financial issues interact and impact patient presentations and interventions, and (3) manage complicated clinical situations creatively and effectively.

No. 92A
AN INSPIRATIONAL MODEL OF CARE IN RURAL LONG-TERM-CARE FACILITIES

David W. Hodo, M.D., *800 Tremont Street, P.O. Box 1334, Selma, AL 36702-1334*

SUMMARY:

Providing geriatric psychiatric care to elders in rural nursing homes can be challenging for many reasons. These include limited on-site access to psychiatrists, psychotherapists, and psychiatrically trained nursing staff; controlled availability of some psychotropic medications; and constrained support services. The range of psychiatric disturbances in rural nursing homes, the role of the psychiatrist in this setting as consultant and/or medical director, and creative therapeutic interventions with patients, families, primary care physicians and nursing staff will be discussed. The presenter will draw upon his many years of experience in treating elderly patients in rural nursing homes in the southern United States to provide viable solutions to difficult clinical situations in this setting, using clinical case studies.

No. 92B
THE PACE MODEL OF COMMUNITY-BASED CARE

Robert K. Dolgoff, M.D., *1749 Martin Luther King Jr Way, Berkeley, CA 94709-2139*

SUMMARY:

PACE programs, sometimes known as On Lok programs, provide all-inclusive medical care for seniors. Program participants are very ill. To gain entry into a PACE program prospective participants must meet the requirements for nursing home placement. Believing that seniors will usually be better off in the community, PACE centers do "whatever is needed" to keep enrollees at home. It works. Only about 10% of the enrollees live in nursing homes.

For the last 12 years, the author has been the psychiatric consultant for two sites at the Center for Elder Independence in Oakland, California. Twelve years ago mentally ill participants tended not to be recognized as having psychiatric needs. When emotional disorders were identified, staff members often felt perplexed, helpless, or frightened. Three times a month the author spends part of his day with professional and nonprofessional PACE staff members interviewing patients and discussing depression, psychosis, agitation, dementia, substance abuse, and other mental disorders. Over the years, staff members have become more comfortable with these problems and have developed innovative techniques that make it possible for even very ill individuals to remain in the community. The author will share cases and methods.

No. 92C
AN ETHNO-CULTURAL MODEL OF CARE IN LONG-TERM-CARE FACILITIES

Ronald Brenner, M.D., *St. John's Episcopal Hospital, 327 Beach 19th Street, Far Rockaway, NY 11691-4423*

SUMMARY:

The number of ethnic minority elderly who reside in nursing homes is increasing rapidly. A few studies have been conducted on the role of ethnic and cultural factors in the design and utilization of long-term care facilities. However, insufficient attention has been given to the role of culture in the health of elderly, including recognition of the importance of crosscultural communication patterns. Incorporating culturally accustomed eating, socialization, and entertainment activities into day programming also is inherently important. Cultural care for the elderly in nursing homes is essential for the health, well-being, growth, and survival of these individuals. The presenter will discuss his experiences regarding ethno-cultural issues in long-term care settings and suggest achievable goals and methods to promote ethno-cultural care for the elderly in nursing homes.

No. 92D
CAN YOU EVER GET PAID FOR TREATING PATIENTS IN LONG-TERM-CARE SETTINGS?

Istvan J.E. Boksay, M.D., *Department of Psychiatry, New York University School of Medicine, 3 N316 Millhauser Labs, 550 1st Avenue, New York, NY 10016*

SUMMARY:

Financing strategies have greatly influenced the development of psychiatric services for older adults. Payment mechanisms and related policies have influenced the identification of patient groups, service organization, service delivery sites, the type and behavior of providers, and the process of evaluation and treatment. Beginning in 1965, with the implementation of Medicare and Medicaid, a substantial proportion of the financial responsibility for the psychiatric care of elderly persons in the United States shifted to the federal government (Medicare) or to shared responsibility between the states (Medicaid) and the federal government. In 1965, before the initiation of Medicare, only about half the population aged 65 years or older in the United States had health insurance. Today, 96% of the elderly are enrolled in the Medicare program.

The presenter will highlight key financial issues that affect the psychiatric care of older adults. Essential details specific to reimbursement of geropsychiatric services are provided. Knowledge of the subtleties of these financing mechanisms should help providers appreciate the range and complexity of payment options for psychiatric care to elderly in long-term care settings and understand how to optimize appropriate payment for services provided to these patients.

No. 92E
BARRIERS TO PSYCHIATRIC CARE IN ASSISTED LIVING FACILITIES

Helen Kyomew, M.D., *Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

Assisted living facilities (ALFs) provide housing, meals and personal care assistance to the elderly and to people with mental and physical disabilities who need support to reside in the community but do not require institutionalization. They provide a long-term care alternative for those who need more assistance than is provided in a retirement community but who do not need the medical and skilled nursing care of a nursing facility. More than 600,000 elderly people in the United States reside in ALFs. Recently, this number has been growing by 15 to 20 percent each year. There is limited research on the mental health of ALF residents. Available data suggest that the prevalence of depressive symptoms in ALF residents is clinically significant, with the provision of social support being an important factor in potentially reducing rates of depression in this population. Assisted living facility residents may have difficulty accessing geriatric psychiatric care for various reasons. These include limited on-site access to psychiatrists, psychotherapists and case managers, insufficient staff education regarding mental health difficulties in ALF residents, and restricted medication assistance. The range of psychiatric disturbances in ALF residents, the role of the psychiatrist in this setting, and the promotion of high quality mental health care in ALFs will be discussed.

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SYMPOSIUM 93—DEVELOPMENTAL DISABILITIES FROM CHILDHOOD TO ADULTHOOD

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize several of the diagnostic and treatment issues that are unique to adults with developmental disabilities.

No. 93A
FETAL ALCOHOL SPECTRUM DISORDERS FOR MENTAL HEALTH PROFESSIONALS: A BRIEF REVIEW

Paula J. Lockhart, M.D., *Department of Psychiatry, Kennedy Krieger, 3901 Greenspring Avenue, 2nd Floor, Baltimore, MD 21211;*

SUMMARY:

Fetal alcohol spectrum disorders is characterized by emotional, behavioral, cognitive, and/or social disabilities that can prevent the individual from functioning independently as an adult. It is therefore an important condition to those providing mental health treatment. With no safe level of alcohol consumption found during pregnancy, symptoms at the severe end of the spectrum can be obvious, easily diagnosed, and extremely debilitating. At the mild end of the spectrum, the disabilities may be subtle, and often attributed to other causes. Because of the lack of widespread knowledge of this disorder by mental health providers, especially in the absence of mental retardation or dysmorphic features, individuals with fetal alcohol spectrum disorders are often not identified as having an organically based mental health or cognitive disorder; thereby reducing their ability to qualify for special support services found to improve long-term outcome. There is much the mental health professional can provide to improve the lives of these individuals. Accordingly, the mental health community needs to be prepared, as the disorder becomes more widely recognized by affected patients and their families, to provide formal, accurate diagnoses and sensitive, creative options to address these issues in all aspects of treatment.

No. 93B
BEHAVIORAL INTERVENTIONS FOR AUTISM AND DEVELOPMENTAL DISORDERS IN ADULTS

Joel D. Bregman, M.D., *North Shore Long Island Jewish Health, 4300 Hempstead Turnpike, Bethpage, NY 11714;* John Gertz, M.D.

SUMMARY:

Even with the increasing use of pharmacological interventions in treating children and adults with autism, behavioral interventions remain a significant treatment approach for promoting the social, adaptive, and behavioral functioning of these individuals. The sophistication of these strategies has increased substantially, reflecting advancements in technique and refinements in behavioral assessment. Of particular importance has been the development of improved methods of identifying environmental factors and events that precipitate and maintain maladaptive patterns of behavior.

This presentation discusses the recent literature regarding specific behavioral interventions developed to ameliorate the core features of autism and reduce the behavioral symptoms frequently associated with the syndrome (e.g. aggression, self injury, destructive behavior, noncompliance, agitation, stereotypy). Categories of behavioral interventions that will be discussed include antecedent and consequence interventions, skill acquisition treatments, and respondent conditioning procedures. The differential efficacy of these interventions will be described. Community implementation of behavioral interventions will also be presented.

No. 93C
SUBSTANCE USE DISORDERS IN YOUNG ADULTS WITH AND WITHOUT LEARNING DISABILITIES

Joseph H. Beitchman, M.D., *Hospital for Sick Children, 555 University Avenue, Toronto, ON M56 1X8, Canada;* Lori Wilson, Arlene Young, Edward Adlaf

SUMMARY:

This presentation reports on young people with and without learning disabilities (LD) and substance use disorders (SUD). Participants were assessed for LD at ages 12 and 19 years and for SUD and psychiatric disorders at age 19. Participants with LD at ages 12 and 19 were more likely to develop an SUD or a psychiatric disorder compared with participants without consistent LD. Participants with LD at age 19 were more likely to have concurrent SUD or psychiatric disorder compared with those without LD at age 19, while participants with LD at age 12 showed only a trend toward increased rates of SUD at age 19 when compared with participants without LD at age 12. Participants with and without LD did not differ in substance use, consumption levels, or onset history. In a multivariate model, adolescent LD was associated with three-fold increased risk for SUD after behavioral problems and family structure had entered the model. Although those results provide some support for the notion that adolescents with LD are at increased risk for SUD, LD also appears to confer a general risk for adverse outcomes.

No. 93D
PSYCHOPHARMACOLOGY IN MENTAL RETARDATION AND PERVASIVE DEVELOPMENTAL DISORDERS

Bryan H. King, M.D., *Dartmouth Hitchcock Medical Center, One Medical Center Drive, Lebanon, NH 03756*

SUMMARY:

Psychotropic medications are commonly used in individuals with mental retardation (MR) or pervasive developmental disorders (PDD). The atypical neuroleptic medications hold much promise in terms of potential benefit for those with significant behavioral disturbances, including aggression and self-injury. While no single drug or class of medication has yet emerged as consistently effective, antidepressants, adrenergic medications, and new anticonvulsants may also find an important place in the treatment of some individuals with mental retardation and PDD. Evidence is accumulating to support the shift from typical to atypical neuroleptic agents in these populations. However, much work remains with respect to elaborating the knowledge base concerning the use of psychotropic medications for these individuals in every age group. This includes advances in the emotional and behavioral assessment, identification of predictors of drug response, and additional controlled drug trials involv-

ing those with MR and PDD. It remains axiomatic that medication be used in the context of a comprehensive treatment plan.

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SYMPOSIUM 94—UPDATE ON TREATMENT OF STIMULANT ABUSE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize stimulant abuse in patients, diagnose its common psychiatric comorbidities, a treat it effectively using both psychosocial and pharmacological modalities.

No. 94A
RECOVERY-ORIENTED PSYCHOSOCIAL TREATMENT

Douglas M. Ziedonis, M.D., *Department of Psychiatry, UMDNJ, Robert Wood Johnson Medical School, 675 Hoes Lane, Room D349, Piscataway, NJ 08854*

SUMMARY:

Psychosocial interventions continue to be the cornerstone of cocaine addiction treatment. This presentation will provide a practical overview of psychosocial treatments for treating addiction, including relapse prevention, 12-Step Facilitation, Motivational Enhancement Therapy, Community Reinforcement Approach, and couples/family therapies. Specific goals and techniques used in these approaches will be presented. Psychotherapy in the treatment of addiction is crucial in developing a therapeutic alliance that promotes recovery, increases motivation to change, develops general and specific coping skills to reduce the likelihood of relapse, and facilitates developing alternative highs. Psychotherapy can also help the patient improve interpersonal functioning; improve their understanding of the nature of addiction and the course of recovery; find meaning, purpose, and sense of connection in their lives; and maintain compliance with treatment. Treatment-matching issues will be discussed including motivational level, social support, relapse potential, recovery status, history of prior treatments and response, co-occurring mental illness, and other substance use disorders and compulsive behaviors. Psychosocial treatment models from the recovery community will be presented and how complementary approaches (music, art, meditation, etc) have been integrated with the evidence-based behavioral therapies. Participants will learn about resources and training materials on psychosocial treatments.

No. 94B
THERAPY AND PLACEMENT APPROACHES FOR COCAINE ABUSE TREATMENTS

David R. Gastfriend, M.D., *Department of Psychiatry, Massachusetts General Hospital, 388 Commonwealth Avenue, Lower Level, Boston, MA 02115;* Gurmit Shimi Kang, M.D., Sandrine Pirard, M.D., Estee Sharon, Psy.D.

SUMMARY:

Approaches for treating stimulant abuse may be organized in terms of two domains: therapy modality and level of care. Therapy modalities have been studied in controlled, manual-driven, multisite designs. The NIDA Cocaine Collaborative Treatment Study compared cognitive therapy, supportive-expressive therapy, individual drug counseling (all delivered with group drug counseling), vs. group drug counseling alone. Unexpectedly, individual + group drug counseling produced the best outcome, regardless of psychiatric comorbidity. Self-help participation was a key outcome influence. Level of care matching has also been studied in three studies of the Patient Placement Criteria published by the American Society of Addiction Medicine (ASAM PPC). These trials used a comprehensive, reliable, computerized implementation of the ASAM PPC. Two studies naturalistically compared matching-mismatching, one in a VA and another in a public New York City sample. Another study used a random control, multisite match-mismatch design in eastern Massachusetts. Multidimensional results indicate that matching patients to level of care based on their clinical and psychosocial characteristics (including attitude toward treatment) improves treatment outcome and efficiency. Together, these findings suggest that patients with stimulant abuse require psychosocial treatments with a coherent recovery-oriented message, adequate treatment intensity, and consideration of motivational, relapse prevention, and environmental support needs.

No. 94C
PHARMACOLOGICAL TREATMENT OF STIMULANT ABUSE

David A. Gorelick, M.D., *Department of Clinical Pharmacology, NIH NIDA IRP, 5500 Nathan Shock Drive, Baltimore, MD 21224–0180*

SUMMARY:

Numerous pharmacological treatments for stimulant abuse have been evaluated, but none has been consistently effective in controlled clinical trials. Some medications showing promise in clinical trials, but not FDA-approved for this indication, include the selective MAO inhibitor selegiline, anticonvulsants such as phenytoin and vigabatrine, and disulfiram (perhaps by increasing brain dopamine activity). Some promising new approaches undergoing preclinical or phase I clinical evaluation include compounds (e.g., GBR 12909) that bind to the presynaptic dopamine transporter, a major site of action for cocaine; antibodies that bind cocaine peripherally, thus preventing it from entering the brain (cocaine vaccine); and enhancement of cocaine metabolism with the naturally occurring enzyme butyrylcholinesterase. A particularly difficult group of patients to treat are those abusing other drugs in addition to stimulants, e.g., "speedballers." Buprenorphine, a partial mu-opiate agonist, has shown some promise in the treatment of such patients.

No. 94D
PSYCHIATRIC COMORBIDITY IN STIMULANT ABUSERS

Richard N. Rosenthal, M.D., *Department of Psychiatry, Saint Luke's Roosevelt Hospital Center, 1090 Amsterdam Avenue, 16th Floor, Suite G, New York, NY 10025*

SUMMARY:

Epidemiologic and treatment-survey data consistently indicate that psychiatric comorbidity is very common among stimulant abusers and alters the course and recommended treatment of the substance use disorder. This presentation will focus upon treatment issues of co-occurring disorders after reviewing important epidemiologic and diagnostic issues specific to this population. Stimulant abusers often present for treatment with complaints of psychiatric symptoms, especially depression and anxiety. In addition, stimulants are known to directly cause psychotic symptoms as well as a variety of mood and anxiety symptoms, and as such, diagnosis of non-substance-related (NSR) mental disorders in this group is not straightforward. Yet, it is important to accurately elucidate the present diagnoses in order to provide the most specific and effective treatments. New approaches to behavioral treatment of stimulant abusers with differing NSR psychiatric diagnoses such as schizophrenia, mood disorders, and PTSD will be presented, with information on how traditional addiction approaches have been effectively modified for the mentally ill. In addition, novel pharmacotherapeutic strategies that have been developed for stimulant abusers with differing comorbidity will be reviewed, including recent work from the Texas Medication Algorithm Project's Treatment of Substance Abuse Co-occurring With Other Mental Disorders.

No. 94E
METHAMPHETAMINE ABUSE: 2004 UPDATE

Steven L. Batki, M.D., *Department of Psychiatry, SUNY Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210*

SUMMARY:

Methamphetamine abuse continues to be a serious and growing problem in the United States. Deaths involving methamphetamine use have increased in recent years and the spread of methamphetamine is particularly extensive in the western United States including the Pacific Northwest, Arizona, Hawaii, and especially California. Methamphetamine is prominently associated with severe forms of psychiatric and medical morbidity. Psychiatric effects include psychosis and depression with suicidal behavior. Among the most serious medical consequences may be an increase in HIV risk. Methamphetamine use has been closely linked to high-risk HIV behaviors, and methamphetamine users have some of the highest HIV seroprevalence rates among drug users. There is a need for medical treatments for methamphetamine abuse, but there are no established, effective pharmacotherapies, although a number of medications are theoretically plausible to utilize, and research trials are under way. Treatment remains primarily psychosocial, utilizing cognitive-behavioral strategies focusing on motivational counseling and relapse prevention in a group setting. This presentation will review the clinical features, assessment, and treatment of methamphetamine abuse and its sequelae.

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SYMPOSIUM 95—DEPRESSIVE PERSONALITY DISORDER VERSUS DYSTHYMIC DISORDER

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should better understand characteristics of, overlap of, and distinctions between these chronic mood syndromes.

No. 95A
CONCEPTUAL ISSUES IN THE OVERLAP OF DEPRESSIVE PERSONALITY AND DYSTHYMIA

Steven Huprich, Ph.D., *Department of Psychology, Baylor University, PO Box 97334, Waco, TX 76798-7334*

SUMMARY:

While depressive personality disorder and dysthymia have been evaluated for their similarities, a fundamental question to be addressed is whether evidence exists that demonstrates a distinctiveness between the two disorders. Perhaps one of the most important questions to consider in the inclusion of depressive personality disorder in the next version of DSM is whether depressive personality disorder is actually a personality disorder. The current paper will briefly review the history of chronic depressive disorders in the DSM system, followed by research that has distinguished the two disorders. A recent study will be presented, in which depressive personality disorder and dysthymia symptoms were differentiated by the relative contribution of state-depression and related personality traits. There will also be a discussion of important questions to be addressed in forthcoming research on the distinction between the two disorders.

No. 95B
LONGITUDINAL COMPARISON OF DEPRESSIVE PERSONALITY DISORDER AND DYSTHYMIC DISORDER

John C. Markowitz, M.D., *Department of Personality Studies, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 129, New York, NY 10032;* Andrew E. Skodol II, M.D., Eva Petkova, Ph.D., Hui Xie, Ph.D., David J. Hellerstein, M.D.

SUMMARY:

Few studies have compared the related diagnostic concepts of depressive personality disorder (DPD) and dysthymic disorder (DD). We attempted to replicate the findings of Klein and Shih in longitudinally followed patients with personality disorder or major depressive disorder in the Collaborative Longitudinal Personality Disorders Study.

Methods: Subjects (N=665) were rated at baseline and after two years (n=546) by trained assessors using structured clinical interviews and self-reports.

Results: Only 44 subjects (24.6% of 179 DPD and 49.4% of 89 early-onset DD subjects) met criteria for both disorders. Subjects with DPD had increased likelihood of other Axis II diagnoses, particularly avoidant (71.5%) and borderline (55.9%) PDs. DPD was associated with low levels of positive and high levels of negative affectivity

on dimensional measures of temperament. Subjects with DPD had lower likelihood of remission of baseline major depressive episodes at two-year follow-up, whereas subjects with DD did not. Kappa and intraclass correlation coefficients indicated instability of the DPD diagnosis over two years; only 31% (n=47) of 154 subjects meeting criteria on blind retesting.

Conclusions: DPD and DD appear to be related but differing diagnostic constructs. The validity of DPD is supported by its predicted relationship to temperamental measures, but weakened by temporal instability.

No. 95C
DEPRESSIVE PERSONALITY: 10-YEAR FOLLOW-UP

Daniel N. Klein, Ph.D., *Department of Psychology, State University of New York at Stony Brook, Psychology B Building, Stony Brook, NY 11794-2500*

SUMMARY:

Depressive personality is a controversial construct that has been included in the DSM-IV appendix as a condition requiring further study. In this presentation, I will discuss the results of a 10-year prospective naturalistic follow-up study of depressive personality. Subjects were 142 outpatients with Axis I depressive disorders. The patients were assessed with semi-structured interviews for Axis I and II disorders at 30-month intervals, for up to five evaluations. Depressive personality was assessed using both the DSM-IV and Akiskal (1983) definitions. We found that depressive personality was moderately stable over time using both categorical and dimensional measures. In addition, depressive personality traits were associated with a poorer course of Axis I mood disorders, even after controlling for severity of depressive symptoms.

No. 95D
IMPACT OF COMORBID DYSTHYMIC DISORDER ON OUTCOME IN PERSONALITY DISORDERS

David J. Hellerstein, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 101, New York, NY 10032;* Andrew E. Skodol II, M.D., John C. Markowitz, M.D., Eva Petkova, Ph.D., Hui Xie, Ph.D.

SUMMARY:

Objective: The goal of our study was to investigate the impact of dysthymic disorder (DD), a form of chronic depression, on outcome in individuals with personality disorders (PD) over time.

Method: The Collaborative Longitudinal Study of Personality Disorders is a longitudinal study of 573 subjects with four targeted PDs (borderline, avoidant, schizotypal, and obsessive-compulsive) compared with 95 subjects with major depression but no PD. A total of 116 subjects were diagnosed at baseline with coexisting dysthymic disorder (DD), of whom 109 (94%; or 19% of the PD study sample) were PD subjects. A series of regression analyses were performed to assess impact of DD on outcome. The primary hypothesis was that DD diagnosis at baseline would be associated with worse outcome over a two-year follow-up period, including persistent PD diagnosis; impaired psychosocial functioning (on the Longitudinal Interval Follow-up Evaluation (LIFE)); and frequent ER visits, suicide attempts, and psychiatric hospitalizations.

Results: Baseline DD diagnosis was associated with persistence of PD diagnosis at two-year follow-up, particularly for borderline and avoidant PDs. On the LIFE, baseline DD diagnosis was associated with worse outcome on global social adjustment, life satisfaction, recreation, and friendships, but not on areas such as employment or relationship with spouse. Contrary to expectation, ER visits, suicide attempts, and psychiatric hospitalizations were not increased.

Conclusions: Baseline DD comorbidity is associated with persistence of PD diagnosis over time, and with worse outcome on many, but not all, measures.

Funding source: Supported by NIMH grants R01 MH50837, MH50838, MH50839, MH50840, MH50850.

No. 95E
CLINICAL CORRELATES OF CHRONICITY IN DEPRESSION: RESULTS FROM THE RHODE ISLAND MIDAS PROJECT

Mark Zimmerman, M.D., *Department of Psychiatry, Rhode Island Hospital, 235 Plain Street, Suite 501, Providence, RI 02905;* Iwona Chelminski, Ph.D.

SUMMARY:

Upon presentation for treatment, a patient indicates that his/her current symptoms of major depressive disorder have lasted for more than two years. Thus, the patient meets the DSM-IV chronic depression specifier. What clinical features and comorbid disorders should the clinician be more vigilant about assessing because they are more frequent in chronic than nonchronic depression? While longitudinal studies have examined the predictors of depression persistence, we are unaware of studies that have compared patients who do and do not meet the DSM-IV criteria for chronic depression. Using data from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project, we will examine the demographic and clinical differences between chronic and nonchronic depressed outpatients. The MIDAS project is a large clinical epidemiological study in which semi-structured interviews for DSM-IV Axis I and Axis II disorders have been incorporated into a hospital-affiliated, though community-based, clinical practice. Patients were interviewed with the Structured Clinical Interview for DSM-IV (SCID) and the Structured Interview for DSM-IV Personality (SIDP-IV). To date, 1,800 patients have participated in the MIDAS project, more than 600 of whom received a principal diagnosis of major depressive disorder. In the results to be presented, we will compare chronic and nonchronic depressives on demographic characteristics, symptoms of depression, indices of depression symptom severity, history of suicidal behavior and psychiatric hospitalization, social and occupational functioning, and the frequency of comorbid Axis I and Axis II disorders.

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SYMPOSIUM 96—BEHAVIORAL TREATMENTS FOR DRUG DEPENDENCE Collaborative Session with the National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should know recent research advances, and understand the effects of four different types of behavioral treatments for drug use disorders, including cognitive-behavioral therapy ("relapse prevention"), individual drug counseling, lower-cost contingency management, and behavioral couples counseling.

No. 96A
DURABILITY OF COGNITIVE-BEHAVIORAL THERAPY EFFICACY FOR SUBSTANCE ABUSERS

Bruce J. Rounsaville, M.D., *School of Medicine, Yale University, 15 Woodland Drive, Woodbridge, CT 06525*

SUMMARY:

Based on social learning theories of substance use disorders, cognitive-behavioral coping skills therapy (CBT) focuses on implementation of effective coping skills for recognizing, avoiding, and coping with situations that increasc risk of drug use. CBT's efficacy is supported by randomized clinical trials of patients with dependence on alcohol, nicotine, cocaine, and marijuana. A particularly distinctive CBT characteristic is that benefits appear not only to be durable but to become stronger after treatment ends. Five separate clinical trials of CBT for substance abusers have demonstrated this "sleeper effect" (i.e. growing superiority to comparison treatments after the end of treatment). This presentation will review the evidence for CBT's enduring effects, present findings on the potentially mediational role of homework completion and skill acquisition, and propose strategies for maximizing the efficacy of CBT. CBT is most efficacious for patients who finish treatment, complete homework assignments, and achieve abstinence by the end of treatment. Efficacy may be enhanced by augmenting CBT with contingency management interventions focused on treatment retention and homework compliance.

No. 96B
HIV RISK REDUCTION AND SUBSTANCE ABUSE TREATMENT

George E. Woody, M.D., *Department of Psychiatry, TRI at the University of Pennsylvania, 600 Public Ledger Building, Philadelphia, PA 19106*

SUMMARY:

Persons with substance use disorders have been shown to have high levels of HIV risk. For those dependent on opioids, the main risk factor is sharing injection equipment. For persons dependent on cocaine and other stimulants, the main risk factor appears to be unprotected sex though sharing injecting equipment also contributes. Persons with alcohol dependence also have increased sexual risk, though not to the same degree as those with cocaine or other stimulant dependence. Studies have consistently shown that methadone maintenance reduces HIV risk. The contribution of drug counseling and psychotherapy beyond that achieved with methadone alone has not been well studied but it would be expected to have additional effects. No effective pharmacotherapy is available for cocaine, amphetamine, or other stimulant dependence, but behavioral treatments, particularly drug counseling, have been shown to be associated with reductions in HIV risk behavior, mainly due to reduction in unprotcctcd sex. HIV-risk reduction in alcohol treatment has not been well studied but reduction in unprotected sex is likely. This presentation will review studies showing that behavioral treatments for persons with a wide range of substance use disorders reduce HIV risk.

No. 96C
LOW-COST CONTINGENCY MANAGEMENT IN COMMUNITY SETTINGS

Nancy M. Petry, Ph.D., *Department of Psychiatry, University of Connecticut Health Center, 263 Farmington Avenue, MC-3944, Farmington, CT 06030-3944*

SUMMARY:

Contingency management treatments that provide vouchers as reinforcers upon objective evidence of drug abstinence have efficacy in reducing drug use. However, these procedures have rarely been implemented in community settings, and their expense has been considered prohibitive because they usually allow for $1,000 in vouchers per patient. Another contingency management approach has been developed that provides the opportunity to draw from a bowl and have a chance of winning prizes as the reinforcer, rather than vouchers. Typically, this system provides about $250 in prizes per patient. A series of studies will be described demonstrating the efficacy of this system when implemented with a range of substance abusing patients in community-based treatment settings. Specifically, studies comparing the voucher and prize systems will be described, as will studies evaluating magnitudes of prize reinforcers, and the adaptation of this technique for use in group treatment format. In addition, studies comparing different targets of reinforcement (drug abstinence, compliance with goal-related activities, and attendance at treatment) will be reviewed.

No. 96D
COGNITIVE-BEHAVIORAL THERAPY AND NALTREXONE FOR COCAINE DEPENDENCE

Joy M. Schmitz, Ph.D., *Department of Psychiatry, University of Houston, HSC, 1300 Moursund Avenue, Houston, TX 77030;* Angela L. Stotts, Ph.D., John Grabowski, Ph.D.

SUMMARY:

Cocaine dependence is a complex disorder accompanied by a wide range of symptoms and problems. Combined treatments that target both pharmacological and psychological aspects of cocaine dependence have been recommended, but not yet widely investigated. This paper describes two parallel studies in which we evaluated the effects of naltrexone (NTX) and cognitive-behavior therapy (CBT) for cocaine dependence (Study 1) and cocaine-alcohol dependence (Study 2). Both studies utilized a full factorial design in which randomized subjects (n=85 in Study 1; n=80 in Study 2) received one of four treatment conditions for 12 weeks: NTX and CBT; NTX and drug counseling (DC); placebo and CBT; placebo and DC. NTX was 50 mg per day or a matching placebo, administered in double-blind fashion. The CBT focused on coping skills training and relapse prevention, while the DC emphasized education and support. Results from Study 1 revealed a significant three-way interation (time X medication x therapy), suggesting less cocaine use over time among subjects receiving CBT and 50mg NTX. In contrast, Study 2 results suggested initial improvement in the CBT (vs DC) group, but failed to support a medication effect. Together, these studies address the potential value and limitations of combined NTX-CBT treatment.

No. 96E
BEHAVIORAL FAMILY COUNSELING AND NALTREXONE FOR MALE, OPIOID-DEPENDENT PATIENTS

William S. Fals-Stewart, Ph.D., *RIA, State University of New York, Buffalo, 1021 Main Street, Buffalo, NY 14203;* Timothy J. O'Farrell, Ph.D.

SUMMARY:

Objective: Although the opioid-antagonist naltrexone has been shown to be an effective intervention with highly motivated opioid-dependent patients, it has not been widely used in practice largely because of poor compliance. The purpose of this study was to examine the effects of using family members to observe naltrexone ingestion by opioid-dependent patients as part of a medication compliance contract.

Method: Men ($N = 124$) entering treatment for opioid dependence who were living with a family member were randomly assigned to one of two 24-week treatments: (1) behavioral family counseling (BFC) plus individual treatment (patients had both individual and family sessions and took naltrexone daily in presence of family member) or (2) individual-based treatment only (IBT; patients were prescribed naltrexone and were asked in counseling sessions about compliance, but there was no family involvement).

Results: BFC patients, compared with their IBT counterparts, ingested more doses of naltrexone, attended more scheduled treatment sessions, had more days abstinent from opioids and other drugs during treatment and during the year after treatment, and had fewer drug-related, legal, and family problems at one-year follow-up.

Conclusions: These results indicate family-involved medication contracts can enhance naltrexone compliance among opioid-dependent patients, leading to improved treatment response and outcomes.

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SYMPOSIUM 97—ITALIAN PSYCHIATRY: 25 YEARS OF CHANGES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize the characteristics and changes in the Italian community psychiatry network.

No. 97A
ITALIAN PSYCHIATRISTS AND ITALIAN PSYCHIATRY: 25 YEARS OF CHANGES

Mariano Bassi, M.D., *Department of Mental Health, Viale Pepoli 5, Bologna 40123, Italy*

SUMMARY:

Italian psychiatry is probably more debated than is known in the international arena. Law 180 of 1978 introducing a radical community psychiatry system, has drawn worldwide attention giving space to debates and comments ranging from enthusiastic to frankly disparaging. Still recently this interest was marked by a well attended symposium on Lessons Learned from Italian Reforms in Psychiatry, held at the 2003 annual meeting of the Royal College of Psychiatrists in Edinburgh. Historical analyses of how the reform movement took momentum, produced a law, and how it was enacted, can be found elsewhere.

Now most Italian psychiatrists work in the public mental health system. The mental health department is the network that provides for outpatients and inpatients, for emergencies and for psychosocial rehabilitation, for drug therapy and the different psychotherapies. In Italy the mental health departments number 234. There are 5,561 psychiatrists working in the public mental health system (18% of the total number of the mental health workers) and 95.7% are state employees.

No. 97B
INTENSIVE COMMUNITY CARE: IS IT THE SAME IN ITALY AND THE REST OF THE WORLD?

Angelo Fioritti, M.D., *Program on Mental Health of Rimini, Axienda Usl Rimini, Rimini, Italy*

SUMMARY:

Aim: It is assumed that descriptions of services such as intensive case management (ICM) and assertive community treatment (ACT) imply recognized patient groups and processes. We tried to identify whether two ACT services in different health care contexts (e.g., Italy, the U.K., and the U.S.) serve patients with similar sociodemographic and clinical characteristics.

Method: Different researchers collected data on ACT patients in Italy, U.K. and U.S. Sociodemographic data, illness history, use of services and of medication were compared.

Results: As expected, in Italy patients significantly more often lived with their family and were employed. U.K. and U.S. patients were more ethnically diverse. In U.K. and U.S. a greater number suffered from psychotic disorders. Polypharmacy was much greater in Italy.

Discussion: Service descriptions can be misleading when used across differing health care contexts and need adequate input characterization to draw meaningful conclusions. Background social variables, organization and philosophy of psychiatric systems of care, as well as professional education, may all differ substantially between countries and influence the actual implementation of psychosocial care programs.

No. 97C
VARIATIONS IN MENTAL HEALTH SERVICE PROVISION IN ITALY AND THEIR LINKS WITH SOCIOECONOMIC PREDICTORS

Giuseppe Tibaldi, *Centro Studi E Richerche Psichiatria, Via Leoncavallo 2, Turin, Italy*

SUMMARY:

Aim: To investigate the extent of variability of Italian catchment area service structures 25 years after the implementation of national psychiatric reform. Service systems in nine contrasting Italian catchment areas will be described and relationships with sociodemographic variables explored.

Method: The European Service Mapping Schedule (ESMS) and European Socio-Demographic Schedule (ESDS) were used to describe (1) area sociodemographic characteristics; (2) services available in each area; and (3) service use in each area.

Results: Most Italian centers have a fairly broad range of service types available, but great differences emerged in quantity and pattern of service provision and use. In contrast to Northern Europe, high unemployment rates did not appear to be associated with high rates of service utilization. Southern Italian areas tended to have both high male unemployment and low service utilization rates. Trieste has a distinctive service configuration.

Discussion: Variability in levels and patterns of service use remains great long after the implementation of psychiatric reform laws. The basis of variations warrants further exploration. In particular, it is unclear whether low rates of service utilization in some relatively deprived areas reflect unmet need, lower demand for services in areas with strong family ties, or a combination.

No. 97D
RESIDENTIAL CARE IN ITALY: A NATIONAL SURVEY

Giovanni De Girolamo, M.D., *Department of Mental Health, Viale Pepoli 5, Bolagna 40123, Italy;* Angelo Picardi, M.D., Giovanni Santone, M.D.

SUMMARY:

Objective: The 'PROGRES' (PROGetto RESidenze', Residential Care Project) project is aimed to survey the main characteristics of all Italian non-hospital residential facilities (NHRFs) (Phase 1) and to assess in detail 20% of the NHRFs and the patients who live there (Phase 2).

Method: In Phase 1 structured interviews were conducted with the managers of all Italian NHRFs. In Phase 2, 20% of the surveyed facilities were evaluated by a research assistant who met with staff and then carried out an in-depth evaluation of each patient.

Results: On May 31, 2000, in Italy there were 1,370 NHRFs with 17,138 beds, with an average of 12.5 beds each and a rate of 2.98 beds per 10,000 inhabitants. Discharge rates were very low. Most had 24-hour staffing. In phase 2, 265 NHRFs have been evaluated in great detail, as well as 2,962 residents.

Conclusions: There is marked variability in the provision of residential places between different regions; discharge rates are generally low: NHRFs serve a very disabled population who in the past would have been admitted for lengthy stays in mental hospitals. However, the boundary between housing needs and treatment-rehabilitative aims of residential facilities seems unclear and needs to be identified.

No. 97E
COMMUNITY TREATMENT OF SCHIZOPHRENIA IN ITALY

Mirella Ruggeri, M.D., *Sezione di Prichiat Ria - DMSF, Dispedale Policlinco Ple Scoro, Verona 37134, Italy;* Antonio Lasaluia, M.D., Michele Tansella, M.D.

SUMMARY:

Aim: Care for people with schizophrenia, as in the Italian model of community care, should address a wide range of outcomes, including professional and consumer perspectives and assess effectiveness of care in various life areas. The aims of the study are: (1) to measure changes in psychopathology, functioning, needs for care, and quality of life occurring in a three-year period; (2) to assess the frequency of "good" and "poor" outcomes.

Method: Data obtained in several studies performed in the South-Verona Mental Health Service setting will be presented, detailing in particular the results of a three-year follow-up of an annual treated prevalence cohort of 107 patients with an ICD-10 diagnosis of schizophrenia attending the service.

Results: Mean symptom severity (especially negative symptoms) and some types of needs for care (especially social needs) worsen; quality of life shows no change over the study period.

Discussion: The outcome for schizophrenia at three years depends upon (1) the domain of outcome used, (2) whether staff or consumer ratings are used, and (3) the degree of stringency of the definitions used for good and poor outcome.

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SYMPOSIUM 98—WITHDRAWN

SYMPOSIUM 99—MIND, BRAIN, AND INTERPERSONAL EXPERIENCE IN PSYCHOTHERAPY

EDUCATIONAL OBJECTIVES:

At the end of this symposium, the participant should demonstrate an understanding of how the mind emerges from processes in the brain as they occur in the interaction between two people. Participants will be able to examine processes that create the present moment, are central to emotions, and give rise to intersubjective and narrative experience.

No. 99A
THE PRESENT MOMENT IN PSYCHOTHERAPY

Daniel N. Stern, M.D., *University of Geneva, c/o Center for Human Development, 11980 San Vicente Boulevard, Los Angeles, CA 90049*

SUMMARY:

Interactions between therapist and patient occur in the present moment. But what is this unit of experience? How do events from the past influence our present experience and how we move toward

the future? Philosophical, psychological, and neurobiological dimensions will be explored in this presentation that examines the qualities of "now" that influence our everyday experience of life and shape the power of psychotherapists to help their patients. Each moment of lived experience has a "horizon of the past" that shapes the contours of the subjective sense of the immediate "now" of the present. Likewise, the way our brains enable our minds to experience the present also creates a "horizon of the future" that carves our way forward through time. The patient's experience of the therapist occurs within the present; the therapist's capacity to sense the internal state of the patient's present moment enables a sense of affective joining to occur that may be pivotal in creating a therapeutic alliance. In this shared intersubjective present moment, a "moment of meeting," pivotal change processes can occur. Understanding the temporal, subjective, and intersubjective aspects of this interval of our subjective present moment is helpful in a psychotherapist's view of how to create change within the therapeutic process.

No. 99B
THE CENTRAL ROLE OF EMOTION IN PSYCHOTHERAPY

Diana Fosha, Ph.D., *Department of Psychology, Adelphi University, 80 University Place, New York, NY 10003*

SUMMARY:

The objective of this presentation is to offer participants ways of applying psychological and neuroscientific principles to understanding the central role of emotion in psychotherapy. What is emotion? Why is the experience of emotional arousal within the safety of an emotionally-engaged therapeutic relationship thought to be essential for deep and lasting change to occur? What is the relationship between synaptic change and emotional processes? How does the communication of emotional states facilitate therapeutic change? The presentation will explore these central questions and will include a theoretical portion, case presentation, and discussion. As a result of this presentation participants will have an increased understanding of the nature of emotion, affective communication, and the dyadic regulation of intense emotional experiences in the process of psychotherapy. Looking toward neuroscience and developmental research into mother-infant moment-to-moment interaction for some clues, this presentation will explore the nature of mind-brain processes and how the therapist's understanding of the complex interpersonal nature of emotion can facilitate effective therapeutic practices.

No. 99C
INTERSUBJECTIVITY, NARRATIVE, AND THE BRAIN IN PSYCHOTHERAPY

Daniel J. Siegel, M.D., *UCLA School of Medicine, 11980 San Vicente Boulevard, Suite 809, Los Angeles, CA 90049*

SUMMARY:

This presentation will discuss how therapeutic relationships can build on two fundamental processes of human consciousness that can give rise to two different forms of intersubjective joining experiences. In the here-and-now form of awareness, the creation of representations of the internal state of the other person, likely mediated in part via the mirror neuron system, can be proposed to allow the creation of shared internal states of intention and emotion in the present moment. In the past-present-future form of awareness, our narrative process enables us to attempt to make sense of our own and other's mental experience. Patients feel understood by therapists when their minds are embedded within the therapist's momentary attunement as well making-sense narrative process. Recent neuroscience studies have revealed that the orbitofrontal region of the prefrontal cortex may play a crucial role in the mediation of several processes involved in self-regulation and include attuned communication and autobiographical awareness. This presentation will explore the possibility that both of these forms of intersubjective joining known to be a part of secure attachment relationships may help promote the development of these prefrontally mediated processes in both normal development and in the psychotherapeutic process.

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SYMPOSIUM 100—FROM RESEARCH TO CLINICAL PRACTICES IN TREATING PATIENTS WITH BPD

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to apply findings from research to clinical care of BPD.

No. 100A
LEVELS OF CARE: A SCIENTIFIC AND CLINICAL OVERVIEW

John G. Gunderson, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478-9106*

SUMMARY:

This presentation will summarize empirical studies on the effectiveness of the various levels of care for borderline patients, i.e., hospital, residential, partial hospital, and outpatient. The particular value of intensive outpatient care will be highlighted. It will then provide an overview about the clinical indications for placing patients in the most appropriate level of care. Rather than seeing these levels as competing, the case will be made that the goals for each differ and that each serves different functions. This has implications for expectable and optimal lengths of stay and for the issues that research still needs to address.

No. 100B
INTENSIVE OUTPATIENT AND PARTIAL HOSPITAL CARE FOR BPD

Anthony Bateman, M.D., *Department of Psychotherapy, Saint Anns Hospital, Halliwick Unit, Saint Ann's Road, London N15 3TH, United Kingdom*

SUMMARY:

Psychoanalytically-oriented partial hospital (PH) treatment for borderline personality disorder has been shown to be more effective than treatment as usual in a randomized, controlled trial and, over 18-months follow-up, improvements at the end of treatment were maintained. PH treatment consisted of once-weekly individual psychotherapy, three times per week group analytic psychotherapy, and expressive therapy once a week in the context of informal, milieu patient-patient and patient-staff contact during other activities. Focus of treatment was on increasing "mentalization," namely, the capac-

ity to think about mental states of oneself and others as separate from, yet potentially causing actions. But the complexity of the PH program makes it problematic to establish effective components of treatment. An intensive outpatient treatment has now been developed consisting of only once-weekly group and individual therapy. This program is the subject of a randomized, controlled trial. Some data from a pilot study will be presented and the essential elements of mentalization-based treatment will be described, which include a focus on affect and its mental representation and an emphasis on the stability of the self-structure. Preliminary results suggest that this focus of therapy is more effective than an equally structured therapy.

No. 100C
COMPARING PSYCHOTHERAPIES FOR PATIENTS WITH BPD: A PROGRESS REPORT

Otto F. Kernberg, M.D., *Department of Psychiatry, New York Presbyterian Hospital, 21 Bloomingdale Road, White Plains, NY 10605-1504*

SUMMARY:

This presentation will provide information about the early findings of the psychotherapy research project of the Personality Disorders Institute at the department of psychiatry of the Weill Cornell Medical College. Brief definitions of transference-focused psychotherapy, dialectic behavior therapy, and supportive psychotherapy will be followed by the report on early results of our empirical studies, and on clinical observations that complement the statistical analysis. Particular areas to be explored are those of the problems of dropout, management and changes of aggression, suicidality, and the treatment effects on personality functions at large.

No. 100D
EFFECTS OF PSYCHOTHERAPY ON MDD IN PATIENTS WITH BPD

Janine L. Stevenson, M.D., *Department of Psychiatry, Westmead Hospital, PO Box 388, Northbridge 1560, Australia;* Russell Meares, M.D.

SUMMARY:

Comorbid depression in patients with borderline personality disorder responds to treatments that primarily address the individual's ongoing sense of personal existence, to which affect is linked, rather than the behaviors that may be secondary to the more fundamental disturbance. Many patients with depressive disorders have comorbid personality disorders and this frequently results in less successful outcomes and greater relapse rates when the standard treatments are used. Treatment of personality pathology in these patients, particularly those with treatment resistant or chronic depression may result in optimal outcomes. Psychodynamic psychotherapy, largely neglected in the treatment of depression in recent years, may be a powerful treatment modality in patients who fail to respond to other treatments.

No. 100E
A RANDOMIZED TRIAL OF PSYCHOEDUCATION FOR PATIENTS WITH BPD

Mary C. Zanarini, Ed.D., *McLean Hospital, 115 Mill Street, Belmont, MA 02478;* Frances R. Frankenburg, M.D.

SUMMARY:

Clinical experience suggests that most borderline patients are not told of their diagnosis. Of those who are told that they may have borderline personality disorder (BPD), most are not provided with up-to-date information concerning the disorder.

In this report, we describe the results of a randomized trial of psychoeducation for newly diagnosed borderline patients. Fifty women between the ages of 18–30 meeting both DIB-R and DSM-IV criteria for BPD and who are in no current treatment will be enrolled in the study. Thirty will be randomized to participating in a half-day psychoeducation workshop. During this workshop, a set curriculum concerning the phenomenology, etiology, treatment, and course of BPD will be presented. The other 20 subjects will be randomized to a wait list. All 50 will be followed weekly for 12 weeks. Follow-up assessments include measures of borderline psychopathology, psychosocial functioning, and use of emergency mental health services.

It is hypothesized that borderline patients who become informed consumers will be less symptomatic, have better psychosocial functioning, and use fewer emergency mental health services than borderline patients who remain uninformed about the BPD diagnosis.

Data from the completed study will be presented and the clinical significance of these findings will be discussed.

Funding Source: Eli Lilly

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SYMPOSIUM 101—MEANING IN SUICIDE: OVERCOMING BARRIERS AND CONNECTING DIVERSE PERSPECTIVES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate an understanding and coalescence of the psychiatric, psychological, sociological, and experiential struggles of those who die by suicide and those they leave behind.

No. 101A
EXISTENTIAL MEANING: UNIFYING DIVERSE PERSPECTIVES TO UNDERSTANDING SUICIDE

James R. Rogers, Ph.D., *Department of Counseling, University of Akron, Carroll Hall 127, Akron, OH 44325-5507;* Karen M. Soyka, M.S.

SUMMARY:

With relatively few exceptions, the contemporary study of suicide has shied away from attempts to understand suicide as a "meaningful" behavior. Instead researchers in the social-behavioral and medical sciences have sought to identify psychiatric, sociological, psychological, biochemical, and genetic characteristics of suicidal individuals that differentiate them from non-suicidal folks. While

this approach has arguably increased our knowledge of various sets of "correlates" of suicide and other suicidal behaviors, it has not had any measurable effect in terms of reducing the incidence and prevalence of completed and non-fatal suicidal behaviors. Additionally, researchers in suicidology have rarely collaborated across disciplinary lines and have systematically avoided including the experiences of suicide survivors and suicide attempters as sources of data for the contextual understanding or meaning of suicidal behaviors. Together, this has resulted in a significant gap between the scientific and experientially-based understandings of suicide. Most notably, this gap is evident in the differences in the language used in the scientific community and by survivors and attempters as they search for understanding.

In this presentation, we discuss the importance of *existential meaning* and shared language for advancing our understanding of suicide and provide a theoretical framework for cross-disciplinary research and the inclusion of suicide survivors and attempters as partners in the suicide research endeavor.

No. 101B
MEANING IN SUICIDE FROM THE SURVIVOR'S PERSPECTIVE

Carla Fine, M.S., *477 West 22nd Street, New York, NY 10011*

SUMMARY:

In spite of—or maybe even in addition to—all the research, studies, and theories about suicide, for survivors the question will always remain "Why?" As survivors try to understand the possible causes of our loved one's decision to die, we look to move beyond our own personal shock and grief in order to find some kind of meaning in this seemingly senseless act. When my husband, a prominent New York City physician, killed himself almost 15 years ago, I was initially silenced by my enormous sense of guilt as well as the stigma that defines this topic. After several years, I was able to tell my story—and those of many other survivors—in my book No Time to Say Goodbye: Surviving the Suicide of a Loved One. Since that time, I continue to meet with thousands of people from across the U.S. and Canada who have experienced the suicide of a person they loved and trusted.

Survivors' observations and detailed descriptions of our loved one's last minutes, hours, days, months, and even years can offer great insight and a much needed dimension to the current dialogue about suicide. By widening the circle of discussion to include different perspectives, survivors can also learn new information and consider new possibilities to help us in our healing process, as well as validate our personal and unique experiences as witnesses on the frontlines.

No. 101C
APPROACHES TO ENGAGING PEOPLE OF COLOR IN PROGRAM INITIATIVES FOR SUICIDE PREVENTION AND INTERVENTION

Donna H. Barnes, Ph.D., *Department of Psychiatry, Howard University, Mental Health Clinic, 530 College Street, NE, Washington, DC 20060*

SUMMARY:

Those who organize program initiatives for suicide prevention and intervention have expressed concerns that diverse populations rarely take advantage of their programs and/or services. This presentation will address approaches to remedy the low participation rate of minorities in these program initiatives. Discussed will be new developments on outreach strategies used to reach minority populations and the barriers to participation will be examined. Other factors considered are behavioral patterns of the various populations and the importance of understanding these diverse patterns. Behavior is governed by knowledge, beliefs, experience, and other environmental factors that differ from the dominant population.

When examining behavior it is necessary to have clarity on traditional avenues used by minority populations to facilitate obtaining education and/or services for suicidal illness. This presentation will not only address the need for outreach strategies and eliminating barriers that keep minority populations from participating, but will outline recognized behavioral patterns that exist in these populations that would affect participation.

No. 101D
SUICIDE: WHAT SURVIVORS WANT FROM MENTAL HEALTH CARE PROFESSIONALS

Frank R. Campbell, Ph.D., *Baton Rouge Crisis Intervention, 4837 Revere Avenue, Baton Rouge, LA 70808*

SUMMARY:

As a first responder to the scenes of suicides, the presenter has learned first hand the impact of suicide for the family, and various other relationships including those who provided mental health treatment for the deceased. The LOSS Team (Local Outreach to Suicide Survivors) was the first Active Postvention Model (APM) for suicide survivors. The APM approach places a team (the LOSS Team) of trained first responders at the scene of a suicide while the body is still present. Although the LOSS Team has reduced the amount of time between death and seeking help from 4.5 years to 39 days, the team has also learned a great deal about what helps survivors following suicide. Campbell will share what survivors have told the LOSS Team that they wanted from their loved ones' mental health care professional.

No. 101E
THE CLINICIAN'S PERSPECTIVE: WHY IS THIS SUBJECT SO TOUGH FOR US?

Michael F. Myers, M.D., *Department of Psychiatry, University of British Columbia, 2150 West Broadway, Suite 405, Vancouver, BC V6K 4L9, Canada*

SUMMARY:

Evidence-based research and anecdotal reports by residents and early career psychiatrists continue to note that the topic of suicide is given short shrift in our training programs and beyond. Many describe a "conspiracy of silence" when a patient kills himself or kills herself. While some psychiatrists nervously brag that they have been in practice for several years without losing a patient to suicide, others live with deeply felt and unrelenting shame and guilt. In this paper, I will explore the following themes: the professional and philosophical attitudes that inform and impede a comprehensive understanding of suicide, the emotional and behavioral effects of parasuicide and suicide on residents and psychiatrists, the institutional and medicolegal barriers to a rigorous and scientific study of completed suicide, and the limitations of our time-honored biopsychosocial model in assessing and treating suicidal individuals. I will argue that, in order to decrease the morbidity and mortality of psychiatric illnesses, it is essential to open our minds and hearts to the insights of other professional disciplines and the painful wisdom of those left awash in suicide's wake.

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1. Rogers JR: The anatomy of suicidology: a psychological science perspective on the status of suicide research. Suicide and Life-Threatening Behavior 2003; 31:9–20.

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4. Campbell FR: Changing the legacy of suicide. Suicide and Life-Threatening Behavior 1997; 27:(4).
5. Myers MF: When Physicians Commit Suicide: Reflections of Those They Leave Behind. Videotape, Vancouver, Canada, 1998.

SYMPOSIUM 102—INDIVIDUALIZING INTERPERSONAL PSYCHOTHERAPY FOR MOOD DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify comorbidities and difficult life circumstances that may lead therapists to modify their treatment approach; identify psychosocial approaches that may be combined with interpersonal psychotherapy to improve outcomes for patients with bipolar disorder and depression.

No. 102A
INTERPERSONAL AND SOCIAL RHYTHM THERAPY FOR BIPOLAR I DISORDER

Ellen Frank, Ph.D., *Department of Psychiatry, University of Pittsburgh, Western Psychiatric, 3811 O'Hara Street, Pittsburgh, PA 15213-2593*

SUMMARY:

Objective: Patients suffering from bipolar disorder may have a genetic predisposition to circadian rhythm and sleep-wake cycle abnormalities that may, in turn, be responsible for some symptomatic manifestations of the illness. Therefore, life events (both negative and positive) that cause disruptions in patients' social rhythms may, in turn, perturb circadian rhythms and sleep-wake cycles and lead to the development of bipolar symptoms. We therefore sought to develop a psychotherapy to modulate both biological and psychosocial factors, thereby mitigating circadian and sleep-wake cycle vulnerabilities and improving overall functioning in patients suffering from bipolar disorder.

Methods: Interpersonal and Social Rhythm Therapy (IPSRT) combines the basic principles of interpersonal psychotherapy with behavioral techniques to help patients regularize their daily routines, diminish interpersonal problems, and adhere to medication regimens. We have conducted a randomized trial in which subjects meeting criteria for bipolar I disorder were assigned to receive either IPSRT or intensive clinical management in addition to protocol-driven pharmacotherapy for acute and long-term treatment.

Results: We will discuss the process of treatment development that preceded the trial as well as our findings with respect to changes in mood disorder symptomatology and changes in stability of daily routines with increasing time in treatment.

No. 102B
INDIVIDUALIZING TREATMENT FOR DEPRESSED PATIENTS WITH CO-OCCURING PANIC OR ANXIETY

Jill M. Cryanowski, Ph.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213;* Ellen Frank, Ph.D., M. Katherine Shear, M.D.

SUMMARY:

Objective: Patients whose major depressive disorder is complicated by symptoms of panic or anxiety have been shown to display a poorer response to both psychotherapeutic and pharmacologic depression treatments. We have adapted interpersonal therapy for depression (IPT) by including modified elements of cognitive-behavior therapy and emotion-focused treatment to more effectively treat co-occurring symptoms of panic and anxiety in this population.

Methods: This 12–24 session intervention expands the model of traditional IPT for depression by explicitly assessing and targeting co-occurring anxiety symptoms and avoidance behaviors that impair function and interfere with interpersonal problem solving.

Results: Data from an open pilot study indicated that 77.8% (14 of 18 patients) treated with this intervention achieved stable remission of the depressive episode (median time to remission = 12.2 weeks). Comparison of pre- to post-treatment scores showed significant reductions in symptoms of depression (13.7 points HRSD-17, 17 points on the BDI, p's < .0001) and anxiety (15.9 points on the HRSA, 11.5 points on the BAI, p's < .0001), as well as increases on functional outcomes (20 point increase on the general function scale of the Q-LES-Q, p < .0001).

Conclusions: Preliminary results with this psychotherapeutic approach are encouraging, and warrant further study.

No. 102C
MOTIVATIONAL INTERVIEWING AND IPT: AN APPROACH TO TREATMENT ENGAGEMENT

Holly A. Swartz, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213;* Nancy K. Grote, Ph.D., Allan Zuckoff, M.D., Ellen Frank, Ph.D., M. Katherine Shear, M.D.

SUMMARY:

Objective: Depressed mothers of children with psychiatric illness represent a vulnerable but difficult-to-engage treatment population. Overwhelmed by the demands of caring for ill children, these mothers typically put their needs behind those of their family and, consequently, their depression remains untreated. Similarly, poor women are twice as likely to be afflicted with perinatal depression as are middle-class women, but are less likely to seek treatment for their depression at a mental health clinic. We developed a brief psychotherapeutic intervention to minimize barriers to care and ameliorate depression in these high-risk groups.

Methods: The nine-session intervention consists of eight sessions of IPT preceded by a feedback and discussion session based on the principles of motivational interviewing and ethnography that is designed to promote treatment engagement.

Results: Open, pilot studies of this intervention in depressed mothers of ill children (N=13) and depressed, low income, pregnant women (N=12) demonstrated low levels of attrition (15% and 25%, respectively) and significant improvement in depression scores from baseline to post treatment for completers (paired t = 4.4, df=10 and paired t=6.34, df=8 respectively; for both, p<0.05).

Conclusion: Preliminary data suggest this novel intervention promotes treatment adherence and is accompanied by high rates of clinical improvement.

No. 102D
GROUP PSYCHOTHERAPY FOR INFERTILE WOMEN WITH DEPRESSION

Ellen F. Olshansky, D.Sc., *Nursing Department, University of Pittsburgh, 3500 Victoria Street, Pittsburgh, PA 15261;* Ellen Frank, Ph.D.

SUMMARY:

Objective: Infertility, affecting approximately 15% of women of childbearing age, frequently co-occurs with depression. Women's interpersonal relationships are often adversely affected by infertility, leading to depression. Interpersonal psychotherapy (IPT) focuses on improving relationships to improve psychological health. Relational cultural theory purports that healthy interpersonal relationships are essential for healthy psychological development. We have developed a group psychotherapy intervention for depressed, infertile women based on a synthesis of IPT and relational cultural theory to decrease depression and strengthen relational behavior (interpersonal relationships).

Methods: This 16-session intervention consists of three individual and 13 group therapy sessions. The IPT problem area is determined during the first individual therapy session. Women then meet in group sessions to improve the relational behaviors that drive the depressive symptoms. The dependent variables, depression and relational behavior, are measured using the Beck Depression Inventory, Hamilton Rating Scale for Depression, Profile of Mood States, the Mutual Psychological Development Questionnaire, Relational Health Indices, and Silencing the Self Scale.

Results: Results of an open, pilot study will be available by April 2004.

Conclusion: This novel intervention combines complementary theoretical approaches to address infertility and its psychological sequelae in depressed women.

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2. Frank E, Shear MK, Rucci P, Cyranowski JM, Endicott J, Fagiolini A, Grochocinski V, Houck P, Kupfer DJ, Maser JD, Cassano GB: Influence of panicagoraphobic spectrum symptoms on treatment response in patients with recurrent major depression. American Journal of Psychiatry 2000; 157:1101–1107.
3. Grote NK, Bledsoe SE, Swartz HA, Frank E: Culturally relevant psychotherapy for perinatal depression in low-income OB/GYN patients. Clinical Social Work, in press.
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SYMPOSIUM 103—BDD: IS IT A MIND, BODY, OR SOCIOCULTURAL PROBLEM AND HOW DO YOU TREAT IT?

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants will be acquainted with all facets of body dysmorphic disorder from demographics, symptom presentation, socio-cultural aspect, cognitive-behavioral, and pharmacological treatments, role of neuro-imaging and cosmetic surgery.

No. 103A
BDD: PHENOMENOLOGY, ETIOLOGY, AND SOCIOCULTURAL INFLUENCES

Sony Khemlani-Patel, Ph.D., *Bio-Behavioral Institute, 935 Northern Boulevard, Suite 102, Great Neck, NY 11021*

SUMMARY:

Western society is laden with unattainable ideals of beauty and thinness, so much so that individuals feel an unrealistic pressure to meet this ideal. In fact, research in the body image and eating disorder literature suggests that the media is one of the most potent messengers of this ideal. Body dysmorphic disorder (BDD), which involves a maladaptive preoccupation with an aspect(s) of physical appearance, has been conceptualized as both an obsessive-compulsive spectrum disorder (OCSD) and a body image disturbance, making it susceptible to current cultural demands of physical perfection. Although all of us are influenced by cultural factors, those with a neuro-biological predisposition seem to be more susceptible. A significant number of patients with BDD seek methods to alter their appearance, from engaging in skin-picking and self-surgery to numerous cosmetic and dermatological interventions. For clinicians treating the OC spectrum disorders, BDD poses as one of the most challenging. This may in fact be due to features it shares with both obsessive-compulsive disorder and the eating disorders, such as high overvalued ideation, obsessions, compulsive behavior, depression, and low motivation in treatment. The phenomenology, epidemiology, assessment tools, as well as socio-cultural aspects of BDD will be presented. This presentation will serve as an orientation to the disorder.

No. 103B
HOW TO APPLY COGNITIVE AND BEHAVIOR THERAPY FOR BDD

Fugen Neziroglu, Ph.D., *Bio-Behavioral Institute, 935 Northern Boulevard, Suite 102, Great Neck, NY 11021*

SUMMARY:

Cognitive-behavior therapy (CBT) has gained popularity in a variety of disorders including body dysmorphic disorder (BDD). The application of CBT, however, differs from one disorder to another, each responding to different treatment modalities. Too often the same treatment techniques are applied to a variety of symptoms and disorders. When patients do not respond, we blame either the patient or CBT for the failure rather than the utilization of incorrect procedures. Although some forms of CBT have become household terms, such as desensitization, thought stopping etc., these forms of treatment are not specific to BDD. This presentation will discuss currently accepted treatment approaches based on research. Emphasis will be placed on cognitive restructuring and behavior therapy, specifically exposure and response prevention. Cognitions pertinent to the disorder and methods to challenge them will be discussed. The role of information processing, assessing perceptual vs. cognitive aspects, will also be indicated. Specific behavioral methods will be presented along with guidelines on how these techniques are applied. The current literature findings will be provided.

No. 103C
UPDATE ON PHARMACOTHERAPY FOR BDD

Katharine A. Phillips, M.D., *Department of Psychiatry, Butler Hospital/Brown University, 345 Blackstone Boulevard, Providence, RI 02906*

SUMMARY:

BDD is a relatively common yet often disabling and difficult-to-treat disorder. Until recently, it wasn't known what constituted efficacious pharmacotherapy for BDD. Research on this topic has rapidly increased in recent years, however, with emerging data consistently indicating that serotonin reuptake inhibitors (SRIs) are often efficacious. Of note, SRIs alone appear efficacious even for patients with delusional BDD. In contrast, other medications (including other antidepressants and antipsychotics as monotherapy) usually appear ineffective. Although data are limited, it appears that higher SRI doses and longer treatment trials than those used for many other psychiatric disorders, including depression, are often needed to effec-

tively treat BDD. Approaches to treatment-resistant BDD have received less investigation, but available data indicate that switching to another SRI is often effective. In addition, several SRI augmentation strategies (e.g., adding buspirone or an atypical antipsychotic) may be helpful. This presentation will offer a recommended approach to the pharmacotherapy of BDD by reviewing the empirical literature—including recent data—as well as offering insights from the presenter's clinical experience.

No. 103D
COSMETIC SURGERY IN BDD

David Veale, *The Priory Hospital North London, The Bourne, Southgate, London N14 GRA, England*

SUMMARY:

Body dysmorphic disorder (BDD) occurs in about 5% of patients seeking cosmetic surgery. Such patients are usually dissatisfied with surgery or their symptoms of BDD are the same or worse after surgery. We conducted a study that compared (1) patients without BDD who had a good outcome after cosmetic rhinoplasty with (2) BDD patients seen in a psychiatric clinic (who crave cosmetic rhinoplasty but do not obtain it). We found that BDD patients who desire cosmetic rhinoplasty were significantly more depressed and anxious than the group without BDD, are more preoccupied by their nose and check their nose more frequently. They are more likely to conduct "D.I.Y" surgery and have multiple concerns about their body. They were more likely to be significantly handicapped and therefore more likely to believe that dramatic changes would occur in their life after a rhinoplasty. The study provides some clues for surgeons who wish to identify patients with BDD who might have a poor prognosis in cosmetic rhinoplasty. We are now conducting a prospective study of cosmetic surgery to validate a screening questionnaire to identify patients with BDD seeking cosmetic surgery and other prognostic factors for dissatisfaction.

No. 103E
SNRI TREATMENT AND FUNCTIONAL IMAGING OF BDD

Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, One Gustave Levy Place, Box 1230, New York, NY 10029;* Andrea Allen, Ph.D., Lauren Priday, B.A.

SUMMARY:

Several open and controlled trials suggest improvement of symptom severity, and even improvement of fixity of belief of body image disturbance with SSRIs. We present data with the SNRI clomipramine (controlled vs. the NRI desipramine) and with the SNRI venlafaxine (open-label data) demonstrating improvement in obsessional preoccupation, compulsive rituals, and delusional conviction in BDD adult outpatients.

In addition, a small fluorodeoxyglucose (FDG) PET imaging study suggests alterations in functional metabolic activity of anterior cingulate and orbitofrontal regions in BDD subjects that suggest differences from both normal controls as well as OCD populations.

Possible impact of SNRIs on functional neurocircuitry in BDD will be discussed.

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3. Phillips KA: Pharmacologic treatment of body dysmorphic disorder: review of the evidence and a recommended treatment approach. CNS Spectrums 2002; 7:453–460.
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SYMPOSIUM 104—MODEL PSYCHIATRY RESIDENCY PROGRAMS ON RELIGION AND SPIRITUALITY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand model curricula on religion and spirituality in psychiatry residency training programs.

No. 104A
RELIGION, SPIRITUALITY, AND CULTURE IN PSYCHIATRIC PRACTICE AT THE UNIVERSITY OF LOUISVILLE

James Hyde, Ph.D., *Department of Psychiatry, University of Louisville, 550 South Jackson Street, ACB, Louisville, KY 40202*

SUMMARY:

This new required six-session (1 1/2 hour each) course in summer 2004 for PGY III psychiatric residents is an expansion of existing annual lectures on religion, spirituality, and faith in the Psychosomatic Medicine and in the Psychiatry and Cultural Issues Seminars. Additional lectures for residents and medical students in the Consultation/Liaison Program include prayer, faith development; faith and healing; evil; demon possession; the religious patient; and spirituality.

Course objectives/goals include introducing PGY III residents to dynamic issues within patients' religious/spiritual and cultural contexts. Four major religious faiths within our community will be studied; residents will learn from research, develop interviewing skills, and gain increased understanding of attitudes about religious/spiritual and cultural practices.

Our curriculum takes advantage of existing relationships within the department of psychiatry's pastoral counseling program. Residents interact with chaplains and pastoral counselors on medical teams in four inpatient and two outpatient units. Faculty for each lecture will consist of professors from three local seminaries, clinical pastoral counselors, and psychiatrists. Each lecture will have two guests, a clergy person and a psychiatrist, who will lead the dialogue with case material provided from clinical settings.

The new program includes a medical school grand rounds on Spirituality and the Practice of Psychiatry, led by a national leader. In addition, we also encourage interested residents to make an annual grand-rounds presentation on issues related to spirituality/faith and health care.

No. 104B
ENHANCING SPIRITUALITY TEACHING AT THE MEDICAL UNIVERSITY OF SOUTH CAROLINA

David W. Hiott, M.D., *Department of Psychiatry, Medical University of South Carolina, 67 President Street, 5 South, Charleston, SC 29425;* Dana King, M.D.

SUMMARY:

The spirituality curriculum in the psychiatry residency at the Medical University of South Carolina (MUSC) is a four-year, integrated, multidisciplinary curriculum designed to teach residents the practical, theoretical, and integral issues at the interface of spirituality and medicine. A fuller understanding of the spiritual issues that patients face and how to address them in the context of mental and physical illness will enrich the knowledge, skills, and compassion of practicing physicians. All psychiatry residents will be expected to attend the quarterly spirituality and health seminars sponsored by the MUSC Spirituality and Health Interest Group. We plan to present lectures (e.g. taking a spiritual history, survey of important issues in psychiatry and spirituality, and health beliefs of the major faith traditions), monthly inpatient conferences focusing on how to deal with spirituality issues in patients on a psychiatry ward, sessions dealing with spiritual issues in the psychotherapeutic settings, and finally didactics on ethical issues, and spiritual issues in critically ill or dying patients (both children and adults), and application of advanced history-taking skills. Residents will have the opportunity to integrate their spiritual history taking skills more fully by assisting in teaching fourth-year medical students during their monthly psychiatry and spiritual issues seminar.

No. 104C
UNIVERSITY OF SASKATCHEWAN CURRICULUM ON SPIRITUALITY AND MENTAL HEALTH

Marilyn D. Baetz, M.D., *Department of Psychiatry, University of Saskatchewan, Room 111, Ellis Hall, 103 Hospital Drive, Saskatoon, SK S7N 0W8, Canada*

SUMMARY:

Canadians have a wide variety of cultural and faith backgrounds and Saskatchewan, specifically, has a large Aboriginal population and rural/urban mix, making cultural competency, including sensitivity to spiritual beliefs, a potentially important factor for consideration in treatment planning. This course will allow opportunity for all child and adult psychiatry residents to develop skills in assessing patients' spirituality in a respectful and non-judgmental way and identify if there is a concern that needs to be pursued.

An introductory workshop incorporating active learning techniques will allow for increased exposure and interaction among the professions (residents, psychiatrists, chaplains, nurses etc). Topics include an overview of religious/spiritual beliefs of the Canadian population and examination of current, credible research on spirituality and the relevance to mental health. Spiritual assessment, ethical issues, traditions, beliefs, and practices of the major world religions as well as definitions and concepts unique to spirituality will be explored.

Spirituality in substance abuse, consultation/liaison, psychotherapy, and human development will be included in seminars and tutorials throughout the year. Residents will be expected to incorporate spiritual assessment into their patient assessment and formulations when indicated. Opportunity for grand rounds, electives, and travel to conferences dedicated to the topic will also be available.

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SYMPOSIUM 105—HEALTH AND LIFESTYLE OF PEOPLE WITH SCHIZOPHRENIA: THE VIEW FROM SCOTLAND

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that people with schizophrenia have significant health and lifestyle problems, over and above the core features of the illness, and that psychiatrists and other secondary care services must make vigorous efforts to help patients deal with these problems.

No. 105A
SMOKING HABITS OF SCOTTISH PEOPLE WITH SCHIZOPHRENIA

Ciara Kelly, M.D., *Department of Psychiatry, Glasgow University, Garnavel Royal Hospital, 1044 GT Western Road, Glasgow G12 OXH, United Kingdom;* Robin G. McCreadie, D.Sc., Roch Cantwell, M.D., John Eagles, M.D., Paul Sclare, M.D., Simon Naji, M.D.

SUMMARY:

Objective: To examine the smoking habits and clinical variables of people with schizophrenia in Scotland: (1) population-based study; (2) samples from three areas in Scotland; (3) first-episode study.

Method: All people with schizophrenia in Nithsdale, Scotland (n= 168) were invited to complete a questionnaire on smoking habits. Mental state and drug related side effects were assessed.

Patients (n=315) in Nithsdale, Glasgow, and Aberdeen were assessed (method 1).

A sample (n=45) of first-episode, never-treated patients were assessed in Glasgow (method 1).

Results: 58% (71% males: 46% females) of the population of people with schizophrenia were current smokers compared with 26% of the local general population; 68% were heavy smokers. Smokers were younger males, had more hospitalizations and poorer childhood social adjustment. In females, there was a positive correlation between age at starting smoking and onset of schizophrenia. 65% were current smokers (72% males: 54% females) and clinical variables were the same as in the first results. 73% of neuroleptic naïve patients were smokers.

Conclusion: The rate of smoking and level of nicotine addiction are high in schizophrenia, even at the onset of psychosis. More than 70% of males smoke. Smokers are younger and more poorly adjusted.

No. 105B
DIET AND CARDIOVASCULAR RISK: DESCRIPTIVE STUDY AND RANDOMIZED CONTROLLED TRIAL

Robin G. McCreadie, D.Sc., *Department of Clinical Research, Crichton Royal Hospital, Bankend Road, Dumfries DG1 4TG, United Kingdom*

SUMMARY:

Objective: To describe the diet of people with schizophrenia and report their risk of coronary heart disease (CHD) and stroke; to measure the impact on eating habits of giving free fruit and vegetables for six months.

Method: A total of 102 community dwelling people with schizophrenia were identified in south-west Scotland. Their dietary habits were assessed by the food frequency section of the Scottish Health Survey questionnaire. Risk of CHD and stroke was measured using the Framingham assessment. Patients were then randomly allocated to receive free fruit and vegetables for six months and associated instruction (FFV+OT), free fruit and vegetables alone (FFV), or to continue as before (TAU).

Results: Fewer patients, when compared with the general population, reached acceptable levels for consumption of fresh fruit and vegetables, milk, potatoes, pasta, rice, or pulses. The mean number of fruit and vegetables consumed per week was 16 (SD14), the mean 10-year risk of CHD in males was 10.5% (SD8) and in females 7% (SD6). After the intervention, the FFV+OT and FFV group were consuming significantly more fruit and vegetables than those in the TAU group, but consumption fell back to pre-intervention levels at six and 12 months after intervention stopped.

Conclusion: The diet of people with schizophrenia is very poor when compared with the general population. Secondary care services must address physical as well as mental health problems. Giving free fruit and vegetables can improve their diet, but the improvement was not sustained.

Funding: Chief Scientist Office, Scottish Executive, Edinburgh

No. 105C
OCULAR ABNORMALITIES IN COMMUNITY-BASED PATIENTS WITH SCHIZOPHRENIA

Moira A. Connolly, *Department of Psychiatry, Gartnavel Royal, 1055 Great Western Road, Glasgow G12 0X4, Scotland;* Roch Cantwell, M.D., Ciara Kelly, M.D., Michael Smith, Norman Button, John Norrie

SUMMARY:

Objective: To ascertain the prevalence of ocular abnormalities in a community cohort of patients with schizophrenia. People with schizophrenia have poorer physical health in general. Limited research suggests that they have a high prevalence of ocular abnormalities, possibly contributed to by smoking and mediction. These adverse effects, which may impair function, are a neglected area of research.

Method: Patients from a defined catchment area are being screened for eye problems using tests of visual activity and a slit lamp examination. Demographic and service use details, PANSS score, smoking status, and lifetime use of specific psychotropic medications, such as phenothiazines, are noted and correlated with the physical findings. Intended sample size = 100.

Results: To date, 50% of subjects approached have participated. Of the first 20 completed eye screens, five have objectively measurable blurred vision and three have cataracts impairing vision (probably medication induced). Three have early hypertensive retinal changes, one has macular scarring, and one has an amblyopic eye. Ten require a new or first prescription of glasses.

Conclusions: Interim results suggest a high prevalence of treatable visual impairment. Standard guidelines on the routine management of patients with schizophrenia need to take this into account. (Final results will be available by May 2004).

Funding: Chief Scientist Office (Scotland).

No. 105D
SEXUAL DYSFUNCTION IN SCHIZOPHRENIA

Shiona M. Macdonald, M.B., *Crichton Hospital, Bankend Road, Dumfries DG1, Scotland;* Jennifer Halliday, M.B., Susan Farrington, B.A., Thomas Macewan, M.B., Susan Wall, Valerie Sharkey, B.S.C., Robin G. McCreadie, D.Sc.

SUMMARY:

Background: That sexual dysfunction occurs in schizophrenia is not in doubt. Previous studies have had weaknesses such as the use of selected populations or the absence of a control group.

Aims: To measure rates of sexual dysfunction in people with schizophrenia compared with the general population.

Method: Sexual dysfunction was assessed by a self-completed gender-specific questionnaire. Ninety-eight (73%) of 135 persons with schizophrenia and 81 (71%) of 114 persons recruited as controls returned the questionnaire.

Results: At least one sexual dysfunction was reported by 82% of men and 96% of women with schizophrenia. Male patients reported less desire for sex, were less likely to achieve and maintain an erection, were more likely to ejaculate more quickly, and were less satisfied with the intensity of their orgasms. Female patients reported less enjoyment than the control group. Sexual dysfunction in female patients was associated with negative schizophrenic symptoms and general psychopathology. There was no association between sexual dysfunction and type of antipsychotic medication.

Conclusions: People with schizophrenia report much higher rates of sexual dysfunction than do the general population. Men and women with schizophrenia have a different pattern of sexual dysfunction.

Also presented will be data on a randomized controlled trial (to finish in September 2003) of sildenafil in erectile dysfunction.

This RCT was sponsored by Pfizer Inc.

No. 105E
THE DENTAL HEALTH OF PEOPLE WITH SCHIZOPHRENIA

Robin G. McCreadie, D.Sc., *Department of Clinical Research, Crichton Royal Hospital, Bankend Road, Dumfries DG1 4TG, United Kingdom*

SUMMARY:

Objective: To report on the dental health of community dwelling people with schizophrenia and to compare results with those found in the general population.

Method: The dental health of 428 people with schizophrenia in six different areas of the United Kingdom was assessed by a self-report questionnaire.

Results: Compared with the general population, significantly more patients in the younger age bands were edentate (3–39% vs 1–20%) and fewer patients had more than 20 teeth (70% vs 83%). None of four dental health targets set by the English Department of Health and the Scottish Office had been achieved in the patient population. More patients had last visited the dentist because of trouble with their teeth; fewer had visited for a check-up. Fewer patients cleaned their teeth daily; this group had more negative schizophrenic symptoms.

Conclusion: The dental health of people with schizophrenia is poor. Community mental health teams and other outreach agencies should encourage people with schizophrenia to attend their community dentist regularly.

This study was funded by Eli Lilly.

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2. Scottish Schizophrenia Lifestyle Group: Diet, smoking and cardiovascular risk in people with schizophrenia: descriptive study. Brit J Psychiatry, in press.
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4. Macdonald S, Halliday J, MacEwan T, Sharkey V, Farrington S, Wall S, McCreadie RG: Nithsdale Schizophrenia Survey 24: sexual dysfunction. Case-control study. British Journal of Psychiatry 2003; 182:50–56.
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SYMPOSIUM 106—DO NOT WAIT UNTIL YOU PRACTICE, KNOW IT NOW: WHAT RESIDENTS AND EMERGENCY CARE PHYSICIANS NEED TO KNOW

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the audience should be able to demonstrate knowledge of the legal, ethical, and manage care issues that they will be and are facing. The audience will be presented with the tools with which they may start a successful practice.

No. 106A
PROFESSIONAL LIABILITY INSURANCE: A PRIMER FOR PSYCHIATRISTS

Martin G. Tracy, J.D., *Professional Risk Management Services, Inc., 1515 Wilson Boulevard, Suite 800, Arlington, VA 22209-2434*

SUMMARY:

The provisions of professional liability insurance policies vary widely from one company to the next. The presentation will walk the attendee through the basic parts of a professional liability policy, highlighting the relevance of each section to the psychiatrist's practice. Special attention is focused on exclusions from coverage and the difference between claims-made policies and occurrence policies.

No. 106B
UNDERSTANDING MANAGED CARE

Shivkumar Hatti, M.D., *600 North Jackson Street, Suite 200, Media, PA 19063*

SUMMARY:

Graduating residents or early career psychiatrists have minimal understanding of managed care concepts. In most urban areas, private psychiatrist services are controlled by carved-out managed care companies.

This presentation will include the following: (1) history of managed care, (2) financial aspects of managed care, (3) issues in managed care contract, (4) specialist subcapitation, (5) risks/rewards of managed care, and (6) future of managed care.

No. 106C
PRIVATE VERSUS ADMINISTRATIVE VERSUS ACADEMIC PRACTICE

David A. Baron, M.D., *Department of Psychiatry, Temple University Hospital, 3401 North Broad Street, Jones Hall 800, Philadelphia, PA 19140-5189*

SUMMARY:

This presentation will highlight training requirements and current career options in administrative private practice, and academic psychiatry. Lifestyle variations and expected compensation will also be compared. Emphasis will be made on demonstrating how to combine these work environments to create a professional rewarding and stimulating career. Ample use of existing opportunities and potential new professional options will be discussed. This is intended to be a highly interactive session.

No. 106D
ETHICS FOR PSYCHIATRY RESIDENTS AND EARLY CAREER PSYCHIATRISTS

Thomas S. Newmark, M.D., *Dept of Psychiatry, Cooper University Hospital, 401 Haddon Ave, E&R Bldg. #356, Camden, NJ 08103*

SUMMARY:

There are ethical principals in psychiatry that all psychiatrists should be aware of. Residents and early career psychiatrists often have little education about ethical principals. These principals apply to all psychiatrists including residents in training.

The first issue is sexual boundary violations. For a psychiatrist to engage a patient in a sexual relationship is clearly unethical. Red flags that a psychiatrist is headed down the slippery slope include spending extra time with a patient; seeing a patient only in the evening and at special times, beginning to feel overly social with the patient and see the patient outside the office setting, and inappropriate hugging or kissing the patient. It is clearly unethical to have sexual relations with a family member of the patient. For example, if the patient is a child, any sexual relationship with an adult family member would be unethical. Also, it is generally felt to be unethical for a teaching psychiatrist to have sexual relations with a resident in training.

The second issue is nonsexual boundary violations. These include entering into inappropriate financial arrangements with the patient and obtaining information regarding business ventures, and socializing with the patient, for example, having dinner or going to the movies. The dynamics of gift giving and the meaning to the patient of accepting or rejecting the gift is also considered unethical.

A third issue to consider is dealing with the press. It is unethical for a psychiatrist to speak publicly on the mental health of a patient or a person who is not their patient (The Goldwater Principal).

REFERENCES:

1. Medical Professional Liability Insurance: A Practitioner's Primer. Physician Insurers Association of America Rockville, M.D.
2. The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry. American Psychiatric Association, Washington D.C., 2001.
3. Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry. 9th ed. Benjamin James Sadock, Virginia Alcott Sadock, pp 1365–1373.

SYMPOSIUM 107—PSYCHIATRY, ETHICS, AND END-OF-LIFE CARE: NEW INSIGHTS AND CHALLENGES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify the interplay of psychiatric issues and ethical dilemmas in the care of seriously ill and dying patients, specifically the significance and origins of demoralization, the spiritual dimensions of suffering, the role of the doctor-patient relationship and countertransference, and the competing models of psychiatric response to requests for assisted suicide.

No. 107A
IMPACT OF DEMORALIZATION ON DECISION MAKING IN PHYSICIAN-ASSISTED SUICIDE

David W. Kissane, M.D., *Department of Psychiatry, Memorial Sloan-Lettering Cancer Center, 1242 Second Avenue, New York, NY 10021;* David M. Clarke, Ph.D., Anthony Love, Ph.D., Simon Wein, M.D.

SUMMARY:

Key features of the proposed demoralization syndrome include (1) meaninglessness or pointlessness, (2) helplessness and hopelessness, (3) nonspecific distress, (4) the development of a desire to die, (5) prominent-social isolation or alienation, and (6) persisting as a mental state across two or more weeks.

Anhedonic depression involves a current loss of interest and pleasure with depressed mood, while demoralization involves a loss of anticipatory pleasure. Demoralization syndrome may co-exist with or be a harbinger for major depression, but exists independently in about 10% of the seriously medically ill.

Using latent trait analysis of symptoms, demoralization and anhedonia have been validated as distinct dimensions. Five factors emerge from validation studies of Demoralization Scale (DS): dysphoria, loss of meaning, disheartenment, hopeless-helpless, and sense of failure. In a study of 101 palliative care patients, DS discriminates a subgroup with high demoralization, yet not meeting DSM-IV major depression criteria.

One pertinent issue for palliative medicine is the capacity of a demoralized patient to give informed consent. Having a disordered relationship to their future, the demoralized's appreciation of the significance of key clinical facts may be colored by their altered assumptive world. They may lose competence to consent to specific treatments, including physician-assisted suicide.

No. 107B
SPIRITUAL INTERPRETATION OF THE DEMORALIZATION SYNDROME AS ALIENATION FROM SELF

Constance A. Jennings, M.D., *Pulmonary Department, Cleveland Clinic, 9500 Euclid Avenue, Desk A90, Cleveland, OH 44195;* David W. Kissane, M.D.

SUMMARY:

Framing the demoralization syndrome in spiritual terms may facilitate understanding of its pathogenesis and treatment. The demoralization syndrome can be interpreted as a phenomenon of alienation from self. This alienation can be viewed as a consequence of the direct effect of suffering in diminishing self-valuation and its indirect effect in diminishing an individual's links to existential domains that sustain self-valuation: meaning, hope, and relationship.

Conversely, the demoralization syndrome exemplifies the adverse effects of illness in a way that also illuminates the larger topic of the role of spirituality within medicine. A psychospiritual approach, focusing on self-valuation as central to wholeness, is most apt for developing an intersectarian framework for incorporating spirituality within medicine in a manner that addresses the deleterious effects of illness on the individual patient. This framework can be fleshed out through an understanding of the impact of illness on meaning, hope, and relationship.

Spirituality is best applied within medicine in the form of individualized, compassionate care with concern for dignity, motivated and guided by spiritual insight.

This presentation will interest caregivers of patients with medical illness and may be of particular interest to palliative care practitioners and those interested in approaches to relating spirituality and medicine.

No. 107C
COUNTERTRANSFERENCE AND ETHICAL ISSUES IN END-OF-LIFE CARE

Brian J. Kelly, M.B., *Department of Mental Health, St. Vincent's Hospital, 299 Forbes Street, Darlinghurst, Sydney NSW 2010, Australia;* Frances T. Varghese, M.B., Dan Pelusi, B.A., Paul Burnett, Ph.D., Marguerite Robertson, M.B., Shirlene Badger, B.A.

SUMMARY:

The ethical dimensions of end-of-life decisions need to be considered within their clinical context. Included in this clinical context are the doctor-patient relationship and the complex tasks of caring for a dying patient. The patterns of countertransference experienced by doctors in this role can provide a framework for examining this interpersonel context of end-of-life care. A study of 252 terminally ill cancer patients and their doctor/s was conducted, investigating the association of both patient and clinician factors with the patient's wish to hasten death (WTHD). The following variables were associated with a high WTHD: (1) the patient's perception of higher burden on others and lower family cohesion as well as higher depressive symptom scores, and recent admission to hospice care (2) the doctor's greater willingness to hasten their patient's death upon request, the doctor's perception of patient distress at the same time as having less experience/training in psychological aspects of care. The findings support the multi-factorial influences on the WTHD in terminally ill cancer patients and provide empirical support for the role of countertransference factors in end-of-life decisions, emphasizing the complexity and clinical challenges involved, and the support and training needs of clinicians.

No. 107D
COMPETING PARADIGMS OF RESPONDING TO ASSISTED-SUICIDE REQUESTS IN OREGON: CASE REPORT

N. Gregory Hamilton, M.D., *MD PC, 2250 NW Flanders Street #306, Portland, OR 97210-5411;* Catherine Hamilton, M.A.

SUMMARY:

Since legalization of assisted suicide in Oregon, two competing paradigms—the traditional clinical and the assisted-suicide competency models—have existed. This presentation will compare these two approaches as applied in an actual case.

The traditional clinical approach emphasizes that patients considering assisted suicide usually suffer from a treatable depression and are deeply ambivalent about their desire for death. Such patients require a thorough evaluation and treatment. Empathy, encouragement, and psychological, social, and spiritual support can be used in combination with pain treatment and palliative care, antidepressant and/or antianxiety medication, and psychotherapy. The clinician using this approach resists assuming the "gatekeeper" role of determining competence alone.

In contrast, the guidebook for Oregon assisted suicides suggests that psychiatric consultation should focus on competence. While acknowledging that depression may affect judgment about assisted suicide, the guidelines claim there is no obligation to treat it. When a depressed patient refuses treatment, that fact poses no legal barrier to a doctor prescribing a lethal overdose, as long as the patient is considered technically competent.

An actual case of a patient requesting assisted suicide demonstrates how these two approaches have become competing paradigms that are difficult, if not impossible, to mix.

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1. Kissane DW: The contribution of demoralization to informed consent. The Hastings Center Report 2004, in press.

2. Jennings CA, Kissane DW: Spirituality and Medicine: Interpretation of the Demoralization Syndrome as Alienation from Self. The Hastings Center Report 2004, in press.
3. Kelly B, Burnett P. Pelusi D, Badger S, Varghese F. Robertson M: Factors associated with the wish to hasten death: a study of patients with terminal illness. Psychological Medicine 2003; 33:75–81.
4. Hendin H: Suicide, assisted suicide, and euthanasia, in Harvard Guide to Suicide Assessment and Intervention. Edited by Jacobs DG. San Francisco, Jossey-Bass, 1999, pp 540–560.

SYMPOSIUM 108—AN INTEGRATION OF THE PATHOPHYSIOLOGY AND PHARMACOTHERAPY FOR PTSD

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) discuss the link between the hypothesized pathophysiology and the pharmacotherapy for PTSD, (2) implement pharmacologic treatment strategies for posttraumatic stress disorder.

No. 108A
NORADRENERGIC FUNCTION IN THE PATHOPHYSIOLOGY AND TREATMENT OF PTSD

Steven M. Southwick, M.D., *Department of Psychiatry, VA Connecticut Healthcare, 950 Campbell Avenue, 151E, West Haven, CT 06516*

SUMMARY:

Preclinical and clinical evidence suggests that central noradrenergic nuclei play a critical role in the response to life-threatening stimuli, fear conditioning, and the pathophysiology of PTSD. In traumatized humans, there is evidence for a sensitized and hyperreactive noradrenergic system in those who develop PTSD. Research findings suggest that enhanced memory for emotionally arousing events in humans depends critically on postlearning adrenergic modulation. Our research also suggests that combat stress-induced decreases in plasma neuropeptide Y may mediate, in part, the noradrenergic system hyperreactivity observed in combat-related PTSD, which may contribute to symptoms of hyperarousal and the expression of exaggerated alarm reactions, anxiety reactions, or both in combat veterans with PTSD long after war. Interventions designed to directly suppress noradrenergic hyperreactivity in trauma survivors with PTSD will be reviewed, with emphasis on the therapeutic effects of the alpha-2-adrenergic agonist guanfacine.

No. 108B
HYPOTHALAMIC PITUITARY ADRENAL AXIS AND SEROTONERGIC FUNCTION IN PTSD

J. Douglas Bremner, M.D., *Department of Psychiatry, Emory University, 1364 Clifton Road, Atlanta, GA 30322*

SUMMARY:

Stress results in long-term alterations in several neurochemical systems including the hypothalamic-pituitary-adrenal (HPA) axis and serotonergic systems. With acute stressors, there is an increase in corticotrophin releasing factor (CRF) from the hypothalamus with associated increased adrenocorticotropin hormone (ACTH) from the pituitary and cortisol release from the adrenal. In chronic PTSD the evidence supports elevated CRF; however, cortisol appears to be normal or low at baseline, with early evidence for increased cortisol response to traumatic reminders. Stress results in dysregulation of serotonergic systems, with some evidence for serotonergic function in PTSD based on challenge and platelet studies. Serotonergic reuptake inhibitors (SSRIs) in animal studies promote neurogenesis in the hippocampus, and in PTSD studies result in improvement in PTSD symptoms and increased hippocampal volume and memory function. New treatments such as CRF antagonists or agents with serotonergic effects may target these specific neurobiological disturbances.

No. 108C
AMINO ACID NEUROTRANSMITTER MODULATION IN PTSD

Lori L. Davis, M.D., *Department of Psychiatry, Alabama & VA Medical Center, 3701 Loop Road East (151C), Tuscaloosa, AL 35404;* Frederick Petty, M.D.

SUMMARY:

In this presentation, we plan to review the current preclinical and clinical knowledge concerning the role of amino acid neurotransmitters, γ-aminobutyric acid (GABA), and glutamate, in the pathophysiology and the treatment of posttraumatic stress disorder (PTSD). Specifically with regard to stress, GABA and glutamate are neurotransmitters that modulate the hypothalamic-pituitary-adrenal axis and limbic system. These systems play major roles in controlling the emotional states of "freeze-flight-or-fight." Recent results of trials of anticonvulsants, namely divalproex, topiramate, and lamotrigine, will be reviewed in detail. Specifically, our research shows significant reduction in PTSD symptomatology in an open-label, eight-week trial of divalproex, and a placebo-controlled study is ongoing. Other investigators have shown positive results with lamotrigine and topiramate. We conclude that the use of anticonvulsants in the treatment of PTSD is promising and that further research is needed to further define the efficacy of anticonvulsants in the treatment of PTSD.

REFERENCES:

1. Southwick SM, Davis M, Horner B, Cahill L, Morgan CA 3rd, Gold PE, Bremner JD, Charney DC: Relationship of enhanced norepinephrine activity during memory consolidation to enhanced long-term memory in humans. Am J Psychiatry 2002; 159(8):1420–2.
2. Bremner JD, Vythilingam M, Vermetten E, et al: Cortisol response to a cognitive stress challenge in posttraumatic stress disorder (PTSD) related to childhood abuse. Psychoneuroendocrinology 2003; 28:6:733–50.
3. Davis LL, Ryan W, Adinoff B, Petty F. A comprehensive review of the psychiatric uses of valproate. Jr Clin Psychopharmacol 2000; 20:1:1S–17S.
4. Petty F, Davis L, Nugent AL, Kramer GL, Teten A, Schmitt A, Stone RC: Valproate therapy for chronic, combat-induced posttraumatic stress disorder. J Clin Psychopharmacol 2002; 22:100–101.

SYMPOSIUM 109—FEELING UNREAL: A CONTEMPORARY OVERVIEW OF DEPERSONALIZATION DISORDER

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize and diagnose depersonalization disorder, describe neurobiological and cognitive processes, and know pharmacological and CBT findings.

No. 109A
THE PHENOMENOLOGY OF DEPERSONALIZATION DISORDER

Daphne Simeon, M.D., *Department of Psychiatry, Mount Sinai Medical Center, One Gustave Levy Place, Box 1230, New York, NY 10029-6574;* Margaret Knutelska, M.P.H., Dorothy Nelson, B.S.C., Orna Guralnik, Psy.D.

SUMMARY:

Large clinical samples of individuals suffering from depersonalization disorder (DPD) had not been described until very recently. We are now better able to systematically elucidate clinical characteristics, antecedents, comorbidity patterns, and treatment responses for the disorder. One hundred and seventeen adult individuals with DPD were consecutively assessed. The illness had an approximately 1:1 gender ratio with onset around age 16. The course was typically chronic, usually continuous, but sometimes episodic. Illness characteristics such as onset, duration, and course were not associated with symptom severity. Mood, anxiety, and personality disorders were frequently comorbid, but did not predict depersonalization severity. Approximately half of the subjects had at least one comorbid Axis II personality disorder. The most common proximal precipitants of the disorder were severe stress, depression, panic, marijuana ingestion, and hallucinogen ingestion; none of these predicted symptom severity. DPD has also been found to be associated with history of interpersonal childhood trauma, in particular, emotional abuse. There were no significant gender differences in the clinical features of the disorder. These findings are compared with other phenomenologic reports of DPD in the literature.

No. 109B
THE NEUROPHYSIOLOGICAL BASIS OF DEPERSONALIZATION DISORDER

Anthony S. David, M.D., *Department of Neuropsychiatry, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF, United Kingdom;* Mary L. Phillips, M.D., Nicholas Medford, M.D., Mauricio Sierra, M.D.

SUMMARY:

Depersonalisation disorder (DPD is a distressing alteration in the perception or experience of the self and/or environment. In addition to feelings of "unreality," sufferers also describe a numbing or absence of emotional reactions. We have carried out a series of psychophysiological studies that reveal a distinct physiological signature in DPD. Patients show an attenuated skin conductance response to unpleasant, arousing stimuli, but not neutral stimuli, which suggests a specific inhibitory mechanism on emotional processing and is quite unlike that seen in patients with anxiety disorders. Such stimuli include facial expressions as well as photos of real-life scenes. Preliminary results also show that patients with depersonalization have aberrant heart phasic responses, decreased heart rate habituation, and increased heart rate variability, which are again, specific to emotional stimuli. Work using fMRI has supported these results with DPD patients failing to activate visual processing and limbic areas in response to arousing pictures, yet showing generally increased frontal activation. A pharmacological model of DPD induced in normal volunteers using ketamine produced similar effects on brain activation as measured using fMRI. Clinically, such effects may be attenuated by lamotrigine. Such work is contributing to a neurobiological account of depersonalization and may have implications for treatment.

No. 109C
NEUROBIOLOGY OF THE DISSOCIATIVE STATES PRODUCED BY KETAMINE

John H. Krystal, M.D., *Department of Psychiatry, Yale School of Medicine, VA Medical Center, 950 Campbell Avenue, West Haven, CT 06516;* J. Douglas Bremmer, M.D., Amit Anand, M.D., Dennis S. Charney, M.D., Cyril Dsouza, M.D.

SUMMARY:

Ketamine is an NMDA glutamate receptor antagonist that has long been known to produce symptoms that resemble endogenous dissociative states and are statistically distinct from the psychotic effects of ketamine. It produces depersonalization, derealization, altered time perception, altered perception of one's body, and perceptual disturbances in most perceptual domains at subanesthetic doses where general orientation is preserved. We have conducted a series of studies that have examined the effects of a variety of pretreatments upon the perceptual effects of ketamine. Studies to date have found that haloperidol and the group II metabotropic glutamate receptor agonist (LY354740) did not attenuate the perceptual effects of ketamine, while lorazepam, nimodipine, and lamotrigine did attenuate these perceptual changes. Each of the agents that attenuates the perceptual effects of ketamine has been used to treat dissociative states as well as mood disturbance (mania or depression) in patients with bipolar disorder. Mechanisms that may underlie the antidissociative effects of these agents will be considered.

No. 109D
COGNITIVE PROCESSES IN DEPERSONALIZATION DISORDER

Orna Guralnik, Psy.D., *Department of Psychiatry, New York University, 270 Lafayette Street, Suite 1209, New York, NY 10012;* Margaret Knutelska, M.P.H., Daphne Simeon, M.D.

SUMMARY:

Depersonalization disorder (DPD) is characterized by a distinct cognitive profile. Although general intellectual functioning is intact, aspects of attention and memory are affected in the disorder, both subjectively and on cognitive testing. We have applied extensive neuropsychological batteries to DPD subjects in three consecutive studies. Depersonalized individuals generally exhibit difficulty in controlling focus of attention on intermittently changing attentional tasks, while demonstrating better selective attention with unchanging tasks. High-noise conditions also challenge their attentional capabilities. Furthermore, depersonalization is associated with deficits in immediate memory, both verbal and visual, especially under information overload, but not in delayed memory. Specifically, there is evidence that depersonalized subjects tend to forget details while remembering the gist of a narrative. They also tend to recall less neutral, as opposed to emotionally charged, material. Finally, explicit memory in depersonalized subjects appears to be more adversely affected by exposure to psychosocial stress. Dissociation severity overall correlates with poorer working memory and greater susceptibility to distraction. In summary, depersonalization presents with both attentional and early memory deficits, which may or may not be related to each other.

No. 109E
NEUROCHEMISTRY AND PHARMACOLOGICAL TREATMENT OF DEPERSONALIZATION DISORDER

Daphne Simeon, M.D., *Department of Psychiatry, Mount Sinai Medical Center, One Gustave Levy Place, Box 1230, New York, NY 10029-*

6574; Margaret Knutelska, M.P.H., Orna Guralnik, Psy.D., Dorothy Nelson, B.S.C.

SUMMARY:

Depersonalization disorder (DPD) is a dissociative disorder characterized by prominent perceptual alterations (depersonalization and often derealization), in the absence of disrupted memory or identity. Neurochemical findings suggest involvement of serotonergic (5HT2A and 5HT2C receptors), endogenous opioid (kappa receptors), and glutamatergic (NMDA receptors) pathways in depersonalization. Depersonalization is also associated with autonomic blunting, as evidenced by an inverse relationship between dissociation severity and urine norepinephrine. There is evidence for HPA axis dysregulation in DPD, with resistance to low-dose dexamethasone suppression, and a possibly abnormal cortisol response to psychosocial stress. Pharmacological treatment of depersonalization remains elusive, but might be in part guided by the neurochemical evidence above. Despite anecdotal promise for serotonin reuptake inhibitors, a randomized, placebo-controlled trial of fluoxetine failed to find efficacy. An open trial of naltrexone suggests that opioid antagonists may be of some benefit. Novel pharmacological approaches will also be discussed.

No. 109F
A COGNITIVE-BEHAVIORAL APPROACH TO DEPERSONALIZATION DISORDER

Anthony S. David, M.D., *Department of Neuropsychiatry, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF, United Kingdom;* Dawn Baker, Ph.D., Elaine Hunter, Ph.D., Mauricio Sierra, M.D., Mary L. Phillips, M.D.

SUMMARY:

Depersonalization (DP) and derealization (DR) experiences are frequently reported in healthy individuals under certain situational conditions, particularly those provoking anxiety. We have developed a cognitive-behavioral model akin to that of panic disorder, which proposes that it is the catastrophic appraisal of the normally transient symptoms of DP/DR, perhaps engendered by a mismatch between cognitive appraisal and the experienced (reduced) physiological response, that results in the development of a chronic disorder. DP/DR symptoms are misinterpreted as indicative of severe mental illness or brain dysfunction leading to a vicious circle of increasing anxiety, and, consequently, increased DP/DR symptoms will result. Responses to symptoms such as specific avoidances, "safety behaviours," and cognitive biases serve to maintain the disorder. Using this framework, we have developed a cognitive-behavioral treatment package for people with DP disorder. This focuses on reappraisal of symptoms, and challenging automatic thoughts and safety behaviors. A preliminary study of this approach carried out over, on average, 11 sessions, in 24 patients with previously intractable DP, shows an overall effective symptom reduction and improvement in levels of functioning as measured by standard scales after treatment, which are maintained at six months follow-up. A randomized, controlled trial of this intervention is now under way.

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SYMPOSIUM 110—PSYCHOSOCIAL IMPACT OF SARS ON PATIENTS, HOSPITALS, AND HEALTH CARE PROVIDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the stresses and coping styles of front-line health care providers caring for patients with highly infectious diseases such as SARS. Participants will learn practical suggestions and helpful policies in dealing with similar future situations.

No. 110A
THE TRAUMATIC IMPACT OF SARS ON NURSES AND HEALTH CARE WORKERS WITH CHILDREN

Robert G. Maunder, M.D., *Department of Psychiatry, Mount Sinai Hospital, 600 University Avenue, Toronto, ON M5G IX5, Canada;* William J. Lancee, Ph.D., Jonathan J. Hunter, M.D., Kenneth E. Balderson, M.D., Sean B. Rourke, Ph.D., Patricia M. Petryshen, Ph.D., David S. Goldbloom, M.D., Donald A. Wasylenki, M.D., Calvin Fones, M.D.

SUMMARY:

Our observations of the first wave of severe acute respiratory syndrome (SARS) in Toronto (February 23–May 22, 2003) suggested health care workers (HCWs) with family at home were experiencing higher levels of SARS-related stress. To empirically determine the short-term effects of SARS on HCWs, we surveyed all willing staff at three Toronto hospitals. Surveys, which included the Impact of Events Scale (IES) and items probing attitudes toward SARS, were distributed and returned between May 13 and June 20.

Results: A total of 1,651 HCWs completed the survey (41.7% non-clinical, 26.5% nurses, 7.1% physicians, 24.7% other). Contact with at least one SARS patient was reported by 21.4%. 41.7% had at least one child. ANOVA demonstrated main effects upon total IES by exposure to SARS patients ($df=1$, $F = 32.23$, $p<.001$), discipline (nurse/not nurse, $df=1$, $F=12.03$, $p = .001$), and having children ($df=1$, $F = 10.45$, $p = .001$). There were no interactive effects. Adjusted R squared for this model = .60.

Conclusions: In addition to the contribution to stress response by exposure to SARS patients, nurses and HCWs with children experienced more intense stress reactions. Further investigation of the longer-term effects of SARS is warranted.

No. 110B
ACADEMIC PHYSICIANS COPING DURING SARS

Donna E. Stewart, M.D., *Women's Health, University Health Network, 657 University Avenue, M/L-2-004, Toronto, ON M5G 2N2, Canada;* Sherry Grace, Ph.D., Karen Hershenfield, B.S.C., Emma K. Robertson, Ph.D.

SUMMARY:

Objectives: To describe the psychosocial impact of SARS on academic physicians.

Methods: An anonymous survey was sent to all physicians in three major teaching hospitals providing care to SARS patients in Toronto, Canada, the city with the largest number of SARS patients outside Asia.

Results: A total of 193 (35.5%) physicians, (including psychiatrists), responded, 23.3% of whom provided direct care to SARS patients. Attitudes, occupational changes, symptoms, concerns, risk assessment, interpersonal relations, and coping methods were reported. Physicians providing direct care to SARS patients experienced significantly greater psychological distress and stigma than physicians not providing direct care. More than 25% of physicians were concerned about spreading SARS to family members; however, most felt invulnerable themselves, despite many physicians (43.5%) knowing infected colleagues. Some physicians (10.9%) reported working, despite experiencing SARS symptoms. The most frequent concerns were about the care of non-SARS patients and loss of physician income.

Conclusion: Physicians felt remarkably invulnerable in the face of a new and virulent disease that disproportionately infected and killed health care workers. Concerns regarding loss of income, inappropriate risk assessment, continued work despite SARS-like symptoms, and psychological distress among physicians providing direct care to SARS patients are problematic areas that should be addressed.

No. 110C
CONSULTATION-LIAISON PSYCHIATRY DURING THE SARS OUTBREAK: RESPONSE TO PATIENTS AND ADMINISTRATION

Jonathan J. Hunter, M.D., *Department of Psychiatry, Mount Sinai Hospital, 600 University Avenue, Toronto, ON M5G 1X5, Canada*

SUMMARY:

In a four-week period in April 2003, 19 SARS patients were admitted to Mount Sinai Hospital in Toronto, 11 of whom were health care workers. The administration was required to immediately create and staff an isolation unit. They also had to drastically alter the functioning of the hospital on a day-to-day basis, to conform to directives issued by the government health services.

The patients in isolation described feelings of fear, loneliness, boredom, and anger. The administrative and other hospital personnel reported fears of becoming infected, or, in turn, infecting others. Additionally, a number of issues arose as a result of the patients being health care workers and in some instances close colleagues.

In this situation consultation-liaison psychiatry was essential to the hospital response. The presentation will describe the role of the C/L team in providing consultation to patients in the isolation unit, and liaison with that unit and others stressed by the situation, including the administrative team itself.

No. 110D
PSYCHOSOCIAL EFFECTS OF QUARANTINE DUE TO SARS IN HEALTH CARE WORKERS

Emma K. Robertson, Ph.D., *Department of Women's Health, UHN TGH, 657 University Avenue, ML2004D, Toronto, ON M5G2N2, Canada;* Karen Hershenfield, B.S.C., Sherry Grace, Ph.D., Donna E. Stewart, M.D.

SUMMARY:

Objective: To systematically examine the psychosocial effects of being quarantined due to exposure to SARS among Toronto health care workers.

Method: Ten qualitative semistructured interviews were conducted, and content analyzed. The interviews explored the experience of quarantine and its effects on social relationships, subjects' perceptions of contracting and spreading SARS, and how SARS affected their perceptions of work.

Results: Three main themes emerged from the data: conflict, duty, and stress. All subjects reported significant psychological stress as a result of quarantine; they felt socially and physically isolated. Many front-line workers felt it was a matter of chance if they contracted SARS, and experienced anxiety while carrying out duties. Conflict between co-workers and management was commonplace, and subjects expressed conflict between one's duty as a health care worker and as a family member who could potentially infect loved ones. Parental and spousal relationships were detrimentally affected, as physical contact with children and partners became limited. Parents had to deal with their children's anxieties and fears, as they experienced stigma due to their health care worker status. Physical symptoms of stress were reported weeks after returning to normal work.

Conclusion: The psychological and social effects of quarantine due to SARS were far reaching for health care workers and their families. These effects need to be understood so mental health professionals can provide adequate, help for future epidemics of life-threatening infectious diseases.

No. 110E
GROUP PSYCHOLOGICAL PERSPECTIVES ON THE SARS EPIDEMIC IN TORONTO

Molyn Leszcz, M.D., *Department of Psychiatry, Mount Sinai Hospital, 600 University Avenue, Toronto, ON M5G 1X5, Canada*

SUMMARY:

The epidemic of Severe Acute Respiratory Distress Syndrome (SARS) had dramatic impact on the provision of medical care, on healthcare providers, on the hospital as an institution, and on the community at large. Perspectives from group psychology help explain the phenomenon of group contagion and regressive psychological responses, evident at many levels of this system. Psychodynamic, social psychological and emotion-based contributions to understanding this group phenomenon will be articulated. The permeability of psychological boundaries, mediated by the fear of infectious contagion is a central consideration in understanding this emotional and psychological phenomenon. This presentation will address the role group psychological understanding plays with regard to the initial prevention, remediation and management of the regressive impact of group contagion on both psychological well being and optimum health care provision.

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SYMPOSIUM 111—TRAUMATIC STRESS: THE BRIDGE BETWEEN NEUROSCIENCE AND PSYCHODYNAMIC PSYCHIATRY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the fact that neurobiology and the clinical field of psychiatry are establishing a theoretical and practical liaison; understand that in the future psychiatrists will have to acquire a deeper knowledge base in the field of neuroscience including neuroanatomy and histology of the brain; understand that the treatment of traumatized patients requires a multidisciplinary eclectic approach which should include the use of the latest neuropharmacologic agents that can serve as growth factors and enhancers of adult neurogenesis.

No. 111A
DISORGANIZED ATTACHMENT ALTERS THE CORTISOL STRESS RESPONSE IN HUMAN INFANTS

Robert D. Levitan, M.D., *Department of Psychiatry, University of Toronto, 250 College Street, Room 1126, Toronto, ON M5T 1R8, Canada;* Eman Leung, M.A., Susan Goldberg, Ph.D., Stephen Matthews, Ph.D., Leslie Atkinson, Ph.D.

SUMMARY:

Objective: Animal studies have shown that early attachment behavior between mother and infant can greatly affect psycho-neuroendocrine development. If this same process occurs in humans, it may provide a model for the intergenerational transmission of stress-related disorders such as PTSD and major depression. We thus examined whether 12–18 month old infants with a disorganized attachment style exhibit changes in HPA-axis activity relative to infants with organized attachment styles.

Method: Salivary cortisol was collected from infants with either organized (N-29) or disorganized (N-3) attachment both before and 20 minutes following a standardized laboratory stressor consisting of brief maternal separations. A third sample 40 minutes post-stressor was collected in 27 of these infants.

Result: In this small sample there were statistical trends ($p<.10$) suggesting that relative to organized infants, disorganized infants (1) secrete less basal cortisol in a novel laboratory setting, (2) mount a more robust cortisol response when confronted by a mild stressor, and (3) show a more rapid recovery in cortisol levels from peak back to baseline. These findings are highly remmiscent of prior data obtained from adults with PTSD.

Conclusion: We hypothesize that the intergenerational transmission of vulnerability to stress-related disorders such as PTSD may be mediated in part by disorganized mother-infant attachment, which is reflected hormonally in a characteristic pattern of cortisol secretion as early as the first year of life.

No. 111B
BIOLOGICAL ASPECTS OF INTERGENERATIONAL RESPONSES TO TRAUMATIC STRESS

Rachel Yehuda, Ph.D., *Department of Psychiatry, Mount Sinai School of Medicine, 130 West Kingsbridge Road, #116A, Bronx, NY 10468*

SUMMARY:

Adult children of trauma survivors also show a greater prevalence of mood and other anxiety disorders. In a sample for which PTSD could be evaluated directly in parents and children, PTSD was present in children of Holocaust survivors with chronic PTSD, but not in children of parents who either never developed PTSD or had recovered from it within several years after World War II. More recently, we have examined neuroendocrine parameters in the putative high-risk group of adult children of Holocaust survivors. This presentation will describe results of all these studies, but will particularly focus on assessment of urinary and plasma cortisol over the diurnal cycle in adult children with and without parental PTSD, and with and without their own PTSD, and comparison subjects. The results will show that low cortisol levels are associated with both parental PTSD and lifetime PTSD. The risk of PTSD and low cortisol also appears to be different between offspring with one vs. two Holocaust parents. Furthermore, there are significant interactions among variables associated with risk for PTSD and cortisol levels. Findings will be interpreted as suggesting that some neuroendocrine alterations may reflect risk factors for PTSD that determine responsiveness to subsequent trauma, whereas other parameters may be more true measure of the consequence of traumatic stress. These data may have consequences for understanding individual differences in, and particularly genetic contributions to, the human response to extreme stress.

No. 111C
THE NEUROBIOLOGY OF COGNITIVE BIAS

Andrei Novac, M.D., *Department of Psychiatry, University of California, 400 Newport Center Drive, Suite 309, Newport Beach, CA 92660-7604*

SUMMARY:

Trauma-related clinical manifestations include a range of disorders from psychopathology (anxiety, depression, substance abuse disorders, and PTSD) to behavioral "adaptations," which are often dsyfunctional toward others and have a perpetuating effect on the cycle of trauma. These "paratraumatic" manifestations include a variety of dysfunctional behaviors that were previously described as secondary traumatization, vicarious traumatization, intergenerational transmission of trauma, and a variety of "survivor behaviors." The cognitive distortions that underlie these paratraumatic disorders will be described as cognitive bias, and the neurobiologic process of brain circuitry developed and consolidated under the effect of traumatic stress will be discussed. Clinical materials and neuroimaging findings will be referred to.

No. 111D
PSYCHODYNAMIC NEUROBIOLOGY

Barton J. Blinder, M.D., *Department of Psychiatry, University of California, Irvine, 400 Newport Center Drive, Suite 706, Newport Beach, CA 92660-7608*

SUMMARY:

Recent advances in our understanding of brain function associated with cognition, affect, and memory have led to new insight into the impact of experience in the individual processing of memory, emotions, motivation, and dreams. A significant part instrumental to the processing of memory in the human brain is the hippocampal formation, functioning as the central area for memory processing. In addition, the amygdala functions as an emotional memory processing unit in the brain, mainly as an interface between threatening stimuli in the environment and defense responses. These recent advances have also been valuable in the study of psychotherapeutic transformation in the brain, which is mediated by three fundamental processes: formation of new structures, synaptic plasticity, and contemporary addition. Emotional influence also impacts executive function. For psychiatrists, neural bases of clinical symptoms and possible mechanism of action of treatment can aide in gauging both

the intensity of therapeutic effort and a realistic expectations of results. Studies have yielded experimental evidence suggesting specific localization of brain metabolic activity in attachment, empathic recognition of expressed affect, anxiety and phobic reactions, eating disorders, and dreams. Both pharmacological intervention and psychotherapy in the treatment of mental conflict and primary neurobiological disregulation should, if successful, produce function and structural change in the brain.

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SYMPOSIUM 112—INSTITUTIONAL ETHICS IN PSYCHIATRY: A MULTIDISCIPLINARY PERSPECTIVE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) describe the differences between individual and institutional ethics; (2) understand the theoretical basis of institutional ethics in psychiatry; (3) apply ethical reasoning to specific dilemmas that confront contemporary psychiatric institutions.

No. 112A
ETHICAL AND LEGAL ASPECTS OF CONFIDENTIALITY IN PSYCHIATRIC INSTITUTIONS

Rebecca W. Brendel, M.D., *Department of Psychiatry, Massachusetts General Hospital, 55 Fruit Street, WRN-605, Boston, MA 02114*

SUMMARY:

Confidentiality is a cornerstone of the doctor-patient relationship. This fiduciary obligation is particularly important in psychiatry, where treatment involves patients' revealing highly sensitive information to their physicians in the course of treatment. Hospitals and other health care institutions have developed policies and procedures for safeguarding the privacy of medical records. Prior to the implementation of the federal Health Insurance Portability and Accountability Act (HIPAA) in 2003, the interests of institutions and individual practitioners regarding confidentiality largely coincided. With few exceptions (such as life-threatening emergencies), a patient's medical information could not be released without the patient's express consent. Psychiatric records were generally accorded special priority for strict confidentiality. However, with increasing complexity of the health care system and greater administrative demands on institutions (e.g., those involving third-party payers), there has been a significant shift in institutional practice regarding patient confidentiality. For example, HIPAA eliminated the consent requirement for release of medical information to many third parties. While this change eases administrative burdens, it may have worrisome implications for confidentiality. This section of the symposium will address the ethical dimensions of HIPAA, describe how institutional and individual challenges to preserve confidentiality differ, and propose future directions for the preservation of patient privacy.

No. 112B
INSTITUTIONAL OBLIGATION TO BALANCE SCIENCE WITH ETHICS IN RESEARCH: ROLE OF THE IRB

Scott E. Lukas, Ph.D., *BPRL/NIC, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

Along with the role of providing health care to those who need it, clinicians, researchers, and the medical institutions that support their efforts have an obligation to advance our knowledge of disease states such that better diagnostic tests, treatments, and prevention measures can be developed. Keen observations and case reports will often offer some insight to a disease process, but prospective research protocols must be followed in order to meet the more global goal of testing and validating hypotheses. However, even though institutions have this obligation to improve the health of the population, such ventures must be done in a manner that follows clear ethical guidelines. It is well recognized that institutional review boards are the official organizations having the role of protecting the rights, safety, and welfare of research participants, but this task becomes more difficult each year as technology, novel medications, and interventions become available. This session addresses the constantly changing challenges that IRBs face as they struggle with issues such as medication trials using unapproved investigational drugs, placebo control protocols, advanced brain imaging, special vulnerable populations, and genetic testing. Using specific examples from IRB archives, symposium participants will gain insight into how IRBs evaluate such protocols for scientific merit, value to society, and safety to the individual participant. Specific emphasis will be placed on these more difficult scenarios because they represent the greatest challenge to scientists as risks of individual participation must be balanced by potential benefits to the population.

No. 112C
SOME FUNCTIONS OF A PSYCHIATRIC HOSPITAL ETHICS COMMITTEE

J. Alexander Bodkin, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

The ethics committee of a psychiatric institution can serve its clinical and academic communities in a variety of ways. Such a committee is generally most effective when it performs primarily consultative rather than disciplinary services for the institution. The committee should include clinicians and academicians who have diverse backgrounds and theoretical orientations but are open-minded, deliberative, pragmatically oriented, and able to advise their colleagues in a respectful and collaborative fashion. The activities of one such psychiatric ethics committee will be described in order to demonstrate the application of these general principles to everyday practice. This ethics committee organizes annual academic grand rounds to educate members of the hospital community on ethical topics such as treatment refusals. It has advised the hospital trustees about managed care arrangements and the ethical concerns that are raised by conflicts between the obligation to provide optimal patient care and the necessity to preserve the institution's fiscal viability. The committee has collaborated with colleagues on complex clinical situations that raised ethical concerns in the minds of other prac-

titioners at the institution. In this same collaborative spirit, it has also consulted to the outpatient clinic regarding the ethics of permitting a staff clinician to offer unconventional treatments.

No. 112D
ETHICAL ROLES, IDENTITY, AND BUREAUCRATIC HEALTH CARE

Jennifer Radden, Ph.D., *Department of Philosophy, University of Massachusetts, 100 Morrissey Boulevard, Boston, MA 02125*

SUMMARY:

At hospital ethics committees, practitioners of psychiatry often present immediate, pressing, and concrete cases and quandaries. The role of the moral philosopher on such a committee is not only to provide theoretical context but also to draw attention to themes and more general ways of looking at the ethical climate in the institution. One aspect of this involves the character of the practitioner, not so much what he or she should do in particular situations, but what kind of person he or she should be in general. This emphasis on the character of the practitioner has particular importance in psychiatric hospitals and managed care settings, where multiple roles invite discrete, but disconnected, responses. The philosopher Alasdair MacIntyre has enunciated the moral dangers of losing one's character in the context of such large bureaucratic systems, emphasizing the importance of retaining an identity that is independent of one's institutional role. MacIntyre's work will be used to develop guidelines for psychiatrists that can help them avoid the ethical pitfalls of losing one's role-independent identity.

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SYMPOSIUM 113—THE EFFECTS OF SEXUAL AND PHYSICAL ABUSE ON WOMEN'S HEALTH

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the high prevalence and impact of physical and sexual abuse in women's health and the need for more identification and treatment of abuse within primary care and chronic care clinics.

No. 113A
THE LASTING EFFECTS OF SEXUAL ABUSE ON HEALTH: WHAT IS THE EVIDENCE?

Jane Leserman, Ph.D., *Department of Psychiatry, University of North Carolina, Medical School Wing C, CB 7160, Chapel Hill, NC 27599*

SUMMARY:

Objective: The goal of this talk is to summarize a vast literature concerning: (1) the high prevalence of sexual abuse history, (2) the long-term impact of abuse on physical and mental health, and (3) the lack of awareness about abuse within medical settings.

Method: The review will focus on both probability-based surveys and studies of primary care clinical samples.

Results: Based on national probability data, the prevalence of child sexual abuse among women has been estimated between 15% and 20%. Lifetime estimates of sexual abuse tend to run higher (25%), and estimates of abuse in chronic pain populations tend to be the highest (50%). Sexual abuse history has been associated with increased risk for headaches (OR=1.3 to 2.2), pelvic pain (OR=1.7 to 2.2), abdominal pain (OR=1.3 to 1.9), gastrointestinal disorders (OR=1.5 to 2.7), genito-urinary disorders (OR=1.4 to 3.2), eating disorders (OR=1.8 to 2.7), substance abuse/dependence (OR=1.5 to 3.7), psychological disorders including depression, PTSD, and increased risk of suicide (OR=1.8 to 5.7), and promiscuity (OR=1.8 to 7.4). Other types of childhood trauma such as physical abuse, parental fighting, and parental neglect have not explained the detrimental health effects of abuse. Furthermore, severe abuse (e.g., rape, injury) has been associated with worse health effects than less invasive abuse (e.g., forced touching).

Conclusions: Despite the high prevalence of abuse and the pervasive long-term health effects, abuse history often remains hidden within medical practice. These findings have important implications for the treatment of patients, especially those with chronic health problems.

No. 113B
THE HEALTH IMPACT OF SEXUAL AND PHYSICAL ABUSE AND PTSD AMONG WOMEN WITH PELVIC PAIN

Samantha Meltzer-Brody, M.D., *Department of Psychiatry, University of North Carolina, Campus Box 7160, Chapel Hill, NC 27599;* Jane Leserman, Ph.D., Wilma I. Castilla-Puentes, M.D., Mimi Butterfield, M.D.

SUMMARY:

Objective: Although there has been growing documentation that sexual and physical abuse are related to long-term decrements in health status, less is known about the effects of PTSD on chronic pain. The primary aim of this study is to examine the impact of abuse history, other major trauma, and PTSD on medical symptoms and health-related daily functioning.

Methods: We administered a questionnaire to 124 consecutive women patients seen in a referral based pelvic pain clinic.

Results: We found that 47.6% reported having either sexual and/or physical abuse history, with 25.8% having severe types of abuse (e.g., rape or life threat). A total of 29.5% had a positive screen for PTSD. Using regression and path analysis, controlling for demographic variables, we found that severe abuse was associated with more medical symptoms (p=.001), more days spent in bed (p=.005), worse daily functioning due to poor physical health (p=.01) (SF-12), and more dysfunction due to pain (p=.003) (SF-12). Other trauma was associated with more medical symptoms (p=.001), and PTSD was significantly related to all measures of poor health status (p<.01).

Conclusion: Interestingly, the effects of abuse were predominately explained by PTSD, indicating that the association of abuse with poor health is due to the development of PTSD resulting from trauma. These findings demonstrate the importance of screening for trauma and PTSD within chronic pain populations.

No. 113C
DOES HAVING A DISABILITY INCREASE WOMEN'S RISK OF SEXUAL AND PHYSICAL ASSAULT?

Senior Author: Kathryn E. Moracco, Ph.D., *Pacific Institute for Research and Wvaluation, 1516 East Franklin Street, Suite 200,*

*Chapel Hill, NC 27514-2812;*Neepa Ray, M.S.C., Daniela Sotres-Alvarez, M.S.C., Lawrence L. Kupper, Sandra L. Martin, Ph.D., Pamela A. Dickens, M.P.H., Donna Scandlin, M.Ed.

SUMMARY:

There is a dearth of empirical information concerning whether having a disability increases women's risk of violent victimization. This study surveyed a representative sample of 5,326 non-institutionalized women to examine whether their disability status affected their risk of being physically and/or sexually assaulted. Disability status was assessed by asking the women about activity limitations, cognitive limitations, special equipment needs (wheelchair, etc.), and whether they considered themselves to have a disability. Violence experiences were assessed by asking about physical assault and sexual assault within the past year. The results showed that 26% of the women had some type of disability. For all women, the prevalence of assault within the past year was 3.1% (95% CI=2.5%–3.7%). Multivariable analysis revealed that women with disabilities were not significantly more likely than other women to have experienced physical assault (OR=1.18, 95% CI=0.62–2.27); however, they had more than four times the odds of experiencing sexual assault (OR= 4.89, 95% CI=2.21–10.83).

No. 113D
TREATING PTSD RELATED TO SEXUAL TRAUMA IN WOMEN

Marian I. Butterfield, M.D., *Department of Psychiatry, Durham VA/ Duke University, 508 Fulton Street, Suite 116A, Durham, NC 27705*

SUMMARY:

Sexual trauma and related victimization of women often results in posttraumatic stress disorder (PTSD). Life threatening interpersonal traumas such as rape are associated with a 8.5-fold increase in PTSD risk as compared with other types of trauma. As many as 1.3 million women in the U.S. have rape-related PTSD. Most women with rape-related PTSD will have it chronically, and will still meet PTSD criteria 10 years after the assault. This presentation continues the overall symposium discussion of the health and mental health effects of victimization and related PTSD in women. This talk will draw from research and clinical work with women veterans with PTSD related to military sexual trauma. The health and mental health effects of rape-related PTSD in women will be presented, including gender differences in hepatitis C risks and rates. Treatment strategies for women with PTSD will be reviewed including pharmacotherapy and psychosocial treatments. Treatment research on guided imagery for PTSD in women veterans with military sexual trauma will be discussed.

No. 113E
SEXUAL ABUSE IN THE CONTEXT OF PSYCHIATRIC DISORDERS

Anita L.H. Clayton, M.D., *Department of Psychiatry, University of Virginia, 2955 Ivy Road, Northridge Suite 210, Charlottesville, VA 22903*

SUMMARY:

Population studies suggest that 13% to 17% of women and 2.5% to 5% of men report childhood sexual abuse (CSA). Women with a history of CSA have a significantly increased risk of subsequently occurring depressive disorders, anxiety disorders, substance use disorders, conduct disorders, eating disorders, borderline personality disorder, suicide attempt, and comorbidity. Among women, rape vs. molestation, knowing the perpetrator vs. strangers, and chronicity of the abuse vs. isolated incidents were associated with a greater risk of some disorders. The presence and severity of abuse is related to the severity of subsequent psychopathologic symptoms. Family malfunction plays a significant general role in the association between CSA and other maltreatment of children, making separation of genetic and environmental factors difficult in the etiology of psychiatric disorders. In particular, a history of maternal sexual abuse is statistically significant in its relationship to a history of abuse in childhood when other background factors are controlled. General population studies demonstrate a two- to three-fold greater likelihood of physical or sexual abuse in children if parents have a history of severe mental illness (SMI).

Abuse in adulthood is almost always preceded by abuse in childhood, and there is a high prevalence of victimization of individuals with SMI and substance use disorders, with sexual abuse more prevalent in women, and physical abuse more common in men. High rates of trauma, particularly physical abuse (81%) and revictimization (three-quarters) are associated with dual diagnosis of drug addiction and schizophrenia in women. Rates of concurrent posttraumatic stress disorder are high, and this risk is associated with CSA and revictimization. In another study, CSA and being raped in adulthood were associated with a particular risk for substance dependence. Greater appreciation of the association of early traumatic experiences and a subsequent adverse course of psychiatric illness may lead to preventative and early intervention approaches that may lessen the associated risk of a poor outcome.

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3. Butterfield MI, McIntyre LM, Stechuchak KM, Nanda K, Bastian L: Mental disorder symptoms in veteral women: impact of sexual trauma connected to the military. J Am Med Women's Assoc 1998; 53(4):198–200.
4. Butterfield MI, Forneris CA, Feldman ME, Beckham JC: Hostility and functional health status in women veterans with and without posttraumatic stress disorder: a preliminary study. J Trauma Stress 2000; 13:735–41.
5. Nelson EC, Heath AC, Madden PA, et al: Association between self-reported childhood sexual abuse and adverse psychosocial outcomes: results from a twin study. Archives of General Psychiatry 2002; 59(2):139–145.

SYMPOSIUM 114—PROVIDING PSYCHIATRIC SERVICES AROUND THE WORLD WITH A SHORTAGE OF PSYCHIATRISTS
The Royal College of Psychiatrists

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand how the problems facing those trying to provide good psychiatric services despite a shortage of psychiatrists have been addressed in many countries and communities throughout the world.

No. 114A
PEER-SPECIALISTS, SELF-HELP GROUPS, AND PSYCHIATRISTS: AN OPPORTUNITY TO EXPAND RESOURCES AND HORIZONS

Peter Stastny, M.D., *AECOM-PHMP, 3050 White Plains Road, Bronx, NY 10467*

SUMMARY:

A historical review of the interface between psychiatrists and consumers who are active in self-help groups or as service providers will be offered. The author's work in investigating the contribution of peer-specialists to quality of life and other outcome variables will be contrasted with other studies addressing related issues. Also, other research considering the effects of self-help groups and peer support on persons diagnosed with serious psychiatric disorders will be reviewed. Self-help groups and peer specialists, i.e., former psychiatric patients providing services to their peers, are a promising avenue to reach a broad group of clients, especially those that report negative experiences with mental health care. The resulting two-way relationships are educational for both parties and may contribute to a positive dialogue between clinical workers and their clients. Like Abraham Low, M.D., the 1934 founder of Recovery, Inc., a highly effective self-help organization for persons who experience psychiatric hospitalization and their families, psychiatrists today may find exciting possibilities in this area.

In conclusion, this new area of interest offers many possibilities for future clinical/consumer dialogues.

No. 114B
THE NEW U.K. GRADUATE MENTAL HEALTH WORKER

Andrew Kent, M.D., *Department of Mental Health, St. Georges Hospital Medical School, Cranmer Terrace, London SW17ORE, United Kingdom*

SUMMARY:

The majority of psychiatric care in the U.K. continues to be provided by general practitioners and allied professionals working in primary care. More than half of all U.K. general practices now employ a trained counselor. Correspondingly, consultation and liaison services to support primary care are increasingly emphasised. Some services, including our own in South West London, have aligned with general practices to support this process. Although the existing service model has been successful, the U.K. government has elected to fund the training of 1,000 entirely new and untested graduate mental health workers. These workers, initially intended to be psychology graduates, are to be trained in "brief therapy techniques of proven effectiveness" and "employed to help GPs manage and treat common mental health problems in all age groups." The plan has not been uncontroversial and concerns have been expressed by existing primary care professionals about the role of the new workers. In this presentation, their training needs and potential role will be discussed in the context of existing U.K. services.

No. 114C
SETTING UP A PSYCHIATRIC SERVICE FOR A GROUP OF AFGHAN REFUGEES LIVING IN PAKISTAN

Khalid A. Mufti, M.D., *KHYB Medical College, 32-EE Nishterabad, Peshawar City 25000, Pakistan (west);* Farooq Naeem, M.R.C.

SUMMARY:

Background: Very high rates of psychiatric morbidity have been recorded among refugees. The refugees from Afghanistan are mainly settled in Pakistan and Iran. In Pakistan, where there is a serious lack of mental health services, these refugees live an underprivileged life. We are describing a service that caters to the mental health needs of a group of Afghan refugees in Pakistan.

Service structure and personnel: The service is aimed at providing help at the grassroots level, specifically aimed at evidence-based interventions. The center operates on most days of the week. There are currently one psychiatrist, two nurses, one primary health care physician, and two social workers. We also have three support workers. These professionals have extensive training and experience of working in the mental health field. The funding is provided by an NGO Horizon patients are referred from their refugee camps through community workers, relatives and friends.

Interventions: A number of interventions are offered, including treatment of acute and distressing conditions as well as long-term care and rehabilitation regular follow up of the clients. A biopsychosocial model toward treatment is employed. Patients are provided with pharmacological, as well as psychological (e.g: counselling, brief celectic psychotherapy) and social interventions (e.g: helping with readjustment in a new culture).

Results: Every day, nearly 60 patients are seen in the center. The center has so far helped 6,000 people. We are currently looking at and to expanding the role of the center, employing more professionals.

Conclusions: Psychiatric help can be provided to displaced persons using their own strengths and support from the family, within limited resources.

No. 114D
MANAGEMENT OF MENTAL HEALTH SERVICES WITH SCARCE RESOURCES: THE KENYAN EXPERIENCE

Marx O. Okonji, M.A., *PO Box 50468, Nairobi 0200, Kenya*

SUMMARY:

Kenya spans a diverse geographic area of 583,000 square kilometers with a population of 30 million. Eighty percent of the population live in rural areas. Before 1960 Mathari Hospital was the only institution providing psychiatric services for the whole country. Since 1962, 16 psychiatric units have been established in the provincial and district general hospitals. Psychiatric nurse training started in 1961. Two hundred psychiatric nurses are deployed in psychiatric units where they diagnose, prescribe, treat, discharge, and run outpatient clinics. Local training of psychiatrists started in 1982. Eighty-six percent of the 50 psychiatrists in Kenya work in urban centers. This is due to reluctance for deployment to rural facilities. To adequately serve the rural population there should be an accelerated and effective training of psychiatric nurses who are easily deployable in rural areas to work under the supervision of the few psychiatrists in those facilities.

No. 114E
THE MARRIAGE OF MODERN AND TRADITIONAL METHODS IN MENTAL HEALTH CARE IN EGYPT

Nasser F. Loza, M.B., *Department of Psychiatry, The Behman Hospital, PO 11421, 32 El Marsad Street - Helwan, Cairo 11421, Egypt;* Sherif F. Atallah, M.R.C.

SUMMARY:

Even though Egypt boasts one of history's oldest psychiatric hospitals (1284 AD) condition of services deteriorated gradually over the centuries. Most significant was the neglect of the community's tolerance and support for the mentally ill, thus abandoning traditional healers, the practice of Zar and other time-honored remedies, for the sake of importing western medicine into Egypt and promoting alienation of mental patients in asylums away from the communities.

This presentation will review the current situation of psychiatric services in the country, showing numbers of mental health workers, their roles, and responsibilities.

Results of a survey looking at attitudes toward mental illness, psychiatric treatments, and their alternatives will be discussed.

We conclude with a proposed marriage of traditional and modern approaches as a possible solution for the limited number of mental health professionals. Pros and cons of this approach are discussed. The lack of standardized practice codes for traditional medicine, the sociopolitical consideration of inviting religious clergy of different backgrounds to contribute to clinical services, are all factors to be considered by health services planners.

REFERENCES:

1. Felton CJ, Statsny P, Shern DL, Blanch A, Donahue SA, Knight E, Brown C: Consumers as peer specialists on intensive case management teams: impact on client outcomes. Psychiatric Serv 1995; 46(10):1037–44.
2. Secretary of State for Health, The NHS Plan. HMSO, London, 2000.
3. Murphy D, et al: Mental health of refugees in inner-London. Psychiatric Bulletin 2002; 26:222–224.
4. The Kenya National Health Sector Strategic Plan 1999 to 2004.
5. Mayers MA: A century of psychiatry: The Egyptian Mental Hospitals PhD thesis, 1984.

SYMPOSIUM 115—MEETING THE CHALLENGE OF ADOLESCENT ADHD

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the challenges faced by an adolescent with ADHD disorder in terms of its impact on behavior and function. This symposium also presents the challenges to clinical management and delineates the additional difficulties of symptom recognition and diagnosis, the impact of comorbidities, and the importance of individualizing treatment.

No. 115A
FUNCTIONAL OUTCOMES IN ADOLESCENTS WITH ADHD

Eric Mick, Sc.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 725, Boston, MA 02114*

SUMMARY:

Follow-up studies have consistently documented the persistence of ADHD into adolescence and adulthood. However, the level of persistence has been inconsistent across studies, possibly due to different definitions of remission across studies. A distinction between different types of remission may clarify components of complex recovery processes. This report examined three different patterns of remission with regard to ADHD symptoms in a longitudinal sample of carefully diagnosed ADHD children. Across five repeated measures, the mean number of symptoms and rate of remission of 128 ADHD subjects (age up to 20 years) was estimated as a function of age of remission in addition to school, social, and emotional domains of functioning. The rate of remission varied considerably with the definition used (syndromatic remission > symptomatic remission > functional remission). Twenty percent of ADHD boys were functioning poorly in all three domains, 20% were functioning well in all three domains. It can be concluded that patterns of remission of ADHD are highly sensitive to the definition of remission. The results show that the majority of adolescents continue to struggle with a substantial number of ADHD symptoms and high levels of dysfunction despite a sizable rate of syndromatic remission by the age of 20. They also provide systematic support for the clinical observation that symptoms of hyperactivity and impulsivity tend to decline at a higher rate than those of inattention.

No. 115B
DIAGNOSTIC ISSUES: THE CHALLENGE OF ADOLESCENT ADHD

Laurence L. Greenhill, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Box 78, New York, NY 10032*

SUMMARY:

ADHD affects 8% to 10% of school-aged children and longitudinal data indicate that symptoms persist into adolescence in 60% to 80% of cases. Key impairments in adolescents with ADHD include poor educational outcomes, higher rates of both criminality and substance abuse, poor social functioning, and increased driving accidents with associated injury.

The clinical characteristics of ADHD change in subtle but significant ways as children mature into adolescents. For example, hyperactivity manifests as restlessness, which may be misinterpreted as boredom or impatience. But the most important change is the decline in motoric hyperactivity symptoms and the increasing predominance of inattentive symptoms. Some affected individuals, particularly females, may remain undiagnosed in childhood, probably because their symptoms are less disruptive. Or they may have developed coping strategies that minimize impairments until the increasing social and academic demands of adolescence reveal them. Furthermore, high rates of comorbidity can make determining the source of impairment difficult. All these issues make the diagnosis and management of adolescents with ADHD especially challenging. The diagnostic criteria of DSM-IV may not always fit this group, and additional rating scales may be useful. In view of the poor outcome associated with ADHD in adolescence, the need for accurate diagnosis is of considerable importance.

No. 115C
COMORBIDITIES IN ADOLESCENTS WITH ADHD

Joseph Biederman, M.D., *Department of Pediatric Psychiatry, Massachusetts General Hospital, 15 Parkman Street, ACC—725, Boston, MA 02114*

SUMMARY:

ADHD is estimated to affect between 4% and 7% of all adolescents. The overall prevalence of comorbidities in this population is unclear, but is presumed to lie somewhere between 51% and 77%, the levels recorded in children and adults. Patients with ADHD and comorbidity often have outcomes significantly worse than patients with ADHD alone. The most common comorbidities for adolescents with ADHD are conduct disorder and oppositional/defiant disorder, with a prevalence between 35% and 50%. Conduct disorder can lead to an increased tendency to antisocial behavior such as bullying, fighting, or stealing. Adolescents with ADHD are also likely to suffer from anxiety and mood disorders (unipolar and bipolar) and are at increased risk of substance use disorder. Comorbidities commonly impact the manifestation and progression of ADHD, so accurate diagnosis in adolescents is critical. The symptoms of ADHD may be masked by the comorbidity, or vice versa. Treatment should be multimodal, and should be focused on treating the most severely impairing condition first. Pharmacological treatment with stimulants is the most effective option for treating the core symptoms of ADHD.

No. 115D
SAFETY AND EFFICACY OF OROS METHYLPHENIDATE IN ADOLESCENTS WITH ADHD

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

SUMMARY:

This multicenter study evaluated the safety and efficacy of once-daily OROS® methylphenidate (MPH) in adolescents with ADHD. The study protocol included an open-label, individual-dose titration phase (≤4 weeks), a two-week double-blind phase where patients (n=177) were randomized to receive either their individually titrated dose of OROS® MPH or placebo, and an eight-week open-label follow-up phase where patients received their individually titrated OROS® MPH. Efficacy was assessed through investigator-, parent-, and self-report across multiple efficacy measures. 37.3% of subjects required the maximum study-permitted OROS® MPH dose of 72 mg to reach a defined efficacy criterion. At the end of the double-blind phase, the OROS® MPH group had significantly reduced ADHD symptoms compared with placebo as rated by investigators (ADHD Rating Scale, p=.001; CGI, p=.011), parents (ADHD Rating Scale, p=.008; Child Conflict Index, p=.005), and subjects (CASS-L, p=.001). After eight weeks open-label follow-up, there were no clinically important effects of treatment on weight or vital signs. Drug-related adverse events occurred in 26% of subjects; all were mild to moderate in severity and showed no correlation with dose level. In conclusion, OROS® MPH is effective across multiple efficacy measures in treating adolescents with ADHD and is well tolerated at doses up to 72 mg.

No. 115E
IMPROVEMENTS IN ADOLESCENTS' DRIVING PERFORMANCE WITH OROS METHYLPHENIDATE

Daniel J. Cox, Ph.D., *Department of Psychiatric Medicine, University of Virginia, Box 800-223, Charlottesville, VA 22908*

SUMMARY:

Adolescent drivers with ADHD are at greatly increased risk for both driving accidents and resultant injury. Simulated driving studies have shown that the driving performance of adolescent males with ADHD improved following methylphenidate (MPH) administration. Furthermore, once-daily OROS® MPH resulted in better, less variable driving than MPH three times daily. To investigate the effect of once-daily OROS® MPH on real-life on-road driving performance in ADHD-diagnosed adolescent males, 12 ADHD diagnosed male adolescent drivers (age 16–18 years) participated in a repeated measure crossover study. Optimal doses of OROS® MPH were prescribed. Drivers twice drove the same 28-mile stretch of road (once on and once off medication, randomized) at the same time of day during daylight hours. A rater sat in the back and recorded driving performance while blinded to medication state. The average OROS® MPH dosage was 0.74 mg/kg. Impulsive errors occurred rarely, whether the driver was medicated or not. Inattentive driving errors were more frequent off medication, compared with on medication (7.8 vs. 4.6, p<0.01). Improvements in driving performance from first to second drive were positively correlated with dosage (r=.60, p<0.01). This study demonstrated that OROS® MPH improves real-life driving performance in adolescent males with ADHD, particularly reducing inattentive errors.

REFERENCES:

1. Biederman J, Mick E, Faraone SV: Age-dependent decline of symptoms of attention deficit hyperactivity disorder: impact of remission definition and symptom type. Am J Psychiatry 2000; 157(5):816–818.
2. Barkley RA, et al: The adolescent outcome of hyperactive children diagnosed by research criteria: I. An 8-year prospective follow-up study. J Am Acad Child Adolesc Psychiatry 1990; 29:546–557.
3. Biederman J, Faraone S, Milberger S, Guite J, Mick E, Chen L, Mennin D, Marrs A, Ouellette C, Moore P, Spencer T, Norman D, Wilens T, Kraus I, Perrin J: A prospective 4-year follow-up study of attention-deficit hyperactivity and related disorders. Arch Gen Psychiatry 1996; 53(5):437–446.
4. Smith BH, Waschbusch DA, Willoughby MT, Evans S: The efficacy, safety, and practicality of treatments for adolescents with attention-deficit/hyperactivity disorder (ADHD). Clin Child Fam Psychol Rev 2000; 3(4):243–267.
5. Cox DJ, Merkel RL, Kovatchev B, Seward R: Effect of stimulant medication on driving performance of young adults with attention-deficit hyperactivity disorder: A preliminary double-blind, placebo-controlled trial. J Nerv Ment Dis 2000; 188:230–234.

SYMPOSIUM 116—HOW TO PRACTICE EVIDENCE-BASED MEDICINE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand what is EBM and the process of practicing EBM, search the literature for different kinds of evidence, interpret commonly used concepts, critically appraise different kinds of studies, including randomized controlled trials and systematic reviews.

No. 116A
INTRODUCTION TO EVIDENCE-BASED MEDICINE

Bryce Templeton, M.D., *Department of Psychiatry, Eastern Pennsylvania Psychiatric Institute, 3200 Henry Ave, Philadelphia, PA 19129-1137*

SUMMARY:

Evidence-based medicine (EBM) is defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients." The medical profession is exhibiting growing interest in utilizing EBM in order to provide our patients with the best possible care. Many clinicians feel that they have been utilizing such an approach throughout their practice. However, with improved techniques in summarizing related randomized controlled trials and with internet access to innovative databases, our opportunities of efficiently acquiring comprehensive summaries concerning diagnosis and treatment, have substantially improved. This introduction will do the following: provide a more detailed definition of evidenced-based medicine, describe the assets and shortcomings of EBM with respect to psychiatry, and provide instruction on how to obtain ready access to the best EBM and related databases available through the internet and/or printed copy. For patients, EBM can help assure correct diagnoses and the selection of optimal treatment. For the practitioner, EBM can help assure that one's practice includes the best available diagnostic and treatment guidelines and also minimizes malpractice liability.

No. 116B
REVIEW OF BASIC STATISTICAL CONCEPTS

Maju Mathews, M.D., *Department of Psychiatry, EPPI Drexel University, 3200 Henry Avenue, Philadelphia, PA 19129*

SUMMARY:

This talk will explore the various statistical concepts commonly encountered in research papers. It will explain what they mean and how to interpret them. The concepts covered will include relative risks, odds ratios, confidence intervals, predictive values, statistical and clinical significance, etc.

The emphasis will be on their interpretation and the relevance to clinical decision making.

No. 116C
CRITICAL APPRAISAL OF RANDOMIZED, CONTROLLED TRIALS

Adedapo B. Williams, M.D., *Department of Psychiatry, University of Illinois, 912 South Wood, Chicago, IL 60612*

SUMMARY:

Objective: This part of the symposium is designed to improve clinicians' understanding of evidence-based medicine (EBM) as regards appraising the evidence from randomized, controlled trials (RCTs), assessing their validity and clinical applicability.

Method: The presenter will (1) give general guidelines on how to appraise randomized, controlled trials and (2) do a critique of a published randomized, controlled trial, using these general guidelines.

No. 116D
CRITICAL APPRAISAL OF SYSTEMATIC REVIEWS AND META-ANALYSIS

Babatunde A. Adetunji, M.D., *Department of Psychiatry, MCP Hospital, EPPI, 3300 Henry Avenue, Philadelphia, PA 19129*

SUMMARY:

The symposium will involve critical appraisal of systematic reviews and meta-analysis. It will discuss what systematic reviews are and how they are combined into a meta-analysis. It will highlight how to search for systematic reviews and how to analyze the results of meta-analysis. The concepts of heterogeneity, odds ratio or relative risk between means will be discussed as well as the interpretation of confidence intervals.

The discussion will be basic and will also emphasize how to determine whether the samples in the studies are similar to participant's patient population, and whether the magnitude of the effect weighted against the cost makes trial in the patient population worthwhile.

REFERENCES:

1. Cooper B: Evidence-based mental health policy: a critical appraisal. British Journal Psychiatry 2003; 183(2):105–113.
2. Greenhalgh T: How to read a paper: the practise of EBM. BMJ Books, 2000.
3. Warner J: Clinicians' guide to reading psychiatric literature: therapeutic trials and systematic reviews. Advan Psychiatr Treat 2002; 8:73–80.
4. Lawrie S, McIntosh A, Rao S: Critical appraisal for psychiatry. Churchill Livingstone, 2000.

MONDAY, MAY 3, 2004

WORKSHOPS

Media Workshop 1
"DRUMMER BOY"

Chairperson: David L. Dawson, M.D., *231 Bay Street North, Hamilton, ON L8R 2R1, Canada*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants will recognize and be able to use in their teaching of students and the general public a powerful tool for conveying an accurate and sympathetic depiction of schizophrenia.

SUMMARY:

"Drummer Boy" is a 115-minute feature film written and directed by David Dawson, psychiatrist and novelist/filmmaker. "Drummer Boy" is the story of 18-year-old Philip Renold, a talented, fun-loving teen and his poignant struggle with schizophrenia. With a full professional cast, multiple locations, "Drummer Boy" is entertaining and engrossing, and yet depicts schizophrenia, Philip, his family and friends, and their reactions and struggles, in a candid, honest, and sympathetic manner. "Drummer Boy" has received rave reviews from the general public, as well as from people suffering from schizophrenia and their families. It showed at the Montreal World Film Festival in September.

REFERENCES:

1. Gabbard G, Gabbard K: Psychiatry and the Cinema. Wash. DC., American Psychiatric Press Inc.
2. Dawson D, Blum H: Schizophrenia in Focus. Human Sciences Press.

Media Workshop 2
THE MOVIE "TRAFFIC": HOLLYWOOD, TEEN SUBSTANCE ABUSE, AND U.S. DRUG POLICY

Co-Chairpersons: Steven E. Hyler, M.D., *Box 130, NYSPI 1051 Riverside Drive, Scarsdale, NY 10032,* Isabel Burk, M.S., *The Health Network, 11 Adam Place, New City, NY 10956-1703*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the influence of the media in shaping public opinion about teen substance abuse and U.S. drug policy.

SUMMARY:

The media have long shown a fascination with portraying the problems of individuals with alcohol and drug abuse. The purpose of this workshop is to present one such recent film as a stimulus to discuss the way that Hollywood depictions can subtly influence the viewing public's perception of substance abuse prevention, treatment, interdiction, and U.S. drug policy.

The film "Traffic" (2000) directed by Steven Soderbergh will be played. This film is a contemporary depiction of America's long-playing war on drugs. The story interweaves the stories of a new, politically appointed, drug czar, his drug addicted daughter, several drug enforcement agents, and the wife of a recently arrested wealthy drug dealer. This film helps eliminate some stereotypes about drug users and their families. The rich mosaic story line examines the supply-chain economics of drug distribution, the effect of drug abuse on teen users and their family, and the inability of the current state and federal systems to deal with the problem.

The co-chairs, who have an interest/expertise in the area of media psychiatry and teen substance abuse, will request that participants compare their experiences as clinicians, parents, and citizens with those presented in the film. A range of options will be discussed.

REFERENCES:

1. Johnston LD, O'Malley PM, Bachman JG: Monitoring the Future. National Survey Results on Adolescent Drug Use: Overview of Key Findings, 2002 (NIH Publication No. 03-5374). Bethesda, MD, NIDA.
2. The Formative Years: Pathways to Substance Abuse Among Girls and Young Women Ages 8–22, The National Center on Addiction and Substance Abuse at Columbia University, NY, February 2003.

TUESDAY, MAY 4, 2004

Media Workshop 3
CULTURAL ASSESSMENT IN CLINICAL PSYCHIATRY: TWO TRAINING VIDEOTAPES

Co-Chairpersons: Francis G. Lu, M.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7M, San Francisco, CA 94110,* Harriett Koskoff, *415 Noe Street, #5, San Francisco, CA 94114*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the five sections of the DSM-IV Outline for Cultural Formulation and apply it in a clinical case.

SUMMARY:

Cultural assessment in clinical psychiatry is essential as part of good clinical care. Trainees and residency training programs must meet ACGME requirements to include sociocultural issues as part of the integrative case formulation. The DSM-IV Outline for Cultural Formulation (pages 843–844) provides a concise clinical tool for cultural assessment. It consists of five sections: 1) Cultural Identity, 2) Cultural Expressions and Explanations of Illness, 3) Cultural Stressors and Supports, 4) Cultural Elements of the Clinician-Patient Relationship, and 5) Overall Cultural Assessment for Differential Diagnosis and Treatment Planning. "The Culture of Emotions" videotape (2002, 58 minutes) is an introductory overview of the outline. After a short prologue, the five sections are described and include short commentaries from 23 cultural psychiatry experts. A second videotape "Working With Asian American Immigrants and Refugees: A Visit with Evelyn Lee, Ed.D, LCSW" (2003, 18 minutes) will be shown and discussed. Dr. Lee, a pioneering spirit for Asian-American mental health, died unexpectedly in March 2003.

REFERENCES:

1. Gaw A: Concise Guide To Cultural Psychiatry. Washington, DC, American Psychiatry Press, 2001.
2. Group for the Advancement of Psychiatry: Cultural Assessment in Clinical Psychiatry. Washington, DC, American Psychiatric Publishing, 2002.

Media Workshop 4
"WHEN BOYS FLY": CLUB DRUGS IN THE GAY MALE COMMUNITY

Chairperson: Petros Levounis, M.D., *Smithers Center, 1000 Tenth Avenue, New York NY 10019*
Participant: Steven J. Lee, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the psychological and medical effects of club drugs,

and GHB in particular, and to recognize biopsychosocial perspectives of club drug use in the gay male community.

SUMMARY:

"When Boys Fly" (2002) is a documentary film about the circuit party subculture of the gay male community. Several thousand gay men from all over the United States and abroad come together on long weekends to party in different major cities and resort towns that have come to be known as "The Circuit." Circuit parties celebrate gay pride and the openly gay lifestyle, but, at the same time, provide a stage for significant substance use and abuse.

The first part of the film (62 minutes) takes us along the circuit party experience of Brandon, Tone, Jon, Todd, and the friends that they make along the way. We are shown the preparation and consumption of gamma hydroxy butyrate (GHB), various intoxication syndromes, and serious medical sequelae. The second part of the film (23 minutes) documents what happened to the original subjects several months and years later.

Between the two parts of the film, we will invite the participants to discuss the subjects' drug use and speculate on their future. At the conclusion of the film, we will explore models of addiction including self-medication and the gateway hypothesis as they relate to the specifies of club drugs in the gay male community.

REFERENCES:

1. Hoerchlerk: Better days, better gays: from the inside out. HX (Homo Extra) 2003; 623:26–28.
2. McDowell DM: MDMA, ketamine, GHB, and the "club drug" scene. In Textbook of Substance Abuse Treatment, Second Edition, edited by Galanter M, Kleber HD, Washington, DC, American Psychiatric Press, 1999, pp 295–305.

WEDNESDAY, MAY 5, 2004

Media Workshop 5
POSTGENOCIDE PSYCHOLOGICAL TRAUMA IN FILM: "THE SUMMER OF AVIYA"

Co-Chairpersons: Maurice Preter, M.D., *536 East 82nd Street, 5C, New York, NY 10028,* Harold J. Bursztajn, M.D., *Department of Psychiatry, Harvard Medical School, 96 Larchwood Drive, Cambridge, MA 02138-4639*
Participants: Leonti H. Thompson, M.D., Yehuda Nir, M.D., Amira Kohn-Trattner, C.S.W., Gila Almagor

EDUCATIONAL OBJECTIVE:

This workshop uses a contemporary film to highlight and discuss postgenocide psychological trauma and its effect on the next generation. At its conclusion, participants will have obtained better understanding of the cultural-historical context of the Shoah and its aftermath as well as of the impact of massive traumatization on children and families in general.

SUMMARY:

A further exploration of postgenocide psychological trauma and its cinematographic representation, which presents and discusses this internationally acclaimed Israeli movie based on the memoirs of Gila Almagor, Israel's leading actress. Set in 1951, "The Summer of Aviya" chronicles the story of one summer in the life of a 10-year-old girl, Aviya, whose mother Henya, a severely traumatized Shoah survivor, has been psychiatrically hospitalized most of the girl's life. Her reunion with her daughter confronts the girl with her mother's inner turmoil and her, at times reenacted, horrific memories.

"The Summer of Aviya" will be used in a postgenocide context to illustrate themes familiar to psychiatrists working with children and adults traumatized by massive and catastrophic loss: The struggle to maintain an inner representation of those lost, the fantasies of their sudden return, the potential for dramatic decompensation in the face of relived traumatization. The conflict between the search for continuity and the longing for closure when the intrapsychic and the interpersonal fabric of meaning and memory is ripped asunder on both an individual and collective basis will also be analyzed with the workshop participants.

REFERENCES:

1. Almagor G: The Summer of Aviya. HarperCollins, 1991.
2. Bowlby J: Loss: Sadness and Depression, Vol. 3. Perseus Books, 1982.

Media Workshop 6
THE BEGINNING STAGES OF COUPLES' THERAPY: VIDEO CASE STUDIES

Chairperson: Ian E. Alger, M.D., *New York Hospital, Cornell, 500 East 77th Street, #132, New York, NY 10162-0021*

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participants should be able to identify the critical issues in couples therapy, particularly as they emerge in the initial three therapy sessions, and to develop an increased awareness of his or her style as a couples' therapist.

SUMMARY:

The presenter will show sequential segments of videotapes of his first three sessions of therapy with a couple. The focus of the workshop will be to identify issues of engagement, problem identification, and change facilitation during these first three therapeutic encounters. Workshop participants will have the opportunity to compare their own clinical experiences related with issues of working with couples, and in dealing with contemporary couples' problems, such as separation and divorce, issues in second marriages, sexuality and intimacy, and conflicts that arise in dual-career marriages. The challenge for the therapist in fostering a collaborative three-person experience will be highlighted in these videotaped sessions and will facilitate workshop participants in sharing their own experiences in dealing with the challenges of marriage in today's world.

REFERENCES:

1. Alger I: Marital therapy with dual-career couples. Psychiatric Annals 1991; 21:8.
2. Gurman AS, Jacobson NS.: Clinical Handbook of Couple Therapy. Guilford Press, 2002.

THURSDAY, MAY 6, 2004

Media Workshop 7
"ROBOT STORIES": EMOTIONAL AND ETHICAL CHALLENGES OF A TECHNOLOGICAL AGE

Co-Chairpersons: Ravi Chandra, M.D., *Department of Psychiatry, Langley Porter, UCSF, 95 Red Rock Way, M305, San Francisco, CA 94131,* John E. Beebe III, M.D., *Jung Institute of San Francisco, 337 Spruce St. San Francisco, CA 94118-1830*
Participants: Paul S. Appelbaum, M.D., Arthur Caplan, Ph.D., Raj Reddy, Ph.D., Greg Pak, B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize current trends in advancing technology and their possible relation/application to psychiatry, as well as understand bioethical issues raised by these trends. Finally they should demonstrate increased competency in cross-cultural issues.

SUMMARY:

"Robot Stories," a new independent feature film, raises substantial questions involving psychodynamics, bioethics, and the challenges of emotional development in a technological age. The film has so far won six major film festival awards (see www.robotstories.net). This media presentation will feature a screening of the 90-minute film on DVD, followed by a panel discussion with psychiatrists, bioethicists, a technologist, and the director of the film, concluded by a question-and-answer session with audience members. The program is expected to open new areas of inquiry not frequently discussed at the APA Annual Meeting, such as how "robots," virtual reality, and artificial intelligence may help or hinder, but certainly affect, human psychology and interpersonal relationships. The workshop will also examine bioethical issues of life-prolongation through medical and computer technology and question how these choices might impact views of self and other. Also, a significant unstated theme of the film is changing cross-cultural trends in American society: the director is biracial, and all of the lead actors are non-Caucasian. This session will explore these intellectual ideas and help the audience metabolize the film's emotional field by witnessing the panel's conversation and then allowing the audience to engage the panel directly.

REFERENCES:

1. Beebe J: At the movies: AI. San Francisco Jung Institute Library Journal. 2001; 20:73–75.
2. Joy B: Why the future doesn't need us. Wired Magazine, April 2000. (available at http://www.wired.com/wired/archive/)

Media Workshop 8
PERSONALITY DISORDERS AND THE "FILM NOIR FEMME FATALE"

Chairperson: Scott Snyder, M.D., *1999 Prince Avenue, Athens, GA 30606-6013*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand how the film-noir femme fatale, with her attendant cluster B psychopathology, was at once a creation of the 1940s and a reflection of profound shifts in the role of American women.

SUMMARY:

Motion pictures can influence the development of both normal and disordered personality. The femme fatale of the film-noir movies of the 1940s and 1950s is representative of several related personality disorders (Cluster B from DSM-IV) characterized by histrionics, self-absorption, psychopathy, and unpredictability. The type of character pathology personified in the femme fatale may be viewed as representative of certain misogynistic conceptualizations of the women of the time. Concurrently, these screen women may have helped to create a certain cultural image for some real-life women of that era as reflected in the areas of fashion and style, personality, and social status. Bidirectional causality is therefore noted in regard to the relationship between these femme fatales and behavioral manifestations of Cluster B personality disorders in society. Specific reference to issues of criminology, economics, gender, as well as feminist viewpoints on this phenomenon will be explored. Quintessential femme fatales will be presented in excerpts from the film-noir classics "Double Indemnity" (1944) and "Out of the Past" (1947) to illustrate these themes. The audience may discuss vintage and contemporary films from their own experience, which they feel reflect Cluster B pathology, especially as it pertains to women.

REFERENCES:

1. Paris J: A diathesis-stress model of personality disorders. Psychiatric Annals 1999; 29:692–697.
2. Place J: Women in film noir. In Kaplan, E.A. (Ed.) Women in Film Noir, edited by Kaplan EA, London, British Film Institute, 1980, pp. 35–67.

MONDAY, MAY 3, 2004

Component Workshop 1
HOW TO TEACH AND LEARN CULTURAL COMPETENCE IN GERIATRIC PSYCHIATRY
APA Committee on Ethnic Minority Elderly

Chairperson: Iqbal Ahmed, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, 4th Floor, Honolulu, HI 96813*
Participants: Warachal E. Faison, M.D., Walter P. Bland, M.D., Kenneth M. Sakauye, M.D., Angela L. Guerrero, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the attendees will understand the elements needed to teach and learn culturally competent geriatric psychiatry. The attendees will become knowledgeable about the components of the curriculum including the goals and objectives, content areas, teaching methods, and resources.

SUMMARY:

This growth has particularly been dramatic in the ethnic minority elderly in the United States. Currently the ethnic minority population is about 17% of the U.S. population, and by the year 2050 it will go up to 36%. Addressing cultural ethnic issues of the elderly becomes important as a result. The role of cultural issues has been recognized with the inclusion with the cultural formulation in the DSM-IV. The need for minority training in both medical school curricula and psychiatric residencies was recognized by the ACGME in its essentials for all psychiatry residency fellowship training, requiring residency programs to address cross-cultural training during the residency, imparting a knowledge base for work with minority populations. As a result in 1996 the APA Committee on Minority Elderly developed a "Curriculum Resource Guide for Cultural Competence for General Psychiatry" with special reference to the elderly. This is currently available at the American Psychiatric Association Web site, but has not been utilized widely. The current Committee on Ethnic Minority will develop and present a more focused curriculum resource guide focusing just on the elderly population at this workshop. The presentation will include goals and objectives, content areas, teaching methods, and teaching resources.

REFERENCES:

1. Curriculum Resource Guide for Cultural Competence: APA Committee on Minority Elderly (Chair, Ken Sakauye), 1996, at the APA website (www.psych.org).
2. Ahmed I: Aging and Psychopathology in Culture and Psychopathology: a Guide to Clinical Assessment. Edited by Tseng WS and Streltzer J. New York, Brunner/Mazel Inc., 1997, pp. 221–239.

Component Workshop 2
CAN'T WORK, SHOULDN'T WORK, MUSTN'T WORK: ASSESSING FUNCTION AND MENTAL IMPAIRMENT IN PSYCHIATRIC ILLNESS
APA Corresponding Committee on Psychiatry in the Workplace

Chairperson: Marcia A. Scott, M.D., *19 Sibley Court, Cambridge, MA 02138*
Participants: Andrea G. Stolar, M.D., Steven E. Pflanz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participants will be able to anticipate work-related problems in patients, differentiate symptoms

and work issues, and facilitate work adaptation and function during an episode of illness.

SUMMARY:

Because of earlier diagnosis, effective treatment, and recognition that mental illness underlies many personality difficulties, the workplace today has more psychiatric patients in competitive jobs, and most patients work except during an exacerbation. Ten percent of workers have an episode of psychiatric illness in a year; 25% in their lifetime. Losing time from work is threatening even to patients in high-level jobs. It's difficult to adapt back to work or find/adjust to a new job, yet patients risk being fired if they work when impaired/unproductive.

The presentation outlines cues for evaluating subtle mental impairment, anticipating loss of function before the patient has to leave work, supporting adaptation/function during relapse, and providing documentation about function to non-medical entities.

1. Steven Pflanz will present questions the physician can use to evaluate baseline mental function and determine current mental impairment that might put the job at risk.

2. Marcia Scott presents cues the physician can use to anticipate an exacerbation of psychiatric illness or deterioration of function in an unstable personality disorder.

3. Andrea Stolar covers strategies the physician can use to support mental function during an exacerbation of a psychiatric illness.

4. A case illustration will accompany each presentation with 45 minutes for audience discussion.

REFERENCES:

1. Recovery from depression, work productivity, and health care costs among primary care patients, Simon, Gregory E MD et al, Gen Hospital Psychiatry 2000; 22:153–162.
2. Disability Evaluation, Demeter, Stephen L, et al, Mosby, St. Louis, 1996.
3. Habeck, R., et al: Employer's factors related to worker's compensation claims and disability management. Rehabilitation Counseling Bulletin, 1991; 34:210–226.

Component Workshop 3
PUBLIC HEALTH AND MENTAL HEALTH PARTNERSHIP IN TERRORISM AND DISASTERS
APA Committee on Psychiatric Dimensions of Disaster

Chairperson: Robert J. Ursano, M.D., *USUHS, 3900 Clevaland Street, Kensington, MD 20895-3804*
Participants: Carol S. North, M.D., Dori B. Reissman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the workshop, the audience will have a greater understanding of the close link between mental health and public health in disaster preparedness and response to terrorism, disasters, and other public health emergencies. This will be highlighted by examples from past disasters including the SARS outbreak.

SUMMARY:

More than two years after the events of September 11, the mental health risks of terrorism and disasters continue to be of significant concerns in the United States. Several public health emergency events, including the SARS outbreak, have further generated concerns on how the psychiatric community can anticipate and prepare for the psychological and behavioral consequences of these events. Significant aspects of the emergency response to these events could greatly benefit from lending a new paradigm to interventions that are largely behavioral, such as quarantine and adherence to recommended public health actions. The recent report titled "Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy" by the Institute of Medicine (IOM) highlights the crucial need for the blending of expertise in both mental health and public health to deal with psychological, behavioral, and functional sequelae. This workshop is for clinicians who wish to learn more about the role of mental health in public health emergencies such as large disease outbreaks, disasters, or terrorism. The discussants in this workshop will first provide an overview of a paradigm to integrate mental health and public health in disaster preparedness, through a summary of the IOM report findings. The application of this paradigm will be illustrated using past emergency health events, including the SARS outbreaks. Lastly, there will be a discussion of how this partnership can shape potential future disaster research. Lastly, the discussants will present strategies to show how psychiatrists can help secure a bridge between mental health and public health to ensure adequate disaster preparedness.

REFERENCES:

1. Ursano RJ, Fullerton CS, Norwood AE, (eds): Terrorism and Disaster: Individual and Community Mental Health Interventions. New York, Cambridge Press, 2003.
2. Institute of Medicine: Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy. Washington, DC. National Academies of Sciences, National Academic Press, 2003.

Component Workshop 4
CHILD SOLDIERS: CHILD VICTIMS OF WAR AND TERRORISM: PSYCHOSOCIAL AND SPIRITUAL NEEDS
APA Alliance

Co-Chairpersons: Mohammad Shafii, M.D., *University of Louisville, 500 South Preston Street, A-Bldg., Suite 210, Louisville, KY 40292,* Rosalind Hayes, B.A., *1336 El Vago Street, La Canada, CA 91017*
Participants: Chet Lowe, M.A., Jon A. Shaw, M.D., Peter Moszynski, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize and address posttraumatic stress with a biopsychosocial framework in children and adolescents, following their exposure to the trauma of terrorism and child soldiering while working with others.

SUMMARY:

According to Amnesty International, children and adolescents are engaged in armed conflict on nearly every continent at this time. There are estimated to be at least 300,000 in more than 30 countries where unimaginable atrocities occur on a daily basis, while children live in a pervasive culture of violence. Recent national and international acts of terrorism affecting the U.S. have accented the urgency for a profound look into psychiatric, social, and spiritual needs of children and adolescents involved either as spectators or participants in acts of war in the U.S. and abroad. In this workshop, Dr. Shafii will be co-chairing and act as moderator of a panel including Peter Mosczynski, foreign policy expert and war correspondent who has covered Africa for 20 years and who adopted a child soldier; Dr. Jon Shaw, terrorism trauma expert; Pastor Chet Lowe, founder of Joseph's House, a sanctuary and school for child soldiers in Liberia; and Rosalind Hayes president of the APA Alliance, who hears the voices of crying children in her sleep. In this workshop we look toward a treatment modality that involves not only the reintegration of the child into family, society, and the workforce, but also the reintegration of the mind/body, one might even say the soul.

REFERENCES:

1. School Violence: Assessment, Management, Prevention: edited by Shafii M, and Shafii SL. Washington, DC, American Psychiatric Publishing Inc. 2001.

2. Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy; edited by Butler AS, Panzer AM. Institute of Medicine of the National Academies; Washington DC, National Academies Press, 2003.

Component Workshop 5
CAREER CHOICES IN PSYCHIATRY: EXPLORING FELLOWSHIP TRAINING
APA Assembly Committee of Area Member-in-Training Representatives

Chairperson: Thor J. Cornelius, M.D., *University of California, Davis, 3180 Venice Street, Sacramento, CA 95691*
Participants: David M. Gellerman, M.D., Richard A. Montgomery, M.D., Charles V. Panadero, M.D., Shauna P. Reinblatt, M.D.

EDUCATIONAL OBJECTIVE:

To identify some advantages and disadvantages of the practice of addiction, child, geriatric, forensic and public psychiatry; to understand the participants' own decision-making process in choosing a fellowship.

SUMMARY:

The practice possibilities in psychiatry are vastly diverse and becoming more so. Psychiatrists, too, vary in their interests, lifestyle goals, and working style, so it's no surprise that the decision of whether to undertake fellowship training is one of the more complex decisions psychiatrists face. This workshop is to help psychiatric residents and established psychiatrists who are considering fellowship training determine whether subspecialty training will meet their needs and further their career goals. Five psychiatrists who are either fellows or have recently completed fellowships in the specialties of child, geriatric, forensic, and addiction psychiatry will discuss their own decision-making process and how they chose the specialty they did. They will also describe what their daily work is like and what drew them to their current work settings. Finally, they will offer their own insight on what was useful to them when making this decision and what they wish they would have done differently. After a brief introduction, speakers will take part in a panel discussion of audience questions. There will be ample opportunity to discuss issues related to career choices, subspecialty training, practice opportunities, and professional lifestyles with the panelists.

REFERENCES:

1. Dorwart R: A national study of psychiatrists' professional activities. Am J Psychiatry 1992; 49:1499–1505.
2. Kaplan HI, Sadock BJ: Synopsis of Psychiatry. Baltimore, Williams and Wilkins, 1998.

Component Workshop 6
FACILITATING RESEARCH ON MINORITY POPULATIONS BY MINORITY RESEARCHERS
APA Assembly Committee of Representatives of Minority/Underrepresented Groups

Chairperson: Jagannathan Srinivasaraghavan, M.D., *Department of Psychiatry, Southern Illinois University, Choate Mental Health Center, 1000 North Main, Anna, IL 62906*
Participants: Renato D. Alarcon, M.D., Mantosh J. Dewan, M.D., Roger D. Walker, M.D., Tana A. Grady-Weliky, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize appropriate questions to raise and avenues to follow in conducting original research in sparsely studied minority population.

SUMMARY:

The American Psychiatric Association's Program for Minority Research Training in Psychiatry (PMRTP) by funding short-term and long-term training opportunities in medical school, residency, and post residency has achieved training of minorities and underrepresented groups in research. The PMRTP is funded by the National Institute of Mental Health and is administered by the American Psychiatric Association. There is a need for more research on minority population in spite of the success of the program. This workshop is aimed at facilitating research on minority populations by minority researchers. The panelists represent minority caucuses such as Native American, African American, Asian American, Hispanic American, and women. Dr. Dewan will speak on generating ideas, choosing the right idea, and collecting data with minimal budget in the absence of a research grant. Dr. Grady Weliky will speak about the PMRTP program and American Psychiatric Institute for Research and Education (APIRE) program and her research with African Americans. Dr. Alarcon will speak specifically on ethnicity and culture-based research on Hispanic Americans. Dr. Walker will expand on his epidemiological research in the American-Indian population. Given the collective experience of the dynamic researchers, useful tips, pitfalls to avoid and areas requiring active research would be addressed. There will be ample time for audience participation and discussion.

REFERENCES:

1. Baker FM, Grady-Weliky TA: Black psychiatric researchers, in Black Psychiatrists and American Psychiatry, Spurlock J. Washington, DC, American Psychiatric Association, 1999, pp. 141–152.
2. Dewan M, Silberman E, Snyderman D: Doing research without grant support. In: Handbook of Psychiatric Education and Faculty Development, edited by Kay J., Siberman E, Pessar L., Washington, APA Press, 1999.

Component Workshop 7
STATE HOSPITAL PSYCHIATRY: BEEN DOWN SO LONG IT LOOKS LIKE UP TO ME
APA Caucus of State Hospital Psychiatrists and American Association of Psychiatric Administrators

Co-Chairpersons: Yad M. Jabbarpour, M.D., *Catawba Hospital, P.O. Box 200, Catawba, VA 24070,* Beatrice M. Kovasznay, M.D., *New York State Office of Mental Health, 44 Holland Avenue, First Floor, Albany, NY 12229*
Participants: Jeffrey L. Geller, M.D., Michael F. Hogan, Ph.D., Kris A. McLoughlin, M.S.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will join colleagues in discussing the challenges facing state hospital psychiatry in the setting of the present mental health system, recognizing APA's "Vision for the Mental Health System," the President's New Freedom Commission on Mental Health's recommendations, and other guiding agents of change.

SUMMARY:

In April 2003, APA presented its "Vision for the Mental Health System." In July 2003, the President's New Freedom Commission on Mental Health presented its report, "Achieving the Promise: Transforming Mental Health Care in America." Although we are in an era of potentially the best psychiatric services for persons with severe mental illnesses, access and provision of care are "in shambles." Mental health systems are a fragmented, "patchwork relic" across federal, state, and local governments. Focus has been made on maximizing the utilization of existing resources, improving coordination of services, and "promoting a full life for people with

mental illness." However, the 2001 Bazelon Report showed that "our states now spend 30% less on mental health care, adjusted for inflation, than they did in 1955."

State hospital psychiatry is the safety net toward recovery. The pendulum swing of deinstitutionalization continues, correlated with homelessness, increased burden on emergency rooms, increased burden on families, and a transinstutionalization of patients into jails and prisons. In the Los Angeles County jail system, 3,300 of its 21,000 inmates require mental health services on a daily basis. It has become "de facto the largest mental health institution in the country."

The National Alliance for the Mentally Ill focuses on decreasing stigma. An ironic stigmatization of state hospital psychiatry exists. Is history repeating itself with the litany of failures of inadequate systems of public sector mental health, described more than 50 years ago by Albert Deutsch in "The Shame of the States"? We've been "down so long it looks like up . . .": How do we as mental health leaders advocate for up?

REFERENCES:

1. A Vision for the Mental Health System, APA Task Force for a Vision for the Mental Health System, 2003.
2. The President's New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America. Rockville, Maryland, 2003.

Component Workshop 8
LEADERSHIP SKILLS FOR PUBLIC ADVOCACY
APA Committee on Public Affairs

Chairperson: Mary H. Davis, M.D., *Integrative Psychiatry, 105 North Lynoon #106, Louisville, KY 40222*
Participants: Nicholas Myers, B.S.C., Ericka L. Goodwin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to develop a vital and effective mental health advocacy program tailored to his or her needs of your state in order to more effectively influence mental health public policy issues including the crisis in public and private services funding, access to care, and scope of practice issues with nonphysician health professionals.

SUMMARY:

The crisis in the public mental health care system in our country, as detailed in the final report of the "President's New Freedom Commission on Mental Health," makes public and governmental advocacy a crucial mission for all APA district branches. APA has responded with "A Vision for the Mental Health System" (April, 2003), and is working with other health professionals and patient advocates to turn the findings of these reports into an agenda for action. This workshop will help you become more familiar with the resources and skills needed to develop an effective state strategy for educating the public and influencing local legislatures and other decision-makers about issues such as access to care, the crisis in funding in the public mental health care system, and the impact of scope of practice issues on safe and effective patient care.

Although all APA members are invited to attend this workshop, it is especially directed toward members in leadership positions such as DB/SA presidents, presidents-elect and DB/SA executive staff. It will include both didactic and interactive learning. Participants will receive an overview of the crisis confronting the public mental health system in the United States and learn about APA resources available to them, including APA's "A Vision for the Mental Health System" and information related to the final report of the President's New Freedom Commission on Mental Health. Effective programs in small, medium, and large DB/SAs will be discussed, with an eye to providing local psychiatrist leaders with information and skills they can use with their own local decision-makers.

REFERENCES:

1. A Vision for the Mental Health System, APA, 2003.
2. The President's New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America, (Final Report, July 2003).

Component Workshop 9
MISSION POSSIBLE: THE SCIENCE OF PSYCHIATRY AND THE ART OF ADVOCACY
APA Committee on Developmental Disabilities

Chairperson: Donald J. Mordecai, M.D., *Kaiser Permanente, 5755 Cottle Road, San Jose, CA 95123*
Participants: Jeremy Veenstra-VanderWeele, M.D., Bryan H. King, M.D., Lee Combrinck-Graham, M.D., Mark Combrinck-Hertz

EDUCATIONAL OBJECTIVE:

To recognize the primary issues involved in playing the role of advocate for our patients, and have some understanding of how to better help patients advocate for themselves.

SUMMARY:

Our patients with developmental disabilities have been practicing effective self-advocacy for years on their own and through groups such as the ARC and NAMI. By acknowledging the psychiatrist's critical role as advocate, we can promote better outcomes for our patients. This component workshop will explore how psychiatrists can work together with their patients to promote patients' mental health and optimal functioning in the community. There will be ample time for audience questions and discussion. Jeremy Veenstra-Vander Weele, M.D., will discuss gaps and opportunities in training psychiatrists to treat and advocate for patients with developmental disabilities. Bryan King, M.D., will discuss the role of the psychiatrist in the process of helping patients to access services for which they are eligible. Issues of definitions and diagnoses and how they relate to service systems will be highlighted. Lee Combrinck-Graham, M.D., will discuss strategies for advocacy at different stages of the patient's development. She will emphasize promoting a patient's abilities, their contribution to the community, and their sense of self as a valuable member of a community. Mark Combrinck-Hertz is a self advocate who will take questions from the audience and the chair regarding his community activities, his work and recreation, and his living situation.

REFERENCES:

1. Aman MG, Alvarez N, et al: Expert consensus guideline series, treatment of psychiatric and behavioral problems in mental retardation. American Journal on Mental Retardation, 2000; 105(3):161–228.
2. King BH: Psychopharmacology in mental retardation. Current Opinion in Psychiatry, 2000; 15:497–502.

Component Workshop 10
BRIDGING ACROSS CULTURE AND GENERATIONS: AN ASIAN-AMERICAN PERSPECTIVE
APA Committee of Asian-American Psychiatrists

Chairperson: Eric C. Li, M.D., *UCLA Neuropsychiatric Institute and Hospital, 760 Westwood Plaza, Los Angeles, CA 90024*
Participants: Yujuan Choy, M.D., John S. Luo, M.D., Salman Akhtar, M.D., Surinder S. Nand, M.D.

EDUCATIONAL OBJECTIVE:

To identify intergenerational conflicts among Asian-Americans, understand the mental health consequences, and learn the various interventions to help prevent and treat these conflicts.

SUMMARY:

Asian-Americans, including Asian immigrants are one of the fastest growing racial groups in the United States. Over time, an intergenerational and intercultural gap may develop as first-generation immigrants maintain their traditional values and subsequent generations become more acculturated. Acculturation differences and conflicts between the two generations, i.e., language gaps, differences in values, may result in a variety of mental health consequences such as eating disorders, depression, anxiety, increased rates of suicide, as well as social, behavioral, and academic impairment.

It is expected that mental health clinicians will be the first to evaluate this group as they present with a variety of psychiatric symptoms. In order to address and manage these psychiatric consequences, it is imperative to recognize the impact these intergenerational/intercultural conflicts have on the patient and family. Participants in this workshop will learn about the challenges in identifying these issues and treatment interventions in the U.S. Asian population. Salman Akhtar, M.D., the 2004 Kun Po Soo Award recipient will lead this discussion.

REFERENCES:

1. Ying YW: Strengthening intergenerational/intercultural ties in migrant families: a new intervention for parents. J Comm Psychology 1999; 27:89–96.
2. Chung R: Gender, ethnicity, and acculturation in intergenerational conflict of Asian American college students. Cultural Diversity and Ethnic Minority Psychology 7:376–386.

Component Workshop 11
VA MENTAL HEALTH'S RESPONSE TO TERRORISM
APA Caucus of VA Psychiatrists

Co-Chairpersons: Albert C. Gaw, M.D., *Department of Psychiatry, University of California, 88 King Street, #401, San Francisco, CA 94107,* Patricia I. Ordorica, M.D., *University of South Florida, Tampa VAMC, Room 116A, 13000 Bruce B. Downs Boulevard, Tampa, FL 33612*
Participants: Laurent S. Lehmann, M.D., Matthew J. Friedman, M.D., Harold S. Kudler, M.D., Mara Kushner, C.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants will be familiar with recent developments in the areas of mental health disaster interventions, evidence-based treatments for acutely traumatized adults and children, and early responses to the mental health consequences of terrorism.

SUMMARY:

The VA's "Fourth Mission," a special responsibility to support DoD and the nation in times of national emergency, has resulted in an enhancement of our mental health response capabilities in times of war or national disaster in recent years. VA clinicians and researchers have assisted survivors and rescue workers at most of the major natural and manmade disasters we have faced including the Oklahoma City bombing and the 9/11/2001 attacks. We have developed our expertise and training and implementation protocols with the help of colleagues, particularly from DoD and HHS. Most recently with DoD collaboration, the VA has created satellite programs and a teleconference titled "Treating War Wounded" to prepare clinicians for returning casualties from chemical, biological, and radiological hazards. This includes recommendations for mental health care. The National Center for PTSD through P.L. 107-287 is meeting the requirement for the VA to create an educational curriculum specifically to prepare VA clinicians to support veterans, DoD personnel, rescue workers, and community survivors of terrorist attacks. That terrorism is based on instilling fear with a goal of demoralizing and disrupting society and highlights the importance of mental health services in preparation for and management of terrorist attacks. In this workshop, you will be invited to participate in a discussion with experts from the National Center on PTSD regarding the role of mental health professionals in addressing terrorism and threats of terrorist acts. This session is relevant for mental health professionals from all disciplines.

REFERENCES:

1. Watson PJ, Friedman MJ, Gibson L, et al: Early intervention for trauma-related problems. In Trauma & Disaster: Response & Management, edited by Ursano RJ, Norwood AE. Review of Psychiatry, Volume 22, Washington, DC, American Psychiatric Press, pp. 97–124.
2. Friedman M.J., Foa E.B., Charney D.S.: Toward evidence-based early interventions for acutely traumatized adults and children. Biological Psychiatry 2003; 53: 765–768.

Component Workshop 12
WHITHER OUR OWN HISTORY? DEBATING THE VALUE OF THE STUDY OF PSYCHIATRY'S PAST
APA Corresponding Committee on History and Library

Chairperson: Avram H. Mack, M.D., *Department of Forensics, Bellevue Hospital, 200 East End Avenue, 9B, New York, NY 10128*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to discuss the issues, benefits, and drawbacks associated with an increased level of attention to the history of psychiatry.

SUMMARY:

This workshop will bring together both historians and clinicians to discuss the merits of studying the history of psychiatry. Specific topics will include the place of history in education, the practice of psychiatry, research, and global psychiatry. We will address ways in which attention to psychiatry's past may impact future discoveries, ethics, advocacy, and clinical practice. Presenters will represent various disciplines within the profession, including forensic psychiatry, biological research, psychotherapy, and education. Finally, a review of some of the most interesting contemporary issues in the history of psychiatry will be presented and discussed.

REFERENCES:

1. Bonnie RJ: Political abuse of psychiatry in the Soviet Union and in China: complexities and controversies. J Am Acad Psychiatry Law 2002; 30:136–44.
2. Mack AH, Feldman J, Tsuang MT: A case of "pfropfschizophrenia": Kraepelin's bridge between neurodegenerative and neurodevelopmental conceptions of schizophrenia. Am J Psychiatry 2002; 159:1104–10.

Component Workshop 13
WHAT'S NEW IN PSYCHIATRY AND THE LAW AT APA?
APA Council on Psychiatry and Law and APA Committee on Judicial Action

Chairperson: Renee L. Binder, M.D., *1221 24th Street, NW #905, Washington, DC 20037*
Participants: Jeffrey L. Metzner, M.D., Alan A. Stone, M.D., Richard G. Taranto, J.D., Howard V. Zonana, M.D.

EDUCATIONAL OBJECTIVE:

At the end of the presentation, the participant will have a more comprehensive understanding of the issues concerning the interface of psychiatry and the law that are reviewed by APA.

SUMMARY:

This workshop will bring members up to date and reference to some of the complex legal issues that have been brought to the attention of the Council on Psychiatry and Law and the Committee on Judicial Action. Panelists will discuss issues related to confidentiality and HIPAA, mental retardation and the death penalty, commitment laws, and how the U.S. Supreme Court regards amicus briefs submitted by APA and other professional organizations.

REFERENCES:

1. Hargrove v. Vermont, 2003, 2nd Circuit.
2. Atkins v. Virginia, 122 Sct. 2242, 2002.

Component Workshop 14
NOVEL CAREERS IN PSYCHIATRY: WOMEN WHO HAVE MADE THEIR OWN WAY
APA Committee on Women

Co-Chairpersons: Melva I. Green, M.D., *Department of Psychiatry, Johns Hopkins University Hospital, 109 Persimmon Circle, Reisterstown, MD 21136,* Madelaine M. Wohlreich, M.D., *Department of Neuroscience, Eli Lilly & Company, 5202 Potters Pike, Indianapolis, IN 46234*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to identify and appreciate creative solutions to professional challenges from the perspectives of pioneers who have built unique careers in psychiatry.

SUMMARY:

In training, psychiatrists are exposed to a limited number of career options. Mentors typically represent traditional choices such as academics, private practice or public sector psychiatry. And yet, those who have established nontraditional paths may have knowledge that could help guide colleagues through diverse career challenges. In this interactive roundtable discussion, innovative psychiatrists who have had unusual careers will be interviewed regarding challenges they faced as well as successful strategies developed. The personal exploration of their experiences including triumphs and mistakes may offer insights to all psychiatrists.

REFERENCES:

1. A Resident's Guide to Surviving Psychiatric Training. Edited by Foreman-El Masri T, Dickstein L. APA, 2003.
2. Heim P, Golants: Hardball for Women: Winning at the Game of Business.

Component Workshop 15
UPDATE ON PRACTICE GUIDELINES: PTSD AND ACUTE STRESS DISORDER
APA Steering Committee on Practice Guidelines

Chairperson: John S. McIntyre, M.D., *Department of Psychiatry, Unity Health System, 81 Lake Avenue, 3rd Floor, Rochester, NY 14608*
Participants: Robert J. Ursano, M.D., Matthew J. Friedman, M.D., Douglas F. Zatzick, M.D., David M. Benedek, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to provide an update and obtain feedback regarding issues on the PTSD/Acute Stress Disorder Guideline.

SUMMARY:

Since its inception in 1991, the APA practice guidelines program has published 13 guidelines. An evidence-based development process results in documents that are both scientifically sound and clinically useful to practicing psychiatrists. In this workshop, panelists will review the outline and content of a new practice guideline that is expected to be submitted to the APA Assembly for review and approval: "Practice Guideline for the Treatment of Patients With Acute Stress Disorder and Posttraumatic Stress Disorder." Persons attending the workshop are invited to comment on the broad array of issues relating to this guideline including the content of the guideline, implications for the field, and strategies for evaluating and disseminating its recommendations.

REFERENCES:

1. Kropnick JL: Brief psychodynamic treatment of PTSD, J Clin Psychol 2002; 58:919–932.
2. Breslaw N: Sex differences in posttraumatic stress disorder. Arch Gen Psychiatry 1997; 54:1044–1048.

Component Workshop 16
PUBLIC PSYCHIATRY: LEADING THE WAY IN TRANSFORMING SERVICE DELIVERY IN THE 21ST CENTURY
APA Council on Social Issues and Public Psychiatry

Co-Chairpersons: Altha J. Stewart, M.D., *111 South Highland #180, Memphis, TN 38111,* Jeffrey L. Geller, M.D., *Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655-0002*
Participants: Stephen M. Thielke, M.D., Kenneth S. Thompson, M.D., Joy D. McQuery, M.D.

EDUCATIONAL OBJECTIVE:

To demonstrate knowledge of the system changes proposed by APA and the President's commission, demonstrate understanding of how implementation of those changes will impact psychiatric service delivery systems, and recognize the differences between traditional models of care and a population-based model of psychiatric service delivery.

SUMMARY:

The practice of psychiatry has broadened over the last decade based on new science and the resultant evidence-based treatment practices. Opportunities for improving access to quality care include advances in psychopharmacology, evidence-based treatments, consumer-driven programs, training, and research. In one area, however, more work is needed—moving to a public-health model of service delivery. A paradigm shift to a more population-based approach to service delivery is needed if psychiatry is to dispel the myths and create the treatment models described in the recently issued "APA Vision for the Mental Health System," the report of the President's New Freedom Commission on Mental Health, and the Surgeon General's supplemental report, "Mental Health: Race, Culture and Ethnicity."

The presenters are all members of the APA Council on Social Issues in Public Psychiatry and will discuss training and workforce development, define "social issues" and their relationship to recovery and rehabilitation in the seriously mentally ill, and the need for more research focused on treatment effectiveness. Discussion of changes needed in mental health funding models and the need to address legislative and policy changes in order to achieve change will also be included as part of an interactive Q&A segment.

REFERENCES:

1. Corrigan PW, Watson AC: Factors that explain how policy makers distribute resources to mental health services. Psychiatr Serv 2003; 54:501–507.

2. Buck J: Medicaid, health care financing trends, and the future of state-based public mental health services. Psychiatr Serv 2003; 54:969–975.

Component Workshop 17
FITNESS TO PRACTICE MEDICINE: THE ROLES OF THE EVALUATING PSYCHIATRIST
APA Corresponding Committee on Physician Health, Illness, and Impairment

Chairperson: John A. Fromson, M.D., *Massachusetts Medical Society, 860 Winter Street, Waltham, MA 02451*
Participants: Richard F. Limoges, M.D., Stuart A. Anfang, M.D., Linda Logsdon, M.D., Michael H. Gendel, M.D., Suzanne E. Vogel-Scibilia, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the concept of "impairment" and its relationship to fitness-for-duty evaluation, outline specific predicaments that a psychiatrist may encounter in treating the physician patient, become familiar with the components of a fitness for duty evaluation and issues specific to this special population, appreciate the obligations associated with mandated reporting and physician-patient privilege, and review evaluation resources available when assistance is required in determining level of impairment.

SUMMARY:

Psychiatrists are often asked to perform fitness-for-duty evaluations on allegedly impaired physicians. Issues include the type of impairment being evaluated, whether a psychiatrist is the most appropriate specialist to perform the evaluation, appreciation for pre-existing psychiatrist-patient relationships, and potential legal reporting obligations or requirements to fulfill. This workshop will explore the clinical, ethical, and forensic issues associated with this type of evaluation. Dr. Linda Logsdon will provide the topic overview. Dr. John Fromson will discuss the multiplicity of meaning inherent in the term "impairment," the appropriateness for psychiatric assessment in a particular case, and the types of programs and examiners that perform these evaluations. Dr. Richard Limoges will examine predicaments faced in the treating psychiatrist's office, including when to seek another expert opinion. Dr. Michael Gendel will discuss the requirements and forensic aspects associated with conducting a fitness-for-duty evaluation in this special population. Dr. Suzanne Vogel-Scibilia will offer a first-person account of a psychiatrist living with a mental illness. Dr. Stuart Anfang will serve as discussant, offering insights regarding fitness-for-duty and disability evaluations.

REFERENCES:

1. O'Brien C: Mental health questions for licensure: who benefits? Arch Fam Med 1999; 8:452.
2. Wall BW, Appelbaum, KL: Disabled doctors: the insurance industry seeks a second opinion. J Am Acad Psychiatry Law 1998; 26:7–19.

Component Workshop 18
TERROR AT HOME: ADDRESSING DOMESTIC VIOLENCE IN YOUR PRACTICE
APA Committee on Family Violence and Abuse

Chairperson: Carole L. Warshaw, M.D., *John M. Stroger Hospital, 3428 North Janssen, Chicago, IL 60657*
Participants: Graeme Hanson, M.D., Sandra L. Bloom, M.D.

EDUCATIONAL OBJECTIVE:

To address the complex issues raised in treating adult survivors of domestic violence, review best practices for treating children who witness domestic violence, understand the impact of trauma/domestic violence work on providers.

SUMMARY:

There is a growing body of research demonstrating that domestic violence has serious mental health consequences for both adult victims and for children who witness the abuse—depression, suicidality, PTSD, and substance abuse are among the most common. In addition, significant numbers of those seen in mental health settings have experienced intimate-partner abuse. For many, the abuse is ongoing, raising a number of complex issues for patients and for the clinicians who treat them. This workshop will provide a framework for addressing several of these issues: providing trauma treatment in the context of ongoing domestic violence; dealing with domestic violence in the context of serious mental illness; responding to issues of culture, community, and spirituality, and attending to concerns about safety, custody, and documentation. The workshop will also provide guidance on assessing and treating children who witness domestic violence, with particular attention to child development, attachment and parenting support, and on attending to the psychological and practice needs of providers working with domestic violence survivors and their children. The workshop will be part presentation and part group discussion.

REFERENCES:

1. Bloom SI: Creating sanctuary: healing from systematic abuses of power. Therapeutic Communities: The International Journal for Therapeutic and Supportive Organizations 2000; 21:67–91.
2. Warshaw C: Women and violence. In Psychological Aspects of Women's Health Care, edited by Stotland N, Stewart D. Washington D.C., American Psychiatric Press, 2001.

Component Workshop 19
APPROACHES TO ASSESSMENT AND DIAGNOSIS OF INFANTS AND SMALL CHILDREN
APA Council on Children, Adolescents, and Their Families

Chairperson: William C. Wood, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston, MA 02114*
Participants: Joan L. Luby, M.D., Jean M. Thomas, M.D., Brian K. Wise, M.D., Harry H. Wright, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to describe psychiatric assessment of infants and toddlers, identify the principal psychiatric diagnostic and classifications systems available for this age group, and understand the utility of the DC: 0-3 and the RDC-PA infant/toddler diagnostic systems.

SUMMARY:

The diagnostic and classification schemas available for infant and toddler mental health are evolving as clinical understanding and research findings progress. Yet the unique qualities affecting assessment, diagnosis, and treatment are complex for this patient population. Diagnosis must take into account the rapid and nonuniform developmental trajectories of children. Assessment requires that the child be understood within a particular caretaking environment, while treatment relies on a collaborative alliance with the child's caretakers. There has been an emergence of empirical data in several diagnostic areas over the last five years, which is permitting more robust identification of symptoms consistent with early childhood psychopathology. The Zero-to-Three Diagnostic Classification (DC: 0-3) and the Research Diagnostic Criteria—Preschool Age (RDC-PA) represent two newer diagnostic classification systems that seek to complement the current DSM as it relates to infants and toddlers. This workshop will address 1) the state of the art in infant/toddler assessment, 2)

empirical evidence supporting the RDC-PA criteria for psychiatric diagnosis in young children, and 3) empirical evidence supporting the DC: 0-3 diagnostic classification system for infants and toddlers. Group discussion will focus on how these co-existing diagnostic paradigms are evolving to meet the needs of both clinicians and researchers.

REFERENCES:

1. Emde RN, Wise BK: The cup is half full: initial clinical trials of DC: 0-3 and a recommendation for revision. Infant Mental Health Journal 2003; 24:437–446.
2. Scheeringa M, et al: Research Diagnostic Criteria—Preschool Age (RDC-PA). Manuscript accepted for publication in the J Am Acad Child Adolesc Psychiatry, 2003.
3. Thomas JM, et al: Practice parameters for the psychiatric assessment of infants and toddlers (0-36 Months). J Am Acad Child Adolesc Psychiatry 1997; 36:21S–36S.

Component Workshop 20
HELPING OLDER PERSONS WITH SCHIZOPHRENIA: TREATMENT, RESEARCH, AND POLICY
APA Council on Aging

Chairperson: Carl I. Cohen, M.D., *Department of Psychiatry, SUNY Downstate, Health Sciences Center, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203*
Participants: Susan K. Schultz, M.D., Harriet P. Lefley, Ph.D., Philip D. Harvey, Ph.D. Stephen J. Bartels, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to more fully understand the current state of knowledge about schizophrenia in older persons and to discuss and conceptualize strategies for service interventions, research, and policy.

SUMMARY:

A crisis has emerged in mental health care. It involves older persons with schizophrenia who have been largely invisible to mental health researchers, providers, and policy makers. Approximately 1% of the population over age 54—about a half-million persons—suffer from schizophrenia. Over the next 30 years, their number will double as post-war baby boomers reach old age. Importantly, this generation of persons with schizophrenia will have spent considerably less time in mental institutions than earlier generations and consequently will need to negotiate health and social service systems that may be ill prepared to deal with them. Older schizophrenic persons are potentially at risk with respect to clinical, social, and service needs. Remarkably, only 1% of the literature on schizophrenia has been devoted to issues of aging. Moreover, currently there are few age-appropriate clinical, rehabilitative, or residential programs, and these deficiencies are more pronounced among minorities. The aims of this session are to examine the current state of knowledge about schizophrenia into later life and to propose strategies for services, research, and policy. With respect to schizophrenia into later life, we will discuss patterns of care, life-course changes and prognosis, biological changes, cognitive functioning and its correlates, implications of medical comorbidity, changes in social functioning and coping, service needs, caregiver issues, policy and financing of services, research strategies, and treatment strategies including use of medications, biobehavioral treatment, rehabilitation, and community services. The audience will be asked to present their experiences with this population and to conceptualize strategies for addressing the topics described above.

REFERENCES:

1. Cohen CI (Ed.): Schizophrenia Into Later Life. Treatment, Research and Policy. Washington, D.C., American Psychiatric Publishing, 2003.
2. Cohen CI, Cohen GD, Blank K, et al.: Schizophrenia and older adults. an overview: directions for research and policy. American Journal of Geriatric Psychiatry 2000; 8:19–28.

TUESDAY, MAY 4, 2004

Component Workshop 21
THE NEUROBIOLOGY OF SELF-AWARENESS: LEARNING FROM AUSTISM AND BPD ABOUT HOW WE KNOW OURSELVES
APA Committee on Psychotherapy by Psychiatrists

Chairperson: Bernard D. Beitman, M.D., *Department of Psychiatry, University of Missouri, 2 Hospital Drive, Columbia, MO 65212*
Participants: George I. Viamontes, M.D., Jyotsna Nair, M.D., Glen O. Gabbard, M.D., Eva M. Szigethy, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to enrich neurobiological understanding of the basis of human self-awareness.

SUMMARY:

Self-awareness is an emergent property of properly functioning human brains. The representation of the self begins in the somatosensory and limbic cortices. Information from these primitive maps is expanded into the full limbic system and the association cortices. Judgments are made about potential value (nucleus accumbens) or risk (amygdala) in connection with the information, and appropriate actions are implemented. Dysfunctions of self-awareness can be caused by a variety of pathological mechanisms that interfere with the creation and/or integration of informational maps in the brain. Autism and Asperger's syndrome are disorders with disturbance of language, restricted interests, and difficulty in social interactions. Recent evidence from animal, neuroanatomical, and scanning studies implicates the orbitofrontal, left medial frontal cortex, amygdala, and cerebellum in the self-awareness deficits in autism and Asperger's syndrome. Reflective function is a construct that derives from attachment theory. It is generally regarded as a measure of a patient's capacity for mentalization, defined as the individual's ability to recognize that one's own and others' perceptions are representations of reality based on beliefs, feelings, and thoughts rather than mirror images of reality as it actually is. Unlike self-reflection, it is a product of implicit procedural memory rather than conscious introspection. Patients with borderline personality disorder generally have impaired reflective functioning, and improving this feature is a major thrust of psychotherapy.

REFERENCES:

1. Viamontes GI, Viamontes CT, Viamontes JA: Neural circuits for self-awareness: evolutionary origins and implementation in the human brain, in Disorders of Self-Awareness. Edited by Beitman BD, Nair J. W.W. Norton, in press.
2. Gabbard GO: Reflective function, mentalization, and borderline personality disorder, in Disorders of Self-Awareness. Edited by Beitman BD, Nair J. W.W. Norton, in press.

Component Workshop 22
BLOOD ON THE FLOOR: RESPONDING TO CATASTROPHIC EVENTS AND HIGH RISKS
APA Committee on Standards and Survey Procedures

Chairperson: Steven I. Altchuler, M.D., *Mayo Clinic, 200 First Street, S.W., Rochester, MN 55905*
Participants: Marlin R.A. Mattson, M.D., Robert A. Wise, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to be aware of what a failure mode effects analysis is and when to perform one; to be aware of what a root cause analysis is and when to perform one.

SUMMARY:

Physicians are committed to providing the best possible care for patients. In medical school and residency, quality of care of typically taught as an individual responsibility. We have learned from other industries that poor outcomes may result from failure of systems to work together, that is, each individual does his or her job, but the interactions between the jobs leads to poor results. Techniques exist to study and improve these interactions.

When a catastrophic event happens, a root-cause analysis is a technique to look backwards at the interactions and determine where the problem occurred and what led to the problem. Proactively, a failure mood effects analysis as a way to look at high-risk processes and determine ahead of time what may go wrong and how to prevent them from happening. During this workshop, we will examine what high-risk processes psychiatrists may experience in their practice. We will review what a sentinel-event analysis is and what a root-cause analysis is, and how to determine which to perform.

REFERENCES:

1. DeRosier J, Stalhandske E, Bagian JP, Nudell T: Using health care failure mode and effect analysis: the VA National Center for Patient Safety's prospective risk analysis system. Joint Commission Journal on Quality Improvement. 2002; 28:248–67, 209
2. Grout JR: Preventing medical errors by designing benign failures. Joint Commission Journal on Quality & Safety. 2003; 29:354–62

Component Workshop 23
THE TIES THAT BIND: CONSIDERATIONS OF CULTURE AND FAMILY IN MENTAL HEALTH TREATMENT
APA/SAMHSA Minority Fellowship Selection and Program Corresponding Committee

Chairperson: Timothy G. Benson, M.D., *Department of Psychiatry, MGH WACC Room 812, 15 Parkman Street, Boston, MA 02114*
Participants: Marketa M. Wills, M.D., Shanta P. Henderson, M.D., Osvaldo Gaytan, Jr., M.D., Denise M. Richardson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the significant influence of immediate and extended family on psychiatric patients; understand family value systems within the context of a larger community; review the family therapy literature with a focus on treatments that emphasize cultural context; and explore the mental health consequences of acculturation, industrialization, and other alterations on traditional family systems.

SUMMARY:

Our fellowship members will take an in-depth look at the family unit. First, we will describe many of the unique aspects of family/extended family/culture that exist in American minority communities. Second, we plan to examine the impact that acculturation and industrialization have had on family systems in modern America. We will pay particular attention to minority and ethnic subpopulations. Third, we will review the literature on family therapies and critique the readings from a cultural perspective. Fourth, we will explore ways families' core beliefs may support or undermine individual treatment for a patient. Finally, we will take a look at the implications of being the first in the family to seek psychiatric treatment. The workshop will draw on all of these themes for a lively discussion between audience and panel.

REFERENCES:

1. Kumpfer KL, Alvarado R, Smith P, Bellamy N: Cultural sensitivity and adaptation in family-based prevention interventions. Prevention Science 2002; 3:241–6.
2. Canino IA, Inclan JE: Culture and family therapy. Child & Adolescent Psychiatric Clinics of North America 2001; 10:601–12.

Component Workshop 24
UNIVERSAL HEALTH CARE AND OTHER MODELS
APA Council on Healthcare Systems and Financing

Chairperson: Barry F. Chaitin, M.D., *Department of Psychiatry, University of California, Irvine, 100 The City Drive, Orange, CA 92868-3298*
Participants: Anita S. Everett, M.D., Bruce J. Schwartz, M.D., Paul H. Wick, M.D., Frederick J. Stoddard, Jr., M.D., Allison M. Wehr, M.D., Manoj R. Shah, M.D., Carrie L. Ernst, M.D., Rodrigo A. Munoz, M.D., Captane P. Thomson, M.D.

EDUCATIONAL OBJECTIVES:

The participant should be able to recognize strengths and failures of the existing health system and its effect on practice; describe models of universal health care; describe/understand the realities and ethical dilemmas of various approaches to universal health care and other models of health care systems and financing including boutique medicine.

SUMMARY:

This workshop is intended for early career psychiatrists and those interested in systems of financing and organizing mental health care; the implications of each for clinical care; and ethical decision making in light of the various health care models. Some describe the current health care system as "broken." Loss of autonomy, burdensome documentation, and low reimbursement may be driving psychiatrists into "boutique psychiatry." This is a new form of care intended to provide individualized psychiatric and substance abuse care for individuals able to pay without health insurance. While it may provide higher income and autonomy for the practitioner, its spread raises serious ethical issues regarding professionalism and access to care. It also has the potential of creating political problems in the scope-of-practice legislative arena. Less-extreme are blends of care which include some form of public or private insurance, but also self-pay by those able to afford it. Potentially more equitable are universal health care proposals that seek to eliminate disparity but may undermine overall quality and service. These include single-payer systems such as Medicare or the Canadian National Health Care System, or blends of public and private universal health care to insure everyone. Each system has unique problems of access, quality, cost, and service delivery. Of particular concern for psychia-

trists is the place that mental health care will hold in these various structures and systems of care.

REFERENCES:

1. Fein R: Universal health insurance—let the debate resume, JAMA, 2003; 290:818–820.
2. Sabin JE: How managed care can be ethical. Health Affairs, 2001; 1 vol. 20.

Component Workshop 25
REVISION OF THE APA ETHICS ANNOTATIONS: FOSTERING DIALOGUE
APA Task Force to Update the Ethics Annotations

Chairperson: Laura W. Roberts, M.D., *Department of Psychiatry, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226*
Participants: Michael R. Arambula, M.D., Richard D. Milone, M.D., Philip Candilis, M.D., S. Nassir Ghaemi, M.D., Scott Y. Kim, M.D., Jennifer Radden, Ph.D.

EDUCATIONAL OBJECTIVE:

"To become familiar with the process and content of the newly revised ethics guideline document of the American Psychiatric Association"

SUMMARY:

The task force responsible for revising the APA ethics principles and annotations will host this workshop in an effort to foster dialogue and to allow for a full and open process of reflection. Issues related to limitations in the existing document will be outlined. The structure and conceptual basis for the revised document will be presented. Key portions of the revised document will be presented. The workshop leaders will invite comments, concerns, and guidance from the workshop participants. Experiences of colleagues in evaluating and monitoring the professional conduct of colleagues will be elicited, and examples of controversial issues will be raised for discussion.

REFERENCES:

1. APA: Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry.
2. Roberts LW, Dyer AR: Concise Guide to Ethics in Mental Health Care.

Component Workshop 26
THE JUVENILE JUSTICE SYSTEM: ASSESSMENT, SERVICES, AND DATA USE
APA Corresponding Committee on Juvenile Justice Issues

Co-Chairpersons: R. Gregg Dwyer, M.D., *University of South Carolina, WSHPI, P.O. Box 119, Columbia, SC 29202,* Carl C. Bell, M.D., *Community Mental Health Council, 8704 South Constance Avenue, Chicago, IL 60617-2746*
Participants: Johnny L. Williamson, M.D., Richard L. Frierson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be able to describe a broad overview of coordinating services for juvenile offenders, to include examples of screening, using assessment data for improving understanding and treatment, and potential dangers of information access.

SUMMARY:

The responsibility for the care and protection of juvenile offenders is shared among several entities including child welfare agencies, the education system, social service agencies, law enforcement, family courts, juvenile correctional facilities, and mental health service providers. How can these systems function together? What information can be used and shared for the benefit of the children, and what are the potential risks? This workshop, designed to facilitate discussion of these questions, will include presentations from a broad system approach to very specific examples, beginning with the description of a city-state partnership program based on community psychiatry principles. A mental health screening method for adolescents entering a juvenile detention system will be presented as well as a study of data collected during intake assessment comparing adolescent sex offenders to non-sex offenders. Finally, the inclusion of juveniles in sexually violent predator classifications and sex offender registries is addressed, with specific attention to recent case law and the debate regarding application of these classifications to juveniles. Presenters will guide participants through their respective topics by soliciting input on ideal content, methods, and use, with real-world examples. Participants will be encouraged to contribute their professional experiences and suggestions.

REFERENCES:

1. Bell CC, McKay M: Constructing a children's mental health infrastructure using community psychiatry principles. J Legal Medicine, in press.
2. Grisso T, Barnum R, Fletcher K, et al: Massachusetts youth screening instrument for mental health needs of juvenile justice youths. J Am Acad Child Adolesc Psychiatry 2001; 40:541–548.

Component Workshop 27
WHEREFORE NEUROSCIENCE: HOW MUCH DOES THE PSYCHIATRIST NEED TO KNOW?
APA/GlaxoSmithKline Fellows

Co-Chairpersons: Joshua L. Roffman, M.D., *Massachusetts General Hospital, 60 Glen Road, #207, Brookline, MA 02445,* Carrie L. Ernst, M.D., *Psychiatry Department, Cambridge Hospital, 91 Trowbridge Street, Apt. 22, Cambridge, MA 02138*
Participants: Asher B. Simon, M.D., Jason M. Morrison, M.D., Konasale M.R. Prasad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the evolving role of neuroscientific thinking in the practice of psychiatry and to weigh the value of neuroscience instruction in today's residency training curricula.

SUMMARY:

In recent decades, the application of neuroscientific principles to psychiatric research has enhanced our understanding of pathophysiology in psychiatric disorders and has contributed to clinical management through rational drug design. At the same time, the role of neurobiologic thinking in the everyday practice of psychiatry remains limited. Today's residency programs place varying emphasis on understanding principles of basic neuroscience; however, many residents find that knowledge of theorized pathophysiologic models does not help them in their clinical work, and the application of these models to future treatment modalities remains unclear.

This workshop will critically examine the rationale for neuroscientific teaching in residency. It will introduce the topic through a review of relevant literature and trends in psychiatric residency curricula. In addition, related survey data from residency training directors will be presented. Prominent innovators in the realms of biological psychiatry, education, and clinical practice (including psychotherapy, pharmacology, and cross-discipline) will be present to discuss this issue. Particular attention will be directed to the present and potential value of neuroscience in diagnosis and treatment across multiple

classes of psychopathology, and, accordingly, to what degree neuroscience should be emphasized in residency training.

REFERENCES:

1. Martin JB: The integration of neurology, psychiatry, and neuroscience in the 21st century. Am J Psychiatry 2002; 159:695–704.
2. Price BH, Adams RD, Coyle JT: Neurology and psychiatry: closing the great divide. Neurology 2000; 54:8–14.

Component Workshop 28
WHAT DO EMPLOYERS WANT? EMPLOYEE MENTAL HEALTH BENEFITS
APA Committee on APA/Business Relationships

Co-Chairpersons: Norman A. Clemens, M.D., *Department of Psychiatry, Case Western Reserve University, 1611 South Green Road, Suite 301, Cleveland, OH 44121-4128,* Jeffrey P. Kahn, M.D., *Cornell University Medical Center, 300 Central Park West, #1C, New York, NY 10024-1513*
Participants: Michael J. Thompson, Liisa Chider, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand how employers make decisions about employee mental health benefits, including workplace issues, cost, perceived quality of care, perceived corporate benefit, and the role that psychiatrists can play in educating corporate decision makers.

SUMMARY:

Employers pay about half of all American mental health care costs. Employers generally choose which plans they want to provide through contracts with insurance and managed care companies. Often with the help of outside benefits consultants, they pay close attention to what their employee benefits plans include and to what they cost. This workshop will present the perceptions of large and small employers on mental health benefits: what they want, what their employees want, what the benefits cost, what the problems are, and how effective their benefit plans are in terms of clinical efficacy, employee satisfaction, and the business bottom line. Three speakers will include a benefits consultant from PricewaterhouseCoopers (a large consulting firm), a human resource director (with benefits responsibility) from a 60-employee advertising agency, and an occupational psychiatrist. This will be an opportunity for psychiatrists to learn more about employer benefit decisions and for the panelists to learn more about psychiatrists' perceptions. The session is for all psychiatrists with interest in health service delivery, mental health benefits, or workplace psychiatric issues.

REFERENCES:

1. Rosenheck RA., Druss B, Stolar M., et al: Effect of declining mental health service use on employees of a large corporation. Health Affairs (Project Hope), 1999; 18:193–203.
2. Kahn JP, Langlieb AM: Mental Health and Productivity in the Workplace: A Handbook for Organizations and Clinicians. San Francisco: Jossey-Bass/Wiley, 2003.

Component Workshop 29
HELPING DISTRICT BRANCHES RELATE TO APA AND TO THEIR MEMBERS
APA Corresponding Committee on District Branch/ State Association Relations

Chairperson: Donald G. Langsley, M.D., *9445 Monticello Avenue, Evanston, IL 60203-1117*
Participants: Nada L. Stotland, M.D., Ann Marie T. Sullivan, M.D., Margo S. Adams

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to more effectively have district branches relate to APA and to their members.

SUMMARY:

Too many APA members and district branch councils know little about the activities of the Assembly and Board of Trustees. Many members don't even know who their Assembly representatives are or what they do. Neither do they know much about activities in other APA DBs such as CME, scientific meetings, or board-preparation activities. Ethics education is sporadic. DB newsletters would benefit from circulating special-newsletter articles to other DBs for reprinting. This could be done for ethics education as well as for notices of DB or Area meetings. DBs depend on staff as well as membership. We would urge DB executives to take advantage of the orientation meetings sponsored and funded by APA. The orientation includes opportunities for DB presidents-elect as well. This corresponding committee is charged with improving the relationship between members, DBs, and APA. The workshop will seek ways to improve the interaction between APA members and their DB and between DBs and APA.

REFERENCES:

1. American Psychiatric Association Operations Manual.
2. Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry.

Component Workshop 30
THE TEACHING OF GAY, LESBIAN, BISEXUAL, AND TRANSGENDER ISSUES
APA New York County District Branch's Committee on Gay and Lesbian Issues

Chairperson: Kenneth B. Ashley, M.D., *Department of Psychiatry, Beth Israel Hospital, 85 East 10th Street, #1F, New York, NY 10003-5407*
Participants: Stewart L. Adelson, M.D., Richard O. Hire, M.D., Elizabeth LeQuesne, M.D., Khakasa H. Wapenyi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the teaching of gay, lesbian, bisexual, and transgender issues in a variety of training settings and ways to implement such teaching.

SUMMARY:

This workshop will present issues associated with the teaching of gay, lesbian, bisexual, and transgender (GLBT) issues in a variety of settings. The results of surveys of the teaching of GLBT issues in medical schools and psychiatry residency programs will be presented, along with recommendations for the development and implementation of curricula. The experiences of teaching GLBT issues in child and adolescent psychiatry training programs will also be discussed. The issues of treating transgender patients will be presented to improve their care. Clinical and personal vignettes of both GLBT faculty and trainees will be presented to illustrate issues of stigma and bias around the teaching of GLBT issues. Audience members will be encouraged to discuss their experiences with the teaching of GLBT issues. Methods of improving the teaching of GLBT issues and treating GLBT patients will be generated during the discussion.

REFERENCES:

1. Polansky JS, Karosic DH, Speier, et al: Homophobia: therapeutic and training considerations for psychiatry. Journal of the Gay and Lesbian Medical Association 1997; 1:41–47.
2. Cabaj R, Stein TS (eds): The Textbook of Homosexuality and Mental Health. American Psychiatric Press Inc, Washington, DC, 1996.

Component Workshop 31
SEX, DRUGS, AND HIV: SYNERGISTIC EPIDEMICS
APA New York County District Branch's AIDS Committee

Co-Chairpersons: Kristina L.N. Jones, M.D., *Department Of Psychiatry, New York Presbeterian Hospital, 119 West 24th Street, New York, NY 10011,* John A.R. Grimaldi, Jr., M.D., *New York Presbyterian Hospital, 119 West 24th Street, New York, NY 10011*
Participants: Bryan J. McGreal, M.D., Mary Ann Cohen, M.D., Elizabeth V. Getter, M.D.

EDUCATIONAL OBJECTIVE:

This workshop is a comprehensive overview of HIV and substance abuse. Psychiatric symptoms resulting from crystal methamphetamine, cocaine, heroin, and alcohol abuse will described. New biological treatments such as buprenorphine, antidepressants, and drug-interactions will be discussed. Psychodynamics of unsafe sex behavior and strategies in harm reduction will be detailed.

SUMMARY:

This workshop is a comprehensive overview of HIV and substance abuse. Psychiatrists interested in substance abuse or HIV are the target audience. Four HIV psychiatrists working in New York City will discuss phenomenology, intervention, and treatment. Crystal methamphetamine and its relationship to high-risk unsafe sex will be discussed. The use of buprenorphine in an HIV substance-abuse treatment setting will be detailed. Advanced concepts in harm reduction, such as interactions between drugs of abuse and antiretrovirals will be described. The psychodynamics of unsafe sex behavior will be explored using case material.

REFERENCES:

1. Miller N: Pharmacotherapies for addictive disorders. Psychiatric Annals 2003; 33:558–573.
2. Megerson B, Cho BC, Mills MV: State agency policy and program coordination in response to the co-occurrence of HIV chemical dependency, and mental illness. Public Health Rep; 118:408–14.

Component Workshop 32
LOOKING BACK, LOOKING FORWARD: PATHWAYS FOR BLACKS IN PSYCHIATRY
APA Committee of Black Psychiatrists

Co-Chairpersons: Michelle O. Clark, M.D., *5248 Village Green, Los Angeles, CA 90016,* N. Kalaya Okereke, M.D., *4440 Banbury Lane, #G, Roanoke, VA 240128*
Participants: Carl C. Bell, M.D., Hugh Butts, M.D., Marketa M. Wills, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session the participants will gain historical perspective on the experience and role of blacks in psychiatry. The challenges, controversies, and identity issues for black psychiatrists will be discussed. We will also consider a vision and mission for blacks in psychiatry for the future.

SUMMARY:

Our component, the Committee of Black Psychiatrists, was instituted as a result of the sociopolitical unrest of the late 1960s that led to activism on the part of the black psychiatrists members. Now over 30 years later we wish to review that history and reflect on the outcome of those efforts toward creating a vision for the future role and mission for blacks in our field.

REFERENCES:

1. Griffith EEH: Race and Excellence: My Dialogue with Chester Pierce, MD. Iowa City, University of Iowa Press, 1998.
2. Spurlock J: Black Psychiatrists and American Psychiatry. Washington, D.C.: American Psychiatric Association, 1999.

WEDNESDAY, MAY 5, 2004

Component Workshop 33
TERRORISM IN AMERICA: THE DISTANT VICTIMS AND THE ROLE OF IMG PSYCHIATRISTS
APA Committee on International Medical Graduates

Co-Chairpersons: Fructuoso R. Irigoyen-Rascon, M.D., *The Center McAllen, 1400 South 6th Street, Suite 301, McAllen, TX 78501,* Godehard Oepen, M.D., *Department of Psychiatry, University of Alabama, 223 Trace Ridge Road, Birmingham, AL 35244-3926*
Participants: Jose M. Canive, M.D., Chowallur D. Chacko, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to evaluate the psychiatric impact of "distant trauma" on the American population after 9/11 and the subsequent conflicts; appraise the value that the special sensibility and talents IMGs have in attending the increased demands of mental health care derived from those events.

SUMMARY:

DSM criterion A for post-traumatic stress disorder determines whether trauma is of sufficient severity and intensity to be capable of producing post-traumatic phenomenology. The DSM-IV criterion is considerably relaxed from DSM-III; technically, it can be met by anyone who watched the television scenes of pain and destruction on September 11, 2001. As a matter of fact, throughout the country—perhaps throughout the world—such trauma has been felt. Nevertheless, most of the psychological impact attention from September 11 has been on direct victims of the attack (people physically in N.Y.C. or D.C. during the attacks). The role of providing psychiatric support and care for distant "victims" has barely been discussed in the literature. Examples would be 1.) Viet Nam veterans who have frequently reported exacerbation of their symptoms after September 11. 2.) the intense anxiety of servicemen's relatives dealing with the uncertainty implied by their deployment in Iraq or Afghanistan; 3.) attitudes that affect anyone who happens to be a "foreigner" in this country. Given that IMGs provide services in the trenches of the mental health arena, cross-cultural sensitivity is most likely present and that in one way or another IMGs possess in their therapeutic armamentarium unique insights about the consequences of terrorism and the subsequent war on terrorism.

REFERENCES:

1. American Psychiatric Association: Diagnostic and Statistical. Manual of Mental Disorders 4th Edition (Text Revision). American Psychiatric Association, 2000.
2. Davidson JT, Foa EB (editors): Post-Traumatic Stress Disorder, DSM-IV and Beyond. American Psychiatric Press, 1993.

Component Workshop 34
CPT CODING AND DOCUMENTATION UPDATE
APA Committee on RBRVS, Codes, and Reimbursements

Chairperson: Chester W. Schmidt, Jr., M.D., *Department of Psychiatry, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, A4C, Baltimore, MD 21224-2735*
Participants: Tracy R. Gordy, M.D., Edward Gordon, M.D., Napoleon B. Higgins, Jr., M.D., Melodie Morgan-Minott, M.D., Joseph M. Schwartz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop the participants will 1) be knowledgeable about current Medicare and CPT coding changes, 2) be updated about Medicare reimbursement concerns, 3) have their individual questions about coding, documentation, and reimbursement answered.

SUMMARY:

The goals of the workshop are to inform practitioners about changes in the RBRVS Medicare physician reimbursement system, modifications in CPT coding, and current issues associated with documentation guidelines. This year's workshop will focus on 1) child/geriatric coding problems, 2) development of a model local medical review policy for Medicare, 3) a review of current Medicare reimbursement issues and concerns, and 4) documentation guidelines for evaluation and management codes. Time will be reserved for questions and comments by the participants about the above topics as well as issues and problems faced by the participants in their own practices.

REFERENCES:

1. CPT 2003. American Medical Association, Chicago, IL.
2. Schmidt CW: CPT Handbook for Psychiatrists 2nd edition, American Psychiatric Press, Washington, DC, 1999.

Component Workshop 35
THE PSYCHIATRIST IN THE SCHOOLS: MEDICATION, BOUNDARIES, AND TRANSFERENCE ISSUES
APA Corresponding Committee on Mental Health and Schools

Chairperson: Eugenio M. Rothe, M.D., *Department of Psychiatry, University of Miami, 275 Glenridge Road, Key Biscayne, FL 33149–1311*
Participants: Hong Shen, M.D., Mary Ann Schaepper, M.D., Trina B. Allen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize some of the most commonly encountered issues of boundaries, transference dynamics, and medication controversies, in order to be able to become a more effective psychiatric school consultant.

SUMMARY:

This presentation will focus on the role of the psychiatrist as a consultant in the school system. It will outline some of the most commonly encountered dynamics, issues of boundaries, and contemporary controversies encountered by the psychiatrist when undertaking this role.

Two of the presenting psychiatrists: (TA, MAS) are also former schoolteachers and will discuss the problems faced by teachers when they encounter students with mental health problems. They will also describe their experience working with issues such as boundaries, stigma, and misconceptions about mental health, seen from "both sides of the fence" (from their experience as schoolteachers, then as consulting psychiatrists).

The third presenter (HS) will discuss the available psychiatric literature and explain the current controversies regarding the use of psychotropic medications in the student population.

The last speaker (EMR) will present data from an unpublished study, which was undertaken for the purpose of clarifying whether students in the special education programs in South Florida were being "overmedicated," following a strong negative campaign in the media, which had brought forth such allegations. This presentation is designed to be interactive and the presenters will strongly encourage and invite audience participation in all the topics that will be presented.

REFERENCES:

1. Berkowitz I: School Consultation and Intervention. Child and Adol. Psychiatry Clinics of N. America. Vol. 10, No. 1, WB Saunders, Philadelphia, 2001.
2. Mattison RE: Use of psychotropic medications in special education students with seriously emotional disturbance. J. Child and Adol. Psychopharmacology. 1999; 9:149–155

Component Workshop 36
TAKING THE FIRST STEP: WHAT ARE MY OPTIONS IN THE TRANSITION TO PRACTICE?
APA Assembly Committee of Early Career Psychiatrists

Chairperson: Murali Gopal, M.D., *Meadville Psychiatric Associates, 11910 Lake Drive, Conneaut Lake, PA 16316*
Participants: Jeffrey A. Naser, M.D., Matthew W. Norman, M.D., Angelique D. Goodhue, M.D., Adam R. Chester, D.O.

EDUCATIONAL OBJECTIVE:

SUMMARY:

The field of psychiatry provides a wide array of career options, from academic/research positions to private practice settings, from crisis management to administrative roles. The task of choosing how one practices, as well as the practice setting, can be a daunting experience. This is even truer just out of training or early in one's career. The transition from residency into practice also includes many obstacles that are not specifically addressed in residency. These issues range from negotiating a contract to everyday issues such as securing malpractice insurance and setting up transcription services. This workshop will present a panel of early career psychiatrists who will discuss their career choices as well as all of the factors they considered in making these choices and arranging their practices. In addition, the aspects of contract negotiation and the day-to-day aspects of practice will be addressed. Presentations will include discussions on various practice settings including private practice, community psychiatry, academics, and hospital-based practices. In addition, career options considered will include general psychiatry, child and adolescent psychiatry, forensic psychiatry, consultation-liaison psychiatry, and administrative roles within psychiatry. Workshop attendees will be invited to participate in a panel discussion.

REFERENCES:

1. Cavanaugh JI: Career decisions in the early post residency years. American Journal of Psychiatry, 1975; 132:277–80.
2. Coons RH Jr: A survey of psychiatric group practice administrators: what does the future hold? Journal of Mental Health Administration, 1986; 13:38–44.

Component Workshop 37
APA ETHICS PROCEDURES
APA Ethics Appeals Board

Chairperson: Wade C. Myers, M.D., *Department of Psychiatry, University of Florida, P.O. Box 100234/JHMHC, Gainesville, FL 32603*
Participants: William Arroyo, M.D., Harriet C. Stern, M.D., Donald G. Langsley, M.D., Spencer Eth, M.D., Laura W. Roberts, M.D., Nada L. Stotland, M.D., Richard D. Milone, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the new APA ethics procedures and thus understand implications for APA members and APA district branches.

SUMMARY:

The APA ethics procedures for investigating complaints of alleged unethical conduct were recently reviewed as a result of the APA president's initiative, with the concurrence of the Board of Trustees. Subsequently, an APA task force, the APA Ethics Committee, and the APA Ethics Appeals Board have extensively modified many existing APA procedures and guidelines in order to conform with the new changes. (Another task force is currently rewriting/revising the Annotations to the "Principles of Medical Ethics..." In view of this, it is imperative that APA members be informed and educated about these changes. This workshop will present the new approaches to the membership. The changes have many implications for the APA District Branches since it at this level that triage of ethics complaints will take place. The intention of this workshop is to provide brief presentations on the changes and to promote participation between the attendees and the workshop presenters. Attention will be given to providing educational guidance for APA District Branch officers and staff. The new educational approach to resolving some ethical complaints will be extensively addressed.

REFERENCES:

1. APA: The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry.
2. APA: Discussion of the Procedures For Handling Complaints of Unethical Conduct.

Component Workshop 38
DOLLARS: THE PHARMACEUTICAL INDUSTRY IN PSYCHIATRIC TRAINING
APA Committee of Residents and Fellows

Co-Chairpersons: William C. Wood, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston, MA 02114,* Geoffrey M. Hopkins, M.D., *Department of Psychiatry, SUNY, Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210*
Participants: David A. Goldberg, M.D., John B. Herman, M.D., Michael D. Jibson, M.D., Michele T. Pato, M.D., Michael E. Thase, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to identify how the pharmaceutical industry funds the training and development of psychiatrists, discuss how this funding changes the incentive structure for career choices and practice patterns, and consider the ethical dilemmas that this funding creates for residents and academic departments.

SUMMARY:

Funding of gifts, research, meals, conferences, travel, continuing medical education, residency expenses, and a host of other items is the subject of intense debate in academic medical centers. Psychiatry trainees, clinicians, researchers, and administrators are acutely aware of the shifting sands of acceptability regarding pharmaceutical industry funding of residency and departmental events that have no other source of funding. The most obvious of these is the provision of meals by pharmaceutical companies at regularly held meetings, such as journal clubs, research groups, case conferences, and the like. Unlike in some of the more handsomely remunerated nonpsychiatry departments, the loss of drug company funding is often not replaceable by psychiatry departmental "slush" funds. However the pharmaceutical company funding is much more profound than the lasagna that may be no longer available. In an era of tight budgets and competitive research funding applications, pharmaceutical companies offer residents, junior faculty, and senior faculty opportunities to engage in academic research, conferences, and even patient advocacy that would simply not exist otherwise. The danger that objectivity will be lost in a sea of $$-induced subjective bias is undeniable. Likewise, the danger that opportunities will be foreclosed and a certain potential for professional employment will be curtailed in the context of passionate idealism seems equally certain. In this panel, seasoned psychiatry educators, researchers, and residents will present perspectives on conflict of interests and the role of the pharmaceutical industry in the funding of resident opportunities and perks. Discussion will aim to highlight the nuanced complexity that pharmaceutical company funding represents for individuals with a range of career aspirations and for departments seeking to grow and support the career development of their residents and faculty.

REFERENCES:

1. Coyle SL: Physician-industry relations, part I: individual physicians, and part II: organizational issues (position paper of the American College of Physicians-American Society of Internal Medicine Ethics and Human Rights Committee). Ann Intern Med 2002; 136, 396–402 and 403–406.
2. Healy D, Thase ME: Is academic psychiatry for sale? Br J Psych 2003; 182, 388–390.

Component Workshop 39
REDUCING DISPARITIES IN ACCESS TO PSYCHIATRIC CARE: APA PERSPECTIVES
APA Steering Committee to Reduce Disparities in Access to Psychiatric Care

Co-Chairpersons: Altha J. Stewart, M.D., *111 South Highland #180, Memphis, TN 38111,* Roger D. Walker, M.D., *Oregon Health Science University, M/S UHN-80, 3181 SW Sam Jackson Park Road, Portland, OR 97201-3098*
Participants: Pedro Ruiz, M.D., Francis G. Lu, M.D., Edward F. Foulks, M.D., Carl C. Bell, M.D., Patricia I. Ordorica, M.D., Richard K. Harding, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize and address disparities in access to psychiatric care among racial and ethnic minority groups a well as among the poor and disadvantaged populations.

SUMMARY:

In 1999, the U.S. Surgeon General released "Mental Health: A Report of the Surgeon General." Later in 2001, a supplement report titled "Mental Health: Culture, Race and Ethnicity" was released. This supplement report focuses on the disparities that exist in this country with respect to the mental health care of racial and ethnic minorities. Those two seminal reports led to the creation in 2001 by

the then APA President, Dr. Richard K. Harding, of an APA steering committee with the charge of developing a "plan of action" for APA to fully address these disparities in access to psychiatric care. Such a plan was designed and introduced to APA and the field at large in 2003. In this workshop presentation, Dr. Harding will introduce the original goal being pursued by this plan of action. Additionally, the members of the APA Steering Committee to Reduce Disparities in Access to Psychiatric Care will address issues pertaining to each of the racial and ethnic minority populations. Finally, input and reactions will be sought from the attendees/participants at large. These interactions could lead to further refinement and implementation of the APA action plan.

REFERENCES:

1. Ruiz P: Access to health care for uninsured Hispanics: policy recommendations. Hospital and Community Psychiatry 1993; 44:958–962.
2. Fiscella K, Franks P, Gold MR, Clancy CM: Inequality in quality: addressing socioeconomic, racial and ethnic disparities in health care. Journal American Medical Association, 283:2579–2584.

Component Workshop 40
NEW CLASSIFICATION OF PSYCHOPATHOLOGY OF INFANTS AND YOUNG CHILDREN
APA Corresponding Committee on Infancy and Early Childhood

Chairperson: Irene Chatoor, M.D., *Department of Psychiatry, Children's National Medical Center, 111 Michigan Avenue, NW, Washington, DC 20010-2916*
Participants: Thomas F. Anders, M.D., Daniel J. Siegel, M.D., Jean M. Thomas, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize that various disorders of feeding, sleep, behavior, and attachment can be reliably diagnosed in infants and young children.

SUMMARY:

This workshop will address specific challenges in the assessment, diagnosis, and treatment of psychopathology in infants and young children. Recently, a national task force of child psychiatrists and psychologists who are experts in the area of infant mental health modified the diagnostic criteria of the DSM-IV and added a few new diagnoses for sleep and feeding disorders in order to provide operational diagnostic criteria for this young age group (JAACAP, in press). In this workshop, Dr. Chatoor will explain that there are six distinct feeding disorders that need to be differentiated because each feeding disorder has a different symptom pattern, different etiology, and responds to different interventions. Dr. Anders will highlight the research and clinical findings related to infant sleep disorders, the syndrome of difficulty in initiating sleep designated as "sleep onset protodysomnia," and the syndrome of difficulty in maintaining sleep, designated as "night waking protodysomnia." Dr. Thomas will explain that there are two proposed developmental patterns of disruptive behavior disorders in toddlers that are defined by comorbidity with affective dysregulation and with neurodevelopmental difficulties. Finally, Dr. Siegel will explore the specific attachment classifications in children and adults that give rise to resilience in security or to vulnerability in the various forms of insecure attachments.

REFERENCES:

1. Chatoor I: Feeding disorders in infants and toddlers: diagnosis and treatment. Child Adolesc Psychiatric Clin N Am, 2002; 11:163–183
2. Goodlin-Jones B., Burnham MM., Gaylor EE., Anders TF: Night waking, sleep-wake organization, and self-soothing in the first year of life. Dev Beh Pediatr, 2001; 22:226–233.

Component Workshop 41
CONSULTATION AND LEGAL CLARIFICATION IN SEXUAL HARASSMENT
APA New Jersey Psychiatric Association

Co-Chairpersons: Rita R. Newman, M.D., *Department of Psychiatry, St. Barnabas Medical Center, 1046 South Orange Avenue, Short Hills, NJ 07078-3131,* Annette J. Hollander, M.D., *Univ. of Medicine and Dentistry of New Jersey, 2821 Sunset Avenue, Englewood, NJ 07631-4414*
Participants: Maria T. Lymberis, M.D., David W. Garland, Esq., Francine Weiss, Esq.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants should be familiar with how to structure consultations in sexual harassment cases, how to advise patients initiating legal action, and how this action may impact on their emotions.

SUMMARY:

Victims of sexual harassment often present the psychiatrist with much material at the initial consultation, often with the expectation that all the abuses they have suffered will be addressed in their legal case. These individuals need to understand at the outset that initiating litigation may have a negative effect on treatment and that there are emotional consequences of litigation. Such individuals can be put through a grueling psychiatric examination (by the other side), which can be considered a "second injury." They need to understand that it is not possible to keep anything private and that legal depositions can last two to four days and can, of themselves, be emotionally draining. The panelists in this workshop, three psychiatrists and two attorneys, will address the psychiatric consultation process and the value of note taking, bearing in mind that all notes are discoverable. They also will discuss diagnoses, recognizing that post-traumatic stress disorder is not of value in sexual harassment cases, except in life-threatening sexual assaults.

REFERENCES:

1. Shrier MD: Sexual Harassment in the Workplace and Academia-Psychiatric Issues, Washington DC, American Psychiatric Press, Inc., 1995.
2. Jensvold MF: Workplace sexual harassment: the uses of and misuse and abuse of psychiatry, Psychiatric Annals: Issue on Women and Therapy, December, 1992.

Component Workshop 42
ONLINE INTERACTION BETWEEN APA, MEMBERS, AND THE PUBLIC
APA Ad Hoc Work Group on Information Systems

Chairperson: Robert C. Hsiung, M.D., *Department of Psychiatry, University of Chicago, 5737 South University Avenue, Chicago, IL 60637*
Participants: Herbert S. Peyser, M.D., William Bruce, B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to describe two recent information technology initiatives of APA.

SUMMARY:

Information technology can improve communication, but it can also be confusing, expensive, inaccessible, and insecure. Two recent APA information technology initiatives are the redesign of its Web

site and the adoption of an "association management system" with a centralized member database. It is hoped that these initiatives have improved communication between APA and its governance and components, district branches, allied organizations, advocacy coalitions, and, most important, members, governmental organizations, and the public. In this workshop, members of the APA Ad Hoc Work Group on Information Systems and the APA Information Technology office present these initiatives and seek feedback from participants. If this work is to be most effective, suggestions and other input from all the above sources is needed.

REFERENCES:

1. Huang MP, Alessi NE: The Internet and the future of psychiatry. Am J Psychiatry, 1996; 153:861–9.
2. Welcome to the American Psychiatric Association. http://www.psych.org

Component Workshop 43
RESPONSE TO THE SIMON BOLIVAR AWARD LECTURE ON LATINO YOUTH IN THE U.S.: DEVELOPMENTAL AND MENTAL HEALTH CHALLENGES
APA Committee of Hispanic Psychiatrists

Co-Chairpersons: Ana E. Campo, M.D., *Department of Psychiatry, University of Miami, 1695 NW 9th Street, P.O. Box 016960 (D28), Miami, FL 33101,* Andres J. Pumariega, M.D., *Department of Psychiatry, East Tennessee State University, 204 McWherter, PO Box 70567, Johnson City, TN 37614-0567*
Participants: Ian A. Canino, M.D., Pedro Ruiz, M.D., Renato D. Alarcon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the developmental and psychosocial challenges uniquely faced by Latino youth in the United States, and understand the clinical, preventive, and policy approaches to better support the needs of Latino youth.

SUMMARY:

The latest census figures have designated the Latino population not only as the largest ethnic/cultural minority group within the United States, but also the youngest such population in our nation, with 34.4 percent under the age of 18. Unfortunately, Latino youth are at higher or increasing risk for a number of adverse psychiatric and psychosocial outcomes, such as higher rates of depression, anxiety, substance abuse, and eating disorders; higher rates of teen pregnancy and school drop-out; and increasing rates of suicide (particularly amongst Latina youth). These findings are troubling given how closely linked the future of Latino youth is to the social and economic health and future of the United States. The lead-off presentation by Dr. Pumariega (2004 recipient of the APA's Simon Bolivar Award) will focus on the mental health challenges faced by Latino youth. This will include challenges from socioeconomic stressors, the stressors related to acculturation and discrimination, and stressors arising from their prior histories and those of their immigrant parents and forbears. The impact of these stressors on the process of child and adolescent development within a Latino cultural context will be discussed. Recommendations for clinical, service system, and public policy approaches to more effectively meet the needs of Latino youth will be presented. The discussants (Drs. Ian Canino, Renato Alarcon, and Pedro Ruiz, all previous Simon Bolivar awardees) will add their perspectives as leaders in Latino mental health on approaches to these complex challenges.

REFERENCES:

1. Pumariega AJ, Pumariega JB: Factores de riesgo de los trastornos mentales y de adiccion entre ninos y adolescents inmigrantes Hispanos. Psychline InterDisciplinary Journal of Med., 4:17–20.
2. Pumariega AJ: Cultural competencies in systems of care for children's mental health. In: The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry, edited by Pumariega AJ, Winters NC. San Francisco, Jossey Bass, 2003, pp 82–106.

Component Workshop 44
PSYCHIATRIC ETHICS IN THE U.S. AND THROUGHOUT THE WORLD
APA Ethics Committee

Co-Chairpersons: Spencer Eth, M.D., *Department of Psychiatry, St. Vincent's Hospital and Medical Center, 144 West 12th Street, Room 174, New York, NY 10011,* Driss Moussaoui, M.D., *University Psychiatric Center, Rue Tarik IBN Ziad, Casablanca 00210, Morocco*
Participants: Wade C. Myers, M.D., Philip T. Merideth, M.D., Ahmed Okasha, M.D., Juan J. Lopez-Ibor, Jr., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session the participant should be able to recognize, compare, and contrast the different codes of psychiatric ethics in force throughout the world.

SUMMARY:

The APA Ethics Committee and the World Psychiatric Association Standing Committee on Ethics will jointly conduct a workshop that will compare, contrast, and discuss codes of medical ethics applicable to the practice of psychiatry that are in operation in the United States and in other countries. Particular issues of concern will include therapeutic boundary violations, confidentiality, consent and involuntary treatment, research and human subject protection, religious constraints on practice, psychiatric involvement in capital punishment, and the influence of religious and cultural factors on professional conduct. In addition, differing approaches to ethics education and enforcement will be highlighted. The audience will have ample opportunities to interact with the workshop presenters, who will all be members of either the APA Ethics Committee or the Standing Committee on Ethics of the World Psychiatric Association.

REFERENCES:

1. AMA: Principles of Medical Ethics with Annotations Procedures of the APA.
2. Helsinki Declaration of the World Medical Association (2000)

Component Workshop 45
THE 2004 MEDICARE UPDATE AND MAKING THE MOST OF THE CARRIER ADVISORY COMMITTEE
APA Medicare Advisory Corresponding Committee

Chairperson: Edward Gordon, M.D., *388 Hardscrabble Road, North Salem, NY 10560*
Participants: Gerald Rogan, M.D., Ellen Jaffe, Seth P. Stein, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop participants will have a greater understanding of how the Medicare review and reimbursement system works. This will enable them to participate with fewer problems. They will also understand the role of the Carrier Advisory Committee in establishing Medicare policy and how they can contribute to the process.

SUMMARY:

The panel and the audience will interact in a discussion of attendees' issues with Medicare after the panel presents an overview of changes that have occurred over the past year that affect how psychiatrists interact with the Medicare program. Of specific interest in the presentation will be a discussion of the Carrier Advisory Committee system and how APA members can interact with their Medicare carriers to effect changes required to have Medicare review policy reflect psychiatry as it is practiced in 2004. The formulation of an APA-developed local medical review policy for psychiatry codes will also be discussed. This workshop is intended for individuals who are responsible for the treatment of Medicare beneficiaries. The workshop is a presentation of the APA's Medicare Advisory Committee.

REFERENCES:

1. American Medical Association: CPT 2004 Professional Edition. Chicago, MA Press, 2003.
2. Medicare Carriers Manual (MCM)—US Government Document, relevant materials will be pulled from the MCM for distribution to attendees.

Component Workshop 46

IS THERE A STANDARD OF CARE FOR THE TREATMENT OF DEMENTIA?

APA Committee on Access and Effectiveness of Psychiatric Services for the Elderly

Chairperson: Allan A. Anderson, M.D., *114 Riverside Drive, Cambridge, MD 21613*
Participants: Marsden H. McGuire, M.D., Julian Offsay, M.D., Douglas A. Kalunian, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop the participant should be able to make an early diagnosis of dementia and understand appropriate treatment options for these patients. The participant will understand how standard of care may vary with the clinical setting and other variables.

SUMMARY:

Dementia has been underrecognized as a cause of cognitive, functional, and behavioral impairment in the elderly. In some cases, it has been confused with normal aging processes; in others, it has been misidentified as depression, anxiety, or substance abuse (conditions that can produce a transient dementia-like picture). Despite improvements in dementia recognition through educational interventions, undertreatment remains a barrier to providing dementia patients with an optimal quality of life. Other variables impacting on the availability and appropriateness of dementia care include the patient's setting (and level of care) and the adequacy of dementia-specific training given to the patient's clinical providers. Attention will be given to the surprising fact that no successful malpractice suits have been generated by the failure to recognize or treat dementia. Interventions affecting disease progression (including secondary complications), quality of life (for patient and caregivers), the cost of care, and provider competencies will be reviewed with the aim of promoting a new standard of care for the treatment of dementia patients.

REFERENCES:

1. Kapp MB: Legal standards for the medical diagnosis and treatment of dementia. Journal of Legal Medicine 2002; 23:359–402.
2. Qizilbash, et al: Evidence-Based Dementia Practice. Oxford, Blackwell, 2003.

Component Workshop 47

BEND IT LIKE BECKHAM: ASIAN WOMEN, ACHIEVEMENTS, AND CULTURAL CONFLICTS

APA Council on Global Psychiatry

Co-Chairpersons: Ramaswamy Viswanathan, M.D., *Department of Psychiatry, SUNY Downstate Medical Center, 450 Clarkson Avenue, Campus Box 127, Brooklyn, NY 11203,* Jacquelyn B. Chang, M.D., *University of California, San Francisco, 1838 El Camino Real, #205, Burlingame, CA 94010*
Participants: Geetha Jayaram, M.D., Michelle B. Riba, M.D., Madelyn H. Hicks, M.D., Madhulika S. Khandelwal, Ph.D., Sudeepta Varma, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to appreciate how some cultural factors help and others dampen Asian women's quest for self-fulfillment; learn constructive ways of conflict resolution, promoting self-fulfillment while preserving family harmony and mental health.

SUMMARY:

The movie "Bend It Like Beckham" has been successful with mainstream Western audiences. It deals with striving for success in soccer by a talented British girl of Indian ethnicity, and with cultural and family conflicts. This kind of struggle is faced in many areas by a number of Asian women in Asian and Western countries. Our panelists will explore these issues, using their personal experiences, experiences with patients, and findings from the literature. We will examine areas such as academic, organizational, and business success, and issues faced by Asian families and children in Western culture. We will explore positive and negative aspects, diversity within cultures, the role of spouses, and the influence of an extensive kinship network. Women in Asian countries have achieved political leadership roles such as prime ministers and presidents, something yet to be achieved by women in the U.S. But they lag behind their American counterparts in other ways. We will explore why. We will discuss how women can be helped in their quest for self-fulfillment, constructive ways of conflict resolution without alienating supportive structures, preventing psychopathology, individual and family interventions by professionals, and the role of social organizations. Audience participation in discussion will be emphasized.

REFERENCES:

1. Viswanathan R, Shah M, Ahad A: Asian-Indian Americans. In Cultural Issues in the Treatment of Anxiety, edited by Friedman S. New York, Guilford Publications, 1997, pp. 175–195.
2. Comas-Diaz L, Greene B (Eds): Women of Color: Integrating Ethnic and Gender Identities in Psychotherapy. New York, Guilford Press, 1994.

Component Workshop 48

BUPRENORPHINE IN THE TRENCHES: WHAT THE GENERAL PSYCHIATRIST NEEDS TO KNOW

APA Corresponding Committee on Training and Education in Addiction Psychiatry and APA Corresponding Committee on Treatment Services for Patients with Addictive Disorders

Co-Chairpersons: Marianne T. Guschwan, M.D., *155 East 31st Street #25-L, New York, NY 10016,* John A. Renner, Jr., M.D., *Boston University School of Medicine, 251 Caseway St, Boston, MA 02114*
Participants: George F. Kolodner, M.D., Samuel M. Silverman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to treat patients using buprenorphine in their outpatient practice,

understand common pitfalls in the utilization of this medication, as well as understand the mechanism of action of buprenorphine.

SUMMARY:

In 2002 the APA Committee on Treatment Services for Patients with Addictive Disorders began a series of workshops on ambulatory detoxification in order to provide a forum for discussion and learning by clinicians who wanted to know more about how to deliver these services outside of traditional inpatient settings. Focusing initially on alcohol, the series moved last year to opioids. With the introduction of buprenorphine in October 2002, outpatient detoxification from opioids as well as opioid-maintenance treatment has become an option for the outpatient practitioner. However, with any new treatment, there is a learning curve, which may serve as an impediment to using it. Representatives from both the Committee on Treatment Services for Patients with Addictive Disorders as well as the Committee on Training and Education in Addiction Psychiatry will review the pharmacology of buprenorphine, effective buprenorphine dosing for detoxification and maintenance, describe several common pitfalls in using this medication, and present cases to educate the audience on how to use buprenorphine in their practices. The audience will have the opportunity to question the presenters about the details of using buprenorphine as well as to discuss cases.

REFERENCES:

1. Fudala PJ, Bridge TP, Herbert S, et al.: Office-based treatment of opiate addiction with a sublingual-tablet formulation of buprenorphine and naloxone. New Engl J Med 2003; 349:949–958.
2. Vastag B: In-office opiate treatment "not a panacea": physicians slow to embrace therapeutic option. JAMA 2003; 290(6):731–735.

THURSDAY, MAY 6, 2004

Component Workshop 49
THE BLAME AND SHAME GAME IN MEDICAL ERRORS: DO YOU WANT TO PLAY IT?
APA Committee on Patient Safety

Co-Chairpersons: Geetha Jayaram, M.D., *Department of Psychiatry, Johns Hopkins University, School of Medicine, 600 North Wolf Street, M-101, Baltimore, MD 21205-2101,* Benjamin C. Grasso, M.D., *29 Twin Ponds Drive, Falmouth, ME 04105-2099*
Participants: David M. McDowell, M.D., Robert Michels, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this dramatic workshop, the participant should be able to distinguish and appreciate the outcomes of two types of response to medical errors: traditional—find the culprit responsible, or constructive—review the elements of the system and build in safeguards to prevent reccurrence.

SUMMARY:

In the landmark 1991 Harvard Medical Practice Study, it was estimated that as many as 1.3 million injuries occur nationwide to patients receiving hospital care: Subsequent research has generated similar findings and caused increasing concern for patient safety. There are multiple impediments to better error detection and reporting. Lack of a common taxonomy, absence of legal protection, and need for financial and other support affect the balance between confidentiality and public accountability, and learning from clinical error. Error prevention involves: 1) creating a taskforce of stakeholders/educators; 2) establishing a central clearinghouse for errors; 3) developing a database for research of near misses as well as errors using a common taxonomy; 4) creating an atmosphere of sharing/learning from errors; 5) incorporating the learned elements into clinical systems. This workshop will use actors to dramatically portray and compare the traditional model and a nonpunitive systems model of reviewing both administrative and clinical treatment elements leading to error reduction.

REFERENCES:

1. LL Leape, TA Brennan, et al: The nature of adverse events in hospitalized patients: results of the Harvard Medical Practice Study II. New England Journal Medicine 1991; 24:377–384.
2. Berwick D: Errors today and errors tomorrow. New England Journal Medicine 2003; 348:2570–2.

MONDAY, MAY 3, 2004

Issue Workshop 1
DISRUPTIVE EMPLOYEES: FEEDBACK-ASSISTED COUNSELING AND TREATMENT

Co-Chairpersons: Eva C. Ritvo, M.D., *Department of Psychiatry, University of Miami, 3026 North Bay Road, Miami Beach, FL 33140,* Gonzalo F. Quesada, M.D., *Physicians Development, 2000 South Dixie Highway, #103, Miami Beach, FL 33133-2441*
Participant: Larry Harmon, Ph.D.

EDUCATIONAL OBJECTIVE:

To recognize disruptive workplace behavior and how it relates to Axis I and II disorders. To demonstrate the use of a survey to conduct a Workplace Behavioral Assessment and enhance patients' understanding of their impact on others. To identify counseling and medication interventions for anger management.

SUMMARY:

As employees experience increasing workplace pressure from advancing technology, corporate layoffs, and competition, it is not surprising that the incidence of "workplace disruptive behavior" continues to rise. Clinicians treating these disruptive employees often rely on patients' self-reports, which may be incomplete or distorted. Based on work with various hospitals and the U.S. Department of Homeland Security, this workshop provides an operating definition of "disruptive" behavior in the workplace. The presenters identify ways to measure "emotional intelligence" and anger-management skills at work. They describe a method to evaluate the actual frequency of the patients' disruptive workplace behavior by using survey feedback from co-workers, and how to measure the impact of disruptive behavior on those co-workers. The program addresses how the personal survey feedback can be presented to a patient as a means to enhance the patient's understanding of, and insight into, his/her disruptive behaviors. Methods to identify and set behavior change goals that are measurable in follow-up surveys are described. Counseling strategies and psychoeducational approaches for anger management are explained. Finally, medication management for aggressive workplace behavior is discussed.

REFERENCES:

1. Harmon L: Opportunities for using clinical skills to solve corporate problems, in Innovations in Clinical Practice. Edited by Ritt I. Sarasota, Fl, Professional Resource Press, 2001.
2. Jeanneret R, Silzer R: Individual Psychological Assessment: Predicating Behavior in Organizational Settings. San Francisco, Jossey-Bass, 1998.

Issue Workshop 2

THE OFFICE OF THE FUTURE: TECHNOLOGY IN PSYCHIATRY

American Association for Technology in Psychiatry

Co-Chairpersons: Robert C. Hsiung, M.D., *Department of Psychiatry, University of Chicago, 5737 South University Avenue, Chicago, IL 60637,* Ronnie S. Stangler, M.D., *University of Washington, 1425 Western Avenue, Suite #101, Seattle, WA 98101-2036*
Participants: Seth M. Powsner, M.D., Daniel A. Deutschman, M.D., Michael Bauer, M.D.

EDUCATIONAL OBJECTIVES:

Participants will 1) use a webcam and personal computer to record a psychiatric interview and 2) describe how technology can enrich our ability to take care of patients.

SUMMARY:

How will psychiatrists practice in the future? Information technology is already changing how psychiatrists manage psychiatric knowledge and practice psychiatry. The presenters review three innovative uses of technology in psychiatry today and conclude with a look to the future. Digital video facilitates teaching in ways that used to be impractical. Webcams replace expensive camcorders. "Home" video software replaces tape-to-tape editing. Teachers can record patient interviews for use in lectures. Interviews by trainees can be recorded and quickly reviewed for supervision. Techniques are discussed, and examples provided.

The course of mood disorders is highly variable. Paper-based mood charting is slow and error-prone. Longitudinal studies using paper tools often have missing and unbalanced data. Software can automate mood charting for decision support, patient education, and research.

Psychiatrists face complex challenges in caring for patients with treatment-resistant disorders. Technology can facilitate complex data retrieval tasks to support decision making. Electronic medical records can allow all relevant data about patients with treatment-resistant disorders to be retrieved in ordered arrays. Future innovations will be in information display, database architecture, wireless networks, and human-computer interaction. These advances will dramatically alter the experience of machines, computing, and communication in psychiatry.

REFERENCES:

1. Pinsky LE, Wipf JE: A picture is worth a thousand words: practical use of videotape in teaching. J Gen Intern Med 2000; 15:805–810.
2. Bauer M, Grof P, Gyulai L, Rasgon N, Glenn T, Whybrow PC: Using technology to improve logitudinal studies: self-reporting with ChronoRecord in bipolar disorder. Bipolar Disord (in press).

Issue Workshop 3

E, K, AND GHB: THE NEW ABCS OF SUBSTANCE ABUSE

Collaborative Session With the National Institute on Drug Abuse

Chairperson: Richard N. Rosenthal, M.D., *Department of Psychiatry, Saint Luke's Roosevelt Hospital Center, 1090 Amsterdam Avenue, 16th Floor, Suite G, New York, NY 10025*
Participants: Ramon Solhkhah, M.D., Petros Levounis, M.D.

EDUCATIONAL OBJECTIVE:

Participants will appreciate the incidence of "club drug" use in clinical practice; understand the properties of MDMA (ecstasy), ketamine, and GHB; and become familiar with the clinical implications associated with "club drug" intoxication and withdrawal.

SUMMARY:

This workshop describes the clinical effects and neurobiologic and pharmacologic properties of the "club drugs," including ecstasy (MDMA, "E," or "XTC"), ketamine ("K" or "Special K"), and gamma-hydroxy butyrate (GHB, "Liquid E," or "Grievous Bodily Harm"). The workshop includes a review of the relevant research and clinical literature, a brief video presentation, and interactive panel and audience discussion. The participant will become familiar with 1) the incidence of "club drug" usage by adolescents and young adults in clinical practice; 2) the neurobiologic properties of the drugs ecstasy (MDMA), ketamine, and GHB; 3) the clinical implications associated with "club drug" intoxication and withdrawal; and 4) treatment strategies for patients who are using or abusing "club drugs." The "club drugs" MDMA, ketamine, and GHB have raised new concerns in the beginning of the 21st century, particularly among adolescents, young adults, and participants in gay circuit parties. While studies in adolescents and adults show a slight decrease in drug use, use of designer drugs is a growing concern. Adolescents continue to use "club drugs" despite an increasing body of evidence that these drugs are neurotoxic and occasionally fatal. Clinicians must become familiar with new trends in substance abuse.

REFERENCES:

1. Koesters SC, Rogers PD, Rajasingham CR: MDMA ("ecstasy") and other "club drugs": the new epidemic. Pediatr Clin N Am 2002; 49:415–433.
2. Rosenthal RN, Solhkhah R: Neurobiologic and clinical properties of the "club drugs," in Clinical Manual of Addiction Psychopharmacology. Edited by Kranzler HR, Ciraulo DA. Washington, DC, American Psychiatric Publishing, (in press).

Issue Workshop 4

FUNCTIONAL IMAGING IN COURT: USES AND CONTROVERSIES

Chairperson: Daniel G. Amen, M.D., *Department of Psychiatry, University of California, Irvine, 4019 Westerly Place, #100, Newport Beach, CA 92660*
Participants: Joseph C. Wu, M.D., Steven E. Rudolph, D.O., Harold J. Bursztajn, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session participants will understand current uses and controversies of functional imaging in both civil and criminal courts. Participants will be aware of standards of evidence (*Kelly-Frye versus Daubert*) used in courts that allow or disallow imaging and the types of cases in which imaging has been used.

SUMMARY:

Brain SPECT and PET imaging are being used increasingly in both clinical and legal settings to help understand complex people and problems. In legal system they have been used to help judges and juries understand aggressive and impulsive behavior, to show the influence of substance abuse on the brain, and to show evidence of brain injury, potential seizure activity, or toxic exposure that can affect the verdict (difference between first-degree murder, second-degree murder, or manslaughter; life or death). This workshop introduces participants to the uses and controversies of using functional imaging in the courtroom. Despite the potential benefit in legal cases, there remain a number of important controversies that need to be addressed regarding imaging, including the issue of the normal brain, technical issues, and the lack of standardization in reading and rendering these studies. This workshop gives basic information, presents five cases in which SPECT or PET has been used in court with

known outcomes, and includes audience discussion of the pros and cons of using imaging in court.

REFERENCES:

1. Annas GJ: Scientific evidence in the courtroom: the death of the Frye Rule. New England Journal of Medicine 1994; 330:1018–1021.
2. Juni JE, Waxman AD, Devous MD, et al: Society of Nuclear Medicine Procedure Guideline for Perfusion Single Photon Emission Computed Tomography (SPECT) Using Tc-99m Radiopharmaceuticals. Reston, Va, Society of Nuclear Medicine, Brain Imaging Council, 1999.

Issue Workshop 5
REINVENTING CAREERS: TRANSITIONS AND LATER-LIFE STRATEGIES FOR PSYCHIATRISTS

Chairperson: Carolyn B. Robinowitz, M.D., *Department of Psychiatry, George Washington University, 5225 Connecticut Avenue, NW, #514, Washington, DC 20015*
Participants: Carol C. Nadelson, M.D., Edward Hanin, M.D., Mary V. Seeman, M.D.

EDUCATIONAL OBJECTIVE:

Participants will become knowledgeable about aspects of late career development, strategies for remaining generative and stimulated, and opportunities and tools to prepare for career transitions.

SUMMARY:

It is never too soon to plan for growing older and how to balancing work, family, and play. This session addresses later-career and later-life issues for psychiatrists. It considers how psychiatrists re-invent themselves and their careers as they grow and progress into the end of their work lives. What changes do they seek or avoid? How can they plan to stay stimulated and generative? How do they balance work, love, family, and play? The first half of the workshop consists of brief presentations by the panelists, all of whom have studied aspects of career and personal development; they describe brief personal, as well as clinical and theoretical vignettes, discuss balance and directions, and provide practical information on opportunities for satisfying career transitions. The second half is designed to be interactive, to encourage questions and comments, and to provide an opportunity for discussion and audience participation. While more specifically intended for mid- to late-career psychiatrists, this workshop may also be of interest to early- to mid-career psychiatrists as they explore their career directions and priorities.

REFERENCES:

1. Seeman M: Scaling down. Am J Psychiatry 2003; 160:847–849.
2. Sher B: It's Only Too Late if You Don't Start Now: How to Create Your Second Life at Any Age. New York, Delacorte Press, 1999.

Issue Workshop 6
DRUG ABUSE AND SUICIDAL BEHAVIOR
Collaborative Session With the National Institute on Drug Abuse

Chairperson: Eric D. Caine, M.D., *Department of Psychiatry, University of Rochester Medical Center, 300 Crittenden Boulevard, Rochester, NY 14642-8409*
Participants: Richard K. Ries, M.D., David B. Goldston, Ph.D., Marsha M. Linehan, Ph.D., Gregory Brown, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants will know more about the relationship between substance abuse and suicidal behavior and the treatment of these comorbid conditions.

SUMMARY:

Suicidal behavior (ideation, attempts, and completed suicide) is a significant public health challenge. Suicide is associated with more deaths annually than homicide or HIV/AIDS. Suicide often occurs in the context of comorbid psychiatric and substance use disorders, and drug and alcohol disorders are among the highest-risk factors for both suicide attempts and completions. Both trait (dispositional characteristics [e.g., hopelessness, personality, chronic psychopathology]) and state (situational factors [e.g., impulsivity, anxiety/depressive moods, acute intoxication]) contribute to the risk of suicidal behavior in drug abusers. However, there are insufficient data regarding the interactions of psychopathology and personality characteristics, drug use and abuse, relationship disruptions, and suicidal behaviors. Nonetheless, potentially effective therapies have been developed recently. This workshop 1) reviews the relationship of addictions and suicide over the course of development from adolescence through adulthood, 2) examines health services impacts of this type of "co-occurring disorder," 3) describes and reports outcomes of a cognitive behavior intervention that has shown promise in reducing subsequent suicide attempts in an urban, low-income substance abusing sample recruited from the emergency department following a suicide attempt, and 4) describes and reports outcomes of a dialectical behavior therapy program focused on suicidal women with borderline personality disorder.

REFERENCES:

1. Linehan MM, Dimeff LA, Reynolds SK, Comtois KA, Welch SS, Heagerty P, Kivlahan DR: Dialectical behavior therapy versus comprehensive validation therapy plus 12-step for the treatment of opioid dependent women meeting criteria for borderline personality disorder. Drug Alcohol Depend 2002; 67:13–26.
2. Goldston DB, Daniel SS, Reboussin BA, Reboussin DM, Frazier PH, Harris AE: Cognitive risk factors and suicide attempts among formerly hospitalized adolescents: a prospective naturalistic study. J Am Acad Child Adolesc Psychiatry 2001; 40:91–99.

Issue Workshop 7
THE BENZODIAZEPINE CONTROVERSY REVISITED

Chairperson: Christopher K. Chung, M.D., *Department of Psychiatry, Harbor UCLA Medical Center, 1000 West Carson Street, Box 498, Torrance, CA 90509*
Participants: Dean M. De Crisce, M.D., John W. Tsuang, M.D., Richardo Medoza, M.D., Karl S. Burgoyne, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will be able to understand 1) the literature surrounding the utility of benzodiazepine therapy, 2) the controversity of chronic use and problematic outcomes, 3) benzodiazepine use in difficult populations, such as the "addicted" patient, and 4) how discontinuation affects patient prognosis.

SUMMARY:

Benzodiazepines are minor tranquilizers that are used to treat panic disorder, anxiety disorders, acute agitation, insomnia, medication side effects, catatonia, alcohol withdrawal, and other psychiatric disorders. They have a high dependency liability; however, they are effective and are considered the "gold standard" in treating selected patients without a substance use disorder history or with whom other medications fail. The Los Angeles County Department of Mental Health excluded most benzodiazepines from the county formulary, affecting the treatment of thousands of patients, as of July 1, 2002. This workshop is intended to engage pharmacotherapists in a discussion, through a moderated panel, audience participation, and literature review, of the controversy surrounding the use of benzodiaze-

pines. The presenters discuss data from an outpatient population of 3,000 patients, examining how the aforementioned formulary change has influenced patient outcomes. They also present experiential and literature data involving the issues surrounding chronic benzodiazepine therapy and use in problematic populations, such as in established "addiction" patients. To utilize the combined clinical experiences of attendees, active audience participation is sought to create a lively and engaging learning experience.

REFERENCES:

1. Salzman C: Issues and controversies regarding benzodiazepine use, in Impact of Prescription Drug Diversion Control Systems on Medical Practice and Patient Care. NIDA Research Monograph 131. Bethesda, Md, NIDA, 1993, pp. 68–88.
2. Couvee J, Timmermans M: The long-term outcome of benzodiazepine discontinuation programme in depressed outpatients. J Affect Disorders 2002; 70:133–141.

Issue Workshop 8
ARE THERE LIMITS TO BOUNDARY LIMITS?

Chairperson: Malkah T. Notman, M.D., *Department of Psychiatry, Harvard Medical School, 54 Clark Road, Brookline, MA 02445*
Participants: Elissa P. Benedek, M.D., Linda M. Jorgenson, J.D., Carl P. Malmquist, M.D., Lawrence B. Inderbitzin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to better evaluate and implement appropriate boundary limits for a range of psychiatric experiences including consultations, psychopharmacology relationships, and intensive psychotherapy.

SUMMARY:

During psychotherapy the boundary limits about certain kinds of relationships are not always clear. Having a sexual relationship during therapy is one area that is considered clearly unethical. Business relationships are not always that clear, although they can involve unethical exploitation. Previous presentations by this group have considered the dilemmas created when therapist and patient are in the same small community, where overlapping relationships may be difficult to avoid. The differences between patient-doctor relationships in intensive treatment such as psychoanalysis and those in diverse treatments such as medication visits, cognitive behavior treatment, counseling, or consultations have not been widely explored. The post-termination boundaries and their ethical and clinical implications have been addressed even less and are even less clear. The concept "once a patient always a patient" has been a cornerstone of APA ethics. This workshop presents two vignettes on videotape representing two different post-termination relationships from two different psychiatric experiences. Each presenter discusses the boundary issues and represents a continuum of positions from the most strict interpretation of "once a patient always a patient" to a less constricted view, depending on the type of therapy and the transactions in question.

REFERENCES:

1. Appelman PS, Jorgenson LM: Psychotherapist-patient sexual contact after termination of treatment: an analysis and a proposal. Am J Psych 1991; 148:1466–1473.
2. Gabbard G, Lester E: Boundary Violations in Psychoanalysis. New York, Basic Books, 1995.

Issue Workshop 9
BROOKLYN MENTAL HEALTH COURT: FELONY OFFENDERS WITH MENTAL ILLNESS

Co-Chairpersons: Nancy J. Needell, M.D., *322 West 57th Street, #27N, New York, NY 10019,* Carol Fisler, J.D., *Center for Court Innovation, 360 Adams Street, Brooklyn, NY 11201*
Participants: Matthew D'Emic, J.D., Lucille Jackson, M.S.W., Kelly O'Keefe, M.P.H., David Kelly, J.D., Mary Beth Anderson, J.D., Lisa Schreibersdorf, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand 1) the concerns of multiple stakeholders in operating a specialty court for offenders with mental illness and 2) a variety of ways in which individualized community-based treatment goals for felony offenders with mental illness can be balanced with public safety requirements.

SUMMARY:

The Brooklyn Mental Health Court (BMHC) is a specialized court for felony cases involving defendants with serious mental illness. Addressing both the treatment needs of offenders with mental illness and the public safety concerns of the community, it links defendants who would otherwise be prison-bound to long-term treatment as an alternative to incarceration. With a panel that includes the judge, the program director, a consulting psychiatrist, the clinical director, a prosecutor, a public defender, and the program evaluator, this workshop 1) provides an overview of the history, structure, and operations of the BMHC; 2) presents the concerns of key stakeholders in the court; 3) explores the procedures used for balancing individual treatment needs and public safety requirements; and 4) presents preliminary data from the program evaluation of the BMHC. The panelists also discuss progress made—and not made—toward bridging the gaps between the criminal justice and mental health systems. The audience is invited to ask questions, to challenge the assumptions and principles presented by the panelists, and to offer suggestions for improvements and new directions.

REFERENCES:

1. Denckla D, Berman G: Rethinking the Revolving Door: A Look at Mental Illness in the Courts. New York, Center for Court Innovation, 2001.
2. Goldkamp J, Irons-Guyns S: Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage. Washington, DC, U.S. Department of Justice, Office of Programs, Drug Courts Office, 2000.

Issue Workshop 10
CAN EARLY INTERVENTION PREVENT PSYCHOSIS? MANAGEMENT OF THE PRODROMAL PHASE

Chairperson: Clarice J. Kestenbaum, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Box 74, New York, NY 10032*
Participants: Eric R. Marcus, M.D., Ian E. Alger, M.D., Lewis A. Opler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant will be able to detect the prodromal signs of schizophrenia and bipolar disorder from phenomenological as well as cognitive behavioral antecedents of psychosis and recognize the importance of accurate diagnosis and early intervention for improving long-term outcomes.

SUMMARY:

Recognizing premorbid manifestations of psychotic disorders provides opportunities for early intervention while raising clinical and ethical questions and challenges. Dr. Kestenbaum briefly describes the research on gene-environment interaction and the relevant prodromal signs and symptoms. She presents clinical vignettes from a university-based prodromal clinic. Dr. Alger discusses research and clinical applications concerning the importance of family intervention in preventing psychotic breakdown. Dr. Marcus discusses prodromal psychotic states in depression, hypomania, and mixed states with special reference to comorbidity with severe personality disorders. Dr. Opler discusses prodromal symptoms and syndromes, the pros and cons of giving antipsychotic medication to individuals at risk for psychosis, and the ethical dilemmas associated with administering antipsychotics to persons who may become but who are not psychotic. The speakers formal presentations are given in the first 45 minutes. The remaining 45 minutes are open for audience participation.

REFERENCES:

1. Miller TJ, McGlashan TH, Woods SW, Stein K, Driesen N, Corcoran CM, Hoffman R, Davidson L: Symptom assessment in schizophrenic prodromal states. Psychiatric Q 1999; 70:273–287.
2. Erlenmeyer-Kimling L, Rock D, Roberts SA, Janal M, Kestenbaum C, Cornblatt B, Hilldoff-Adamo U, Gottesman II: Attention, memory, and motor skills as childhood predictors of schizophrenia-related psychoses: the New York High-Risk Project. Am J Psychiatry 2000; 157:1416–1422.

Issue Workshop 11
DETOXIFICATION OF THE OPIOID-DEPENDENT CHRONIC-PAIN PATIENT

Chairperson: Jon M. Streltzer, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, 4th Floor, Honolulu, HI 96813-2421*
Participants: Carl R. Sullivan, M.D., Thomas R. Kosten, M.D., Brian Johnson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to assess opioid-dependent chronic-pain patients and learn detoxification techniques applicable in various medical settings.

SUMMARY:

Psychiatrists are commonly called upon to help manage the chronic-pain patient who is not doing well with prescription opioid analgesics. Referring physicians who may be comfortable prescribing opioid analgesics may have difficulty stopping them. For the patient who is resistant to detoxification or who complains of increasing pain during detoxification, management issues beyond simple detoxification become critical.

This workshop discusses specific techniques useful in the detoxification of pain patients in different settings. The various settings include 1) an inpatient detoxification unit set up for that purpose, 2) a consultation setting in the general medical hospital, 3) an outpatient clinic, and 4) individual practice.

Issues involved include the choice, dose, and scheduling of medication for detoxification; additional medications used for simultaneous pain management; psychoeducation regarding the patient's condition; psychological support and motivation enhancement during the process; and prevention of relapse.

The potential use of buprenorphine for the detoxification of pain patients is reviewed. Case examples are used to illustrate the various issues and situations involved. Cases from the audience are welcomed.

REFERENCES:

1. Streltzer J: Pain Management in the opioid-dependent patient. Current Psychiatry Reports 2001; 3:489–496.
2. Collins E., Streltzer J. Should opioid analgesics be used in the management of chronic pain in opiate addicts? American Journal on Addictions 2003; 12:93–100.

Issue Workshop 12
DEATH BY SUICIDE: THE WORDS OF THOSE LEFT BEHIND

Chairperson: Michael F. Myers, M.D., *Department of Psychiatry, University of British Columbia, 2150 West Broadway, Suite 405, Vancouver, BC V6K 4L9, Canada*
Participants: James E. Barrett, Carla Fine, M.S., Michelle M. Barwell, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the impact of suicide on loved ones and be better informed about ways of helping.

SUMMARY:

Each year in the United States, more than one-quarter of a million people become survivors, i.e. individuals who lose a family member, friend, or colleague to suicide. This workshop highlights their stories. Dr. Myers gives a brief introduction of this unique loss and its clinical significance, followed by 15-minute presentations by the three speakers. Filmmaker James Edwin Barrett, who lost his mother to suicide when he was 12 years old, discusses the stigma of losing a parent to suicide during the developmental years. He turned to art as a creative outlet when he produced his award winning film *Different Places,* a drama of three lives touched by suicide. Ms. Carla Fine, author of *No Time to Say Goodbye: Surviving the Suicide of a Loved One,* lost her physician husband to suicide. She describes her personal journey of healing and outlines (from research for her book) characteristics common to survivors of this unique loss. Dr. Ted Rynearson, psychiatrist and author of *Retelling Violent Death,* lost his wife to suicide. He discusses ways in which clinicians can best help patients trying to cope with traumatic loss. One third of the allotted time is set aside for interactive discussion with the audience.

REFERENCES:

1. Fine C: No Time to Say Goodbye: Surviving the Suicide of a Loved One. New York, Doubleday, 1999.
2. Rynearson EK: Retelling Violent Death. Philadelphia, Brunner-Routledge, 2001.
3. Barrett J: Different Places. Studio City, CA, Jimnastic Productions, 2001.

Issue Workshop 13
THE AFTER-DEATH TELEPHONE CALL TO FAMILY MEMBERS: CLINICAL PERSPECTIVES

Co-Chairpersons: Sheila M. Loboprabhu, M.D., *Department of Psychiatry, Veterans Administration Medical Center, 116 Gero, 2002 Holcombe Boulevard., Houston, TX 77030,*
James W. Lomax II, M.D., *Department of Psychiatry, Baylor University College of Medicine, 6655 Travis, Houston, TX 77030*
Participants: Jennifer E. Pate, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the therapeutic role of the after-death telephone call made by the clinician to family members in alleviating family distress

after bereavement and to implement newly acquired skills in working with the family around complex emotional issues of bereavement.

SUMMARY:

Clinicians and family members report various emotions ranging from feelings of sadness and loss, anxiety, guilt, happiness, comfort, anger, self-blame, and blaming others after the death of a loved one. This is especially so after the death of a loved one in a traumatic situation such as an accident; sudden or unexpected death; death involving violence, suicide, or dementia; or what is seen as preventable death. Lack of communication from health care providers further contributes to the anxiety and distress reported by patients' families after a patient's death.

This workshop addresses the clinical value of an after-death telephone call made by the treating mental health provider to family members. This telephone call allows the family members and clinician to discuss the patient's death and explores their feelings and emotions surrounding the event. The interaction between the clinician and family members during a telephone conversation after the patient's death is discussed, and specific clinical cases are presented. The psychotherapeutic value of the after-death call in addressing complex emotions and its impact on coping with bereavement by families and clinicians are discussed from a clinical, spiritual, and ethical perspective. The workshop is designed to be interactive, to use real case scenarios, and to draw on participants' own clinical experiences.

REFERENCES:

1. Kirchhoff KT, Walker L, Hutton A, Spuhler V, Cole BV, Clemmer T: The vortex: families' experiences with death in the intensive care unit. Am J Crit Care 2002; 11(3):200–209.
2. Schreiner RL, Gresham EL, Green M: Physician's responsibility to parents after death of an infant: beneficial outcome of a telephone call. Am J Dis Child 1979; 133(7):723–726.

Issue Workshop 14
EARLY TRAUMA, PTSD, AND HIV: ASSOCIATION WITH TRANSMISSION AND NONADHERENCE

Co-Chairpersons: Mary Ann Cohen, M.D., *Mount Sinai Medical Center, 220 West 93rd Street, Suite14A, New York, NY 10025-7413,* Jack M. Gorman, M.D., *Department of Psychiatry, Mount Sinai School of Medicine, One Gustave L. Levy Place, Box 1230, New York, NY 10029*
Participants: Rosalind G. Hoffman, M.D., Heidi E. Hutton, Ph.D., Glenn J. Treisman, M.D., Jeffrey Weiss, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize PTSD in persons with HIV and AIDS, to understand the possible associations of PTSD with HIV risk behaviors and nonadherence to medical care, and to describe the role of the psychiatrist in the prevention of HIV transmission. The participant will have an opportunity to debate the existence of PTSD as a distinct diagnostic entity.

SUMMARY:

In the United States, 40,000 new AIDS cases are reported each year, while 5,300,000 new cases are reported worldwide. The majority of new cases of HIV infection are a result of nonadherence to risk reduction strategies by HIV-negative persons engaging in unprotected sexual behavior and sharing needles and drug paraphernalia in injecting drug use. After infection, nonadherence to treatment compromises effectiveness of antiretroviral therapy and overall health outcomes.

One factor that appears to contribute to nonadherence among HIV at-risk and HIV-positive patients is posttraumatic stress disorder (PTSD) occurring as a result of early childhood trauma. Only a few studies, however, have examined this association. At the Mount Sinai AIDS Center, it was found that of 348 patients referred for psychiatric consultation, 29% of patients reported childhood physical abuse, 24% reported sexual abuse, and 18% reported other childhood trauma. Fifty-two percent had childhood trauma, 30% had adult trauma, and 25% of the 348 patients seen were found to have PTSD. PTSD was found to be associated with HIV risk behaviors in both women prisoners and an STD clinic population associated with Johns Hopkins. In a study of 201 STD clinic patients, Hutton and colleagues at Johns Hopkins found that 14% of the men and 15% of the women had PTSD. The patients with PTSD had higher levels of distress and were more likely to engage in certain HIV risk behaviors than those without PTSD. They were also more likely to have active substance use. Identifying and treating PTSD may help in reducing HIV risk behavior and improve adherence to risk reduction strategies.

Most prevalence studies of psychiatric disorders in persons with HIV do not investigate for PTSD. PTSD is a psychiatric disorder that is often difficult to recognize. Clinicians may find it difficult to diagnose because it is frequently overshadowed by comorbid disorders such as major depressive disorder, substance use disorders, panic disorder, and bipolar disorder. PTSD is especially difficult to diagnose in some persons with AIDS because of concomitant dementia, delirium, and active substance use and its consequences. Some clinicians may find it difficult to diagnose because they do not believe that it exists as a separate diagnostic entity.

This workshop is designed to present the current evidence about the comorbidity of PTSD and HIV and to stimulate debate about controversies regarding PTSD as a separate diagnostic entity. Risk reduction efforts must go beyond focusing only on behavior change, given the high prevalence of distress and psychiatric disorders in the target population. Psychiatrists can play a significant role in prevention of HIV transmission and the suffering that results from nonadherence to care in persons with HIV and AIDS.

REFERENCES:

1. Hutton HE, Treisman GH, Hunt WR, Fishman M, Kendig N, Swetz A, Lyketsos CG: HIV risk behaviors and their relationship to posttraumatic stress disorder among women prisoners. Psychiatric Services 2001; 52:508–513.
2. Cohen MA, Alfonso CA, Hoffman RG, Milau V, Carrera G: The impact of PTSD on treatment adherence in persons with human immunodeficiency virus infection. General Hospital Psychiatry 2001; 23:294–296.

Issue Workshop 15
RESPONDING TO THE IMPACT OF SUICIDE ON CLINICIANS

Chairperson: Eric M. Plakun, M.D., *Department of Admissions, The Austen Riggs Center, 25 Main Street, P.O. Box 962, Stockbridge, MA 01262*
Participants: Jane G. Tillman, Ph.D., Edward R. Shapiro, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to 1) enumerate psychotherapist responses to patient suicide and 2) list practical recommendations for responding to patient suicide from personal, collegial, clinical, educational, administrative, and medicolegal perspectives.

SUMMARY:

It has been said that there are two kinds of psychiatrists—those who have had a patient who committed suicide and those who will. Mental health clinicians often have less contact with death than clinicians from other environments. Nevertheless, each death by suicide of a psychiatric patient may have a more profound effect

on psychiatric personnel than other deaths do on nonpsychiatric colleagues because of powerful emotional responses to the act of suicide and the empathic attunement and emotional availability that is part of mental health clinical work. This workshop offers results from a pilot study revealing seven thematic clinician responses to suicide: initial shock; grief and sadness; changed relationships with colleagues; dissociation; grandiosity, shame, and humiliation; crises of faith in treatment; and an effect on work with other patients. Recommendations derived from this and other studies are offered to guide individually impacted clinicians, colleagues, trainees, training directors, and administrators in responding to patient suicide in a way that anticipates and avoids professional isolation and disillusionment, maximizes learning, addresses the needs of the bereaved family, and may reduce the risk of litigation. The workshop is designed to include ample time for interactive discussion with participants about their own experiences with patient suicides.

REFERENCES:

1. Plakum EM: Principles in the psychotherapy of self-destructive borderline patients. Journal of Psychotherapy Practice and Research 1994; 3:138–148.
2. Powell J, Geddes J, Deeks J, et al: Suicide in psychiatric hospital inpatients. British Journal of Psychiatry 2000; 176:266–272.

Issue Workshop 16
COCAINE AND TOBACCO USE DURING PREGNANCY: ADVERSE OUTCOMES IN OFFSPRING
Collaborative Session With the National Institute on Drug Abuse

Chairperson: Vincent L. Smeriglio, Ph.D., *National Institute on Drug Abuse, 6001 Executive Boulevard, Room 5198, Bethesda, MD 20892-9593*
Participants: Linda C. Mayes, M.D., Barry M. Lester, Ph.D., Lauren S. Wakschlag, Ph.D., Bennett L. Leventhal, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to demonstrate increased understanding of relationships between prenatal exposure to cocaine and tobacco and clinical problems in offspring, from each of the following perspectives: underlying biological models, pathways from exposure to clinical outcomes, and approaches to clinical intervention.

SUMMARY:

In recent years, studies have made impressive advances in examining links between prenatal exposure to illicit drugs and tobacco and the subsequent development of clinical problems in offspring. Utilizing focused presentations and opportunities for interactions between the investigators and the attendees, this workshop examines three fundamental questions: 1) Are there biologically plausible models for increased risk for clinical disorders in cocaine- and tobacco-exposed youth? 2) How does intrauterine exposure to cocaine and tobacco interact with environmental factors, over time, in predicting neurobehavioral vulnerability? 3) Is there evidence of an early emerging clinical pathway that supports a behavioral teratologic explanation for the well-established association between conduct disorder and prenatal exposure to cigarettes? Research results, including those from longitudinal studies, provide the basis for in-depth discussion of scientific and clinical issues, including methodologic, diagnostic, and intervention strategies. Findings from neurobehavioral, clinical, and neuroimaging studies are presented. This data-based workshop is intended for individuals with clinical or research interest in the effects of prenatal risk factors on the development of clinical disorders.

REFERENCES:

1. Mayes L: A behavioral teratogenic model of the impact of prenatal cocaine exposure on arousal regulatory systems. Neurotoxicol Teratol 2002; 24:385–395.
2. Wakschlag LS, Pickett KE, Cook E, Benowitz NL, Leventhal BL: Maternal smoking during pregnancy and severe antisocial behavior in offspring: a review. Am J Public Health 2002; 92:966–974.

Issue Workshop 17
CONTROVERSIES AT THE INTERFACE BETWEEN RELIGION AND PSYCHIATRIC PRACTICE

Co-Chairpersons: Allan M. Josephson, M.D., *Department of Psychiatry, University of Louisville, 200 East Chestnut Street, Louisville, KY 40202-3869,* John R. Peteet, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 02115*
Participants: Yousef Abou-Allaban, M.D., Irving S. Wiesner, M.D., Nalini V. Juthani, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize and formulate an approach to the common clinical and ethical challenges that arise when working with religious issues in treatment.

SUMMARY:

This session explores several of the clinical and ethical challenges that have emerged at the recently expanding interface between religion/spirituality and psychiatric practice, including 1) therapeutic boundaries (When is therapist self-disclosure regarding personal spirituality helpful? When are such boundary crossings harmful? What challenges exist in treating a patient of the same faith, compared to treating a patient of a different faith?) 2) use of spiritual interventions (A number of epidemiologic studies have correlated religiosity with health outcomes, but it can be problematic for an individual clinician to recommend spiritual practices such as meditation, prayer, scripture reading, or participation in worship. What is appropriate and why?) 3) organization relationships (What issues arise in attempting to provide spiritual care within a secular context? Standard psychiatric care within a faith-based organization? What models for collaboration are optimal?) and 4) negative aspects of religion (How should a clinician approach problems presented by cults, abuse by clergy, and religious teachings that appear to reinforce psychopathology?) After brief presentations using case material, discussion of these issues is encouraged among members of the audience and the diverse panel, all authors whose work is included in an upcoming volume on spirituality and world view in clinical practice.

REFERENCES:

1. Josephson AM, Peteet JR (eds): Handbook of Spirituality and World View in Clinical Practice. Washington, DC, American Psychiatric Publishing (in press).
2. Committee on Religion and Psychiatry: Guidelines regarding possible conflict between psychiatrists' religious commitments and psychiatric practice. Am J Psychiatry 1990; 147:542.

Issue Workshop 18
PSYCHIATRIC RESEARCH PERSPECTIVES IN LATIN AMERICA

Co-Chairpersons: Rodrigo A. Munoz, M.D., *Department of Psychiatry, University of California at San Diego, 3130 Fifth Avenue, San Diego, CA 92103,* Pedro Ruiz, M.D., *Department of Psychiatry, University of Texas, 1300 Moursund Street, Houston, TX 77030*
Participants: Javier I. Escobar, M.D., Nora D. Volkow, M.D., Rodolfo D. Fahrer, M.D., Gerardo Heinze, M.D., Jose M. Caldas de Almeida, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to assess and recognize the psychiatric research potentials for Latin America, taking into consideration the research resources available and the research link with the United States.

SUMMARY:

Since World Word II, there has been an extensive migration process toward the United States. Latin America is among the regions most represented in this migratory influx. As a result, there are about 38 million Hispanic Americans residing in the United States. This number represents about 13% of the U.S. population. A positive factor in this regard is research growth and development among Hispanic American psychiatrists in the United States. In comparison, however, little research growth and development has taken place among psychiatrists in Latin America. However, it is important to acknowledge the differences in resources afforded to psychiatric research in the United States and Latin America. The potential research bridges between these two regions are enormous. A close research collaboration between both regions could lead to major research advances and to the creation of new knowledge. In this interactive workshop, potential solutions are sought, and appropriate strategies are explored for reaching consensus in this regard. Public/governmental and private initiatives are explored, as are areas of research interest in both areas of this hemisphere.

REFERENCES:

1. Ruiz P, Varner RV, Small DR, Johnson BA: Ethnic differences in the neuroleptic treatment of schizophrenia. Psychiatric Quarterly 1999; 70:163–172.
2. Caino IA, Rubio-Stipec M, Canino G, Escobar JI: Functional somatic symptoms: a cross-cultural ethnic comparison. American Journal of Orthopsychiatry 1992; 62:605–612.

Issue Workshop 19
PSYCHIATRY IN THE PRIMARY CARE SETTING: MAKING IT WORK FOR THE PSYCHIATRIST

Chairperson: John C. Urbaitis, M.D., *Department of Psychiatry, Sinai Hospital of Baltimore, 2401 West Belvedere Avenue, Baltimore, MD 21215-5216*
Participants: Ian M. Pullen, Joseph M. Schwartz, M.D., Shauna P. Reinblatt, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand several models for the integration of psychiatry in primary care and understand how communication among professionals can influence practice and patient care.

SUMMARY:

Psychiatrists can work successfully in primary care. Many patients in primary care settings have significant psychiatric problems: depression, anxiety including PTSD, as well as somatization and substance abuse. They often are reluctant to see a psychiatrist. Active medical conditions can complicate their psychiatric problems. When psychiatrists see patients in primary care (ambulatory) settings, they can do much to treat the patients and can reach patients who otherwise might not receive effective psychiatric care.

In this workshop, psychiatrists and other clinicians interested in psychiatry in primary care settings can learn more about working with patients in these settings. Psychiatrists with experience in a variety of primary care settings, including public, private, and academic settings, share their clinical and administrative experiences and discuss their experiences with attendees. Topics include engaging patients in treatment, arranging and managing practice sites, communicating with primary care physicians, coordinating treatment, and developing referrals.

REFERENCES:

1. Pullen I, Wilkinson G, Wright A, Gray DP: Psychiatry and General Practice Today. London, Royal College of Psychiatrists and Royal College of General Practitioners, 1994.
2. Ruo B, Rumsfeld JS, Hlatky MA, Liu H, Browner WS, Whooley MA: Depressive symptoms and health-related quality of life. JAMA 2003; 290:215–221.

Issue Workshop 20
NO-SUICIDE DECISIONS, CONTRACTS, AND ASSESSMENT OF RISK: VALUES AND CAUTIONS

Chairperson: Robert C. Drye, M.D., *Department of Psychiatry, University of Arizona, College of Medicine, 2620 South Azalea Drive, Tempe, AZ 85282-2715*
Participants: Cynthia R. Pfeffer, M.D., Robert I. Simon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants will know reliable approaches and necessary cautions in accurate suicide risk evaluation, particularly the use of decisions and contracts.

SUMMARY:

The presenters published an article on their method "No-suicide decisions: patient monitoring of suicidal risk" in 1973. This method has apparently been considerably modified over time into fairly wide use as "no-harm contracts" or similar terms. In a letter to APA members, APA president Dr. Goin warned about the possible dangers in relying on contracts. The Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors, released in November 2003, also contains warnings against using contracts. The presenters are concerned that clinicians with no clear idea of what a decision or contract might be will simply avoid the use of anything that sounds similar, missing out on a valuable approach. The presenters submit 30 years of evidence for the effectiveness of evaluation by decision and clarify the risks of contracts by using a variety of clinical examples involving both adults and adolescents.

REFERENCES:

1. Drye RC, Goulding RL, Goulding ME: No-suicide decisions: patient monitoring of suicidal risk. Am J Psychiatry 1973; 130:171–174.
2. Stanford EJ, Goetz RR, Bloom JB: No-harm contracts in the emergency assessment of suicidal risk. J Clin Psychiatry 1994; 55: 344–348.

Issue Workshop 21
CHRONIC FATIGUE SYNDROME: DISEASE OR ABNORMAL ILLNESS BEHAVIOR?

Chairperson: Peter Manu, M.D., *Department of Psychiatry, Hillside Hospital Medical Services, 75-59 263rd Street, Glen Oaks, NY 11004*

EDUCATIONAL OBJECTIVE:

At the conclusion of the symposium, the participants should have a critical understanding of the CDC's definition of the syndrome and should be familiar with the evidence demonstrating that chronic fatigue syndrome reflects abnormal illness behavior rather than a discrete somatic or psychiatric disorder.

SUMMARY:

Chronic fatigue syndrome (CFS) has become a common diagnosis that is often invoked as an explanation for a variety of somatic

symptoms that lack demonstrable clinical findings, structural lesions, and abnormalities in laboratory test results. The diagnosis is also frequently given to patients with fibromyalgia and Gulf War illness. The goal of the workshop is to examine the evidence and to use the participants' experience in order to answer the following questions: Is CFS a physical disorder? Is CFS a psychiatric disorder? Is CFS a pathological entity or a manifestation of abnormal illness behavior? The workshop includes three 30-minute segments. Each segment includes a 15-minute review of the evidence and a 15-minute interaction with the audience. In the first segment, the presenter describes the current case definition of CFS; presents data regarding the role of viral infections, immunologic dysfunction, hypocortisolism, and neurally-mediated hypotension; and discusses the possibility of occult encephalopathy. In the second segment, the presenter compares CFS and mood disorders with regard to neuroanatomy and brain perfusion, serotonin metabolism, function of the hypothalamic-pituitary-adrenal axis, neuropsychological abnormalities, and response to antidepressants. In the third segment, the presenter explores illness behavior in CFS, including abnormal personality traits, somatic attributions of illness, maladaptive coping, the role of support networks, and the efficacy of cognitive therapy and exercise.

REFERENCES:

1. Manu P, Matthews DA: Chronic fatigue syndrome, in Functional Somatic Syndromes: Etiology, Diagnosis and Treatment. Edited by Manu P. New York, Cambridge University Press, 1998, pp 8–31.
2. Manu P: The Psychopathology of Functional Syndromes: Neurobiology and Illness Behavior in Chronic Fatigue Syndrome, Gulf War Illness, Fibromyalgia and Irritable Bowel Syndrome. New York, Haworth Press, 2003.

Issue Workshop 22
CAREER DEVELOPMENT FOR MINORITY WOMEN PSYCHIATRISTS

Chairperson: Surinder S. Nand, M.D., *Department of Psychiatric Services, VA Chicago Health Care Systems, 820 South Damen, Chicago, IL 60612*
Participants: Nalini V. Juthani, M.D., Tanya R. Anderson, M.D., Patricia I. Ordorica, M.D., Kathleen M. Kim, M.D., Nutan A. Vaidya, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to 1) help younger psychiatrist turn obstacles in their career paths to opportunities and 2) identify role models and mentors among women psychiatrists.

SUMMARY:

Among the minorities, women have done better in terms of actualization of their career goals. Affirmative action has also benefited women in the United States. The number of women psychiatrists has increased significantly. It is a well-known fact that women in general, and women physicians specifically, have faced many obstacles in achieving their career goals and balancing their careers and personal lives. Although women psychiatrists have faced similar obstacles, many have excelled.

In this workshop, four women psychiatrists of different ethnic backgrounds, i.e., African American, Korean, Hispanic, and East Indian, highlight how despite such obstacles they navigated their career paths. The African American woman psychiatrist discusses how she is overcoming difficulties in her academic path to promotion and tenure in the academic world, the Hispanic woman discusses working in the Veterans Affairs system, the Korean woman discusses her role as the deputy head of a large academic department, and the East Indian woman discusses her career path as an international medical graduate.

The workshop is designed to include participation from the audience to help younger psychiatrists discuss obstacles they are facing and to identify mentors and role models among senior women psychiatrists. Discussants identify ethnic similarities and differences among these women psychiatrists' experiences and how each one turned obstacles into opportunities.

REFERENCES:

1. Nadelson CC, Zimmerman V: Culture and psychiatric care of women, in Culture, Ethnicity and Mental Illness. Edited by Gaw AC. Washington, DC, American Psychiatric Press, 1993.
2. Chin EL: This Side of Doctoring: Reflections from Women in Medicine. Thousand Oaks, Calif, Sage Publications, 2001.

Issue Workshop 23
WHAT PSYCHIATRY RESIDENTS CAN EXPECT FROM NIMH-SPONSORED RESEARCH TRAINING

Co-Chairpersons: Joseph R. Calabrese, M.D., *Department of Psychiatry, University Hospital of Cleveland, 11400 Euclid Avenue, Suite 200, Cleveland, OH 44106,* Della M. Hann, Ph.D., *NIMH, 6001 Executive Boulevard, Bethesda, MD 20892*
Participants: Robert L. Findling, M.D., Omar Elhaj, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be familiar with 1) the range of NIMH funding mechanisms available to pursue training in research across the professional life cycle, including Training (T) Awards, Career (K) Awards, and Mental Health Research Education Grants (R25s), and 2) the critical elements of a highly successful research training fellowship.

SUMMARY:

The National Academy of Science (NAS) has reported serious concerns regarding the decline in the number of physician research scientists that has occurred over recent decades. An NIMH-sponsored NAS project has preliminarily reported, "... for psychiatry, the decreasing number of physician scientists is especially problematic." There exists a need for additional research training opportunities for psychiatry residents. The purposes of this workshop are to 1) increase the awareness of the field's urgent need for young research-oriented physicians, 2) discuss the incentives for a research-oriented career, 3) familiarize the targeted audience with the available NIMH funding mechanisms, and 4) provide guidelines on how to initiate a research project and submit an application for a grant to NIMH. In this interactive workshop, the speakers each briefly present their respective segments and are followed by an open forum for questions and answers between the audience and the panel, moderated by the workshop chairs. The audiences for this workshop are: 1) general adult psychiatry residents intending to start a research fellowship at or after the PGY-3 level and 2) child psychiatry residents intending to start a research fellowship at or after the PGY-4 level.

REFERENCES:

1. NIMH Research Training and Development Timetable. (http://www.nimh.nih.gov/grants/training.cfm).
2. Institute of Medicine Report on the Incorporation of Research into Psychiatry Residency Training. (http://www.iom.edu/project.asp?id=3893).

Issue Workshop 24
TREATING PHYSICIANS: ISSUES IN DIVERSITY

Chairperson: Michael F. Myers, M.D., *Department of Psychiatry, University of British Columbia, 2150 West Broadway, Suite 405, Vancouver, BC V6K 4L9, Canada*
Participants: Daniel P. Chapman, Ph.D., Donna M. Norris, M.D., David W. Hodo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize and be comfortable with some of the myriad issues that arise when treating physicians.

SUMMARY:

One of the exciting advances in the field of physician health is an emerging recognition of the diverse matters that ill physicians bring to their treating psychiatrist. In this workshop, four individuals in 15-minute presentations tackle some of these themes. Dr. Chapman gives a state-of-the-art update on what we know and don't know about the epidemiology of psychiatric illness in physicians, including pressing research imperatives. Dr. Norris discusses mental illness in African American physicians (and their children), including the effects of stigma and challenges in gaining access to treatment in this racial/ethnic group. Dr. Hodo describes the unique concerns (boundaries, privacy, confidentiality, limited resources) associated with treating physicians when both the psychiatrist and patient reside in small communities. Dr. Myers talks about complexities in psychotherapy with the suicidal physician and when not to hospitalize. During the 30-minute discussion period, the audience is invited to participate by posing questions, giving commentary, and presenting disguised stories from their practices if they choose.

REFERENCES:

1. Center C, Davis M, Detre T, et al: Confronting depression and suicide in physicians. JAMA 2003; 289:3161–3166.
2. Goldman LS, Myers M, Dickstein LJ: The Handbook of Physician Health: The Essential Guide to Understanding the Health Care Needs of Physicians. Chicago, American Medical Association, 2000.

Issue Workshop 25
DRUG ABUSE AND MENTAL HEALTH TREATMENT IN LIEU OF IMPRISONMENT

Chairperson: Rodrigo A. Munoz, M.D., *Department of Psychiatry, University of California at San Diego, 3130 Fifth Avenue, San Diego, CA 92103*
Participants: David Deitch, Ph.D., Gretchen Burns, Igor Koutsemok, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the changing international attitude on drug addiction, which gradually is leading to alternatives for treatment that avoid prisons and sentences.

SUMMARY:

Currently, the United States has more than 2 million people in correctional environments, jails, and prisons. Numerous national studies have estimated that between 70% and 80% of such offenders have drug overuse problems regardless of the cause of commitment. Recent studies have indicated that less than 15% of these offenders receive any treatment for this disorder. Further data have indicated that among such drug using individuals, 30% have a co-occurring psychiatric disorder. Meanwhile, more than 3 million children under the age of 15 years have one parent being in such custody settings. Compounding these problems is the fact that on average one-half million people are released annually with untreated drug abuse and mental health vulnerabilities.

This workshop reviews significant public health and safety acts in different states that are an effort to provide the option of treatment rather than prison. Many states have also implemented drug treatment initiatives within their prison systems. The presenters describe the outcome findings of such efforts, relating to both treatment and prerelease screening instruments, and highlight issues for continuing care, as well as policy and administrative hurdles that must be understood. Finally, the value of integrated dual diagnosis treatment is discussed.

REFERENCES:

1. Bertram E, Blachman M, Sharpe K, Andreas P: Drug War Politics: The Price of Denial. Berkeley and Los Angeles, University of California Press, 1996.
2. Friedman M: The war we are losing, in Searching for Alternative: Drug Control Policy in the United States. Edited by Krauss MB, Lazear EP. Stanford, Calif, Hoover Institution Press, 1991.

Issue Workshop 26
OBTAINING RESEARCH FUNDING FROM NIH: KEYS TO SUCCESSFUL GRANT WRITING
Collaborative Session With the National Institute on Drug Abuse

Chairperson: Lucinda L. Miner, Ph.D., *National Institute on Drug Abuse, 6001 Executive Boulevard, Suite 5230, Rockville, MD 20852*
Participant: Marina Volkov, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the research funding process at the National Institutes of Health and how to be proactive in the process to increase the likelihood of success.

SUMMARY:

The National Institute on Drug Abuse (NIDA) sponsors this workshop on successful grantwriting strategies for obtaining research funding from the National Institutes of Health (NIH). Participants have the opportunity to learn about the various funding mechanisms available to support research projects, how the NIH evaluates grant applications, and how funding decisions are made. In addition, the keys to writing a good grant application are discussed.

REFERENCE:

1. National Institutes of Health: Grants and funding opportunities. (http://grantsone.nih.gov/grants/index.cfm).

Issue Workshop 27
TO SMOKE OR NOT TO SMOKE: THE DILEMMAS OF TOBACCO-FREE ADDICTION TREATMENTS
Collaborative Session With the National Institute on Drug Abuse

Co-Chairpersons: Petros Levounis, M.D., *Smithers Center, 1000 Tenth Avenue, New York, NY 10019,* Edward V. Nunes, M.D., *Department of Psychiatry, NYS Psychiatric Institute, Columbia University, 1051 Riverside Drive, #51, New York, NY 10032*
Participants: Paul J. Rinaldi, Ph.D., Ronald B. Lonesome, M.D., Lisa Koen, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to 1) demonstrate the main arguments for and against treating nicotine

dependence and other addictions simultaneously and 2) provide recommendations for the implementation of tobacco-free addiction programs.

SUMMARY:

While there is consensus on the need to help all substance abusing patients quit smoking, there is currently an active debate on what strategy works best. Most addiction programs use a *sequential model* in which the treatment of alcoholism or drug addiction comes first and nicotine dependence is deferred to be addressed after cessation of use of the other drugs of abuse. Many inpatient programs allow smoking in restricted areas and during specified times, and almost all AA and NA meetings do not address cigarette smoking as an addiction. However, several clinicians currently support a growing movement toward a *simultaneous model* in which the treatment of all substance dependence, including nicotine dependence, is seriously considered and addressed at the same time.

This workshop explores the pros and cons of the two models, drawing arguments from research and clinical experience. The presenters provide reports from a transition to a tobacco-free environment at the Smithers Center in New York City, a NIDA Clinical Trials Network site (Long Island Node). Participants are encouraged to provide their opinions, share clinical experiences, and help the group formulate recommendations for treatment programs that struggle with the idea of transitioning to "smoke-free."

REFERENCES:

1. Stuyt EB, Order-Connors B, Ziedonis DM: Addressing tobacco through program and system change in mental health and addiction settings. Psychiatric Annals 2003; 33:447–456.
2. Frosch DL, Stein JA: Using latent-variable models to analyze smoking cessation clinical trial data: an example among the methadone maintained. Experimental and Clinical Psychopharmacology 2002; 10:258–267.

Issue Workshop 28
THE TRANSITIONAL OBJECT IN DEMENTIA

Co-Chairpersons: Sheila M. Loboprabhu, M.D., *Department of Psychiatry, Veterans Administration Medical Center, 116 Gero, 2002 Holcombe Boulevard., Houston, TX 77030,* James W. Lomax II, M.D., *Department of Psychiatry, Baylor University College of Medicine, 6655 Travis, Houston, TX 77030*
Participant: Pamela J. Petersen-Crair, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the concept of the transitional object in the patient with dementia and the role that it plays in helping the family and patient cope with separation and loss. Participants should be able to implement newly acquired skills in working with the family around complex emotional issues of separation and loss.

SUMMARY:

The concept of the transitional object in personality development was first proposed by Winnicott and has been extensively discussed in the child psychoanalytic literature. However, there are very few empirical studies on the transitional object in adult development. The transitional object has been discussed in relation to medical illness, aggression, dreams, spirituality and religion, borderline personality disorder, anxiety disorder, fetishes, medication, and body image. There is no literature on the role of the transitional object in dementia.

Dementia is an ongoing process of transition from a healthy, active state to an inactive, dependent state with progressive loss of memory, functional skills, and independence. Patients and their families experience feelings of grief, loss, fear, anxiety, guilt, and anger. This workshop addresses the role of the transitional object in dementia. The presenters discuss various parts of the therapeutic process and treatment setting that may serve as a transitional object in various stages of dementia. The therapeutic relationship serves as the "holding environment" in which various transitions may be safely accomplished. The presenters explore the role of the transitional object from psychodynamic, pharmacologic, spiritual, and ethical perspectives. Participants are encouraged to share their own clinical experiences for discussion.

REFERENCES:

1. Winnicott DW: Transitional objects and transitional phenomena. Int J Psychoanal 1953; 34:89–97.
2. Colarusso CA, Nemiroff RA: Clinical implications of adult developmental theory. Am J Psychiatry 1987; 144:1263–1270.

Issue Workshop 29
BOUNDARY VIOLATION: HISTORY, TYPOLOGY, AND PREVENTION

Chairperson: Albert C. Gaw, M.D., *Department of Psychiatry, University of California, 88 King Street, #401, San Francisco, CA 94107*
Participants: Axel Hoffer, M.D., Thomas G. Gutheil, M.D., Andrea Celenza, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to 1) discuss the history and related concepts of boundary violation, 2) recognize two types of boundary violators, and 3) adopt strategies to keep within professional bounds.

SUMMARY:

Maintaining a clear professional boundary is critical in effective psychotherapeutic work. On the other hand, violation of professional boundary can result in serious harm to the patient and expose the therapist to medico-legal consequences. This workshop traces the history of boundary violation, addresses the typology of violators, and suggests preventive strategies. The goal is to heighten clinicians' awareness in avoiding boundary violation.

Dr. Axel Hoffer, a psychoanalyst/psychotherapist, provides a historical introduction of boundary violation, including the concepts of crossings and violation. Dr. Andrea Celenza, a psychoanalyst and clinical psychologist, discusses the profiles of two types of boundary violators. Using observational data and clinical vignettes, Dr. Celenza highlights the subjective experience of violators at the time of the violation and during the complaint or rehabilitative process. She emphasizes the importance of seeking supervision, discusses warning signs that may arise in the supervisory context, and identifies factors that practitioners can be aware of in their subjective experience to stay within bounds. Dr. Thomas Gutheil, a psychiatrist and medico-legal expert, uses case material to discuss the uses and misuses of boundary theory in 1) lawsuits, 2) licensing board complaints, and 3) ethics complaints.

REFERENCES:

1. Celenza A, Gabbard GO: Analysts and sexual boundary violations: a lost cause? J Am Psychoanalytic Assoc 2003; 51:617–636.
2. Gutheil TG, Gabbard TO: The concept of boundaries in clinical practice and risk-management dimensions. Am J Psychiatry 1993; 150:188–196.

Issue Workshop 30
COGNITIVE THERAPY AND PHARMACOTHERAPY: TEACHING RESIDENTS INTEGRATED TREATMENT METHODS

Chairperson: Donna M. Sudak, M.D., *Department of Psychiatry, Drexel College of Medicine, 3200 Henry Avenue, EPPI, Philadelphia, PA 19129*
Participants: Judith S. Beck, Ph.D., Jesse H. Wright, M.D., Edward S. Friedman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) understand the benefits of combining cognitive therapy and medication management for many psychiatric disorders, 2) integrate interventions in a combined treatment approach, 3) identify skills to teach residents medication management, which will help them attain competency in both cognitive behavior therapy and combined treatment, and 4) review supervisory and evaluation techniques that can be used to demonstrate competence.

SUMMARY:

ACGME requirements for residency training in psychiatry require residents to attain competency in cognitive behavior therapy (CBT), as well as in combining medications and psychotherapy. Cognitive therapy and pharmacotherapy are the most heavily researched treatments available for axis I disorders. Empirical studies support the use of combined CBT and medication as a preferred treatment for severe mental disorders. The combination has been shown to improve outcome and enhance treatment adherence. This workshop focuses on teaching participants methods for training residents in CBT and combined medication and psychotherapy in the outpatient setting. Audience members review a model for the presentation of an integrated approach to trainees, identify key features of CBT that help with patient adherence to medication treatment, and discuss methods of supervision and evaluation that can be used to help residents attain proficiency. After discussing barriers to initiating this approach, participants are asked to discuss ways to effectively implement the program. Resources available to enhance the training experience are discussed.

REFERENCES:

1. Wright JH, Thase ME: Cognitive and biological therapies: a synthesis. Psychiatric Annals 1992; 22:341–358.
2. Wright JH: Combined cognitive therapy and pharmacotherapy, in New Advances in Cognitive Therapy. Edited by Leahy R. New York, Guilford Press (in press).

Issue Workshop 31
TREATING AFRICAN AMERICAN PATIENTS WITH PSYCHOTHERAPY: A TRAINING DILEMMA

Co-Chairpersons: Anu A. Matorin, M.D., *UT-Medical School Houston, 1300 Moursund, Houston, TX 77030,* Henry L. McCurtis, M.D., *Harlem Hospital Center, 506 Lenox Avenue, New York, NY 10037*
Participants: Billy E. Jones, M.D., Pedro Ruiz, M.D., Sudhandshu Nene, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the unique complexities of learning to do psychotherapy with African American patients and exchange ideas in order to develop creative and practical strategies that can be implemented during residency training.

SUMMARY:

The set of "Core Competencies" advocated by the American Council of Graduate Medical Education (ACGME) has had a major impact on graduate psychiatry training, with a renewed emphasis on training programs to demonstrate competency in five areas of psychotherapy. While psychotherapy training is again on the forefront, little emphasis has been given to the issue of cross-cultural psychotherapy involving the racial and ethnic minority groups who reside in the United States. In addition, the issue of race and its relevance to psychotherapeutic treatment has not been adequately addressed during residency training. In this context, this workshop addresses the issues and challenges faced by psychiatric residents when attempting to treat African American patients with psychotherapy. The workshop briefly addresses the case of an African American woman treated with psychotherapy by a PGY-3 resident in the Department of Psychiatry and Behavioral Sciences of the University of Texas Medical School at Houston. The role of supervision in achieving an optimal learning experience during training is also addressed.

REFERENCES:

1. Bland IJ, Kraft I: The therapeutic alliance across cultures, in Clinical Methods in Transcultural Psychiatry. Edited by Opaku SO. Washington, DC, American Psychiatric Press, 1998, pp 266–278.
2. Comas DL, Greene B (eds): Women of Color: Integrating Ethnic and Gender Identities in Psychotherapy. New York, Guiford Press, 1994.

Issue Workshop 32
RISK-MANAGEMENT ISSUES IN PSYCHIATRIC PRACTICE
Psychiatrists' Purchasing Group, Inc.

Chairperson: Alan I. Levenson, M.D., *75 North Calle Resplendor, Tucson, AZ 85716-4937*
Participants: Ellen R. Fischbein, M.D., Martin G. Tracy, J.D., Jacqueline M. Melonas, J.D., Charles D. Cash, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the major psychiatric professional liability risks that lead to malpractice lawsuits, discuss emerging practice trends that increase malpractice risk, and use risk management strategies to decrease major professional liability risks, including those related to suicide, supervision, cybermedicine, HIPAA, etc.

SUMMARY:

Malpractice suits pose a significant problem for psychiatrists, regardless of whether they work in private practice, academic, or institutional settings. At least 8% of practicing psychiatrists are sued each year. It is important that psychiatrists understand the sources of malpractice lawsuits and become aware of malpractice risks in terms of their own work as clinicians, teachers, and administrators. The workshop presents data from the APA-endorsed Psychiatrists' Professional Liability Insurance Program that identify common sources of malpractice actions against psychiatrists. The nature of malpractice lawsuits is described, and data are presented on the cause and outcome of such lawsuits. Special emphasis is placed on malpractice as it relates to the process of supervision and working with nonpsychiatrists and on the risk associated with new forms of telecommunication and cybermedicine. Information is provided regarding malpractice insurance policies and questions that must be addressed when purchasing such a policy. Finally, risk management strategies for practicing psychiatrists, residents, educators, and administrators are discussed.

REFERENCES:

1. Vernick AE: Forensic aspects of everyday practice: legal issues that every practitioner must know. Child Adolesc Psychiatric Clin N Am 2002; 11:905–928.
2. Binder RL: Liability for the psychiatric expert witness. Am J Psychiatry 2002; 159:1819–1825.

TUESDAY, MAY 4, 2004

Issue Workshop 33
MENTAL HEALTH NEEDS OF OUR SOLDIERS AND THEIR FAMILIES

Chairperson: Howard J. Osofsky, M.D., *Department of Psychiatry, LSU Health Sciences, 1542 Tulane Avenue, New Orleans, LA 70112-2865*
Participants: Neal Mazer, M.D., Robert J. Ursano, M.D., Marleen Wong, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize stressors, evaluate symptoms, and provide therapeutic interventions for service men/women and their families at the time of mobilization and deactivation.

SUMMARY:

In contrast to recent limited military engagements, large numbers of troops have been deployed for the initial fighting and subsequent peacekeeping mission in Iraq. Service men and women in the National Guard and their families often feel less prepared than those in the regular military with its ongoing support system. Rapid mobilization and adjustments frequently lead to heightened pressures and, for some, anger. Family members need to cope with general worries, financial pressures, and child care responsibilities and need to be connected to a caring community. Service men and women are stressed by fatigue, heat, combat, and unfamiliar roles in peacekeeping in a hostile environment. They worry about spouses, children, and family members. When National Guard and Reserve members return home and are deactivated, spouses and children receive fewer benefits. Yet they and their families may experience unanticipated domestic and workforce pressures. Spousal conflict is generally underreported because of stigma and to avoid discharge of the service man/woman and protect benefits. After brief presentations, interactive discussions focus on prevention, early recognition of stress symptoms, interventions, and recommendations for services that can be helpful.

REFERENCES:

1. Kirkland FR, Halverson RR, Bliese P: Stress and psychological readiness in post-Cold War operations. Parameters, Summer 1996; pp 79–91.
2. Ursano RJ, Norwood AE (eds): Emotional Aftermath of the Persian Gulf War: Veterans, Families, Communities, and Nations. Washington, DC, American Psychiatric Press, 1996.

Issue Workshop 34
THE IMPACT OF MIGRATION ON ADDICTIVE DISORDERS: A CHALLENGE FOR THE AMERICAS
Collaborative Session With the National Institute on Drug Abuse

Chairperson: Amelia Musacchio de Zan, M.D., *Department of Mental Health, Medical School, Buenos Aires University, Avenue Santa Fe 3802, 7th Floor, Buenos Aires, Argentina*
Participants: Pedro Ruiz, M.D., Patricia I. Ordorica, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to better understand migration processes all along the Americas, especially in the United States, and the impact of said processes on the clinical area of addiction.

SUMMARY:

Addiction is linked to migration processes in the United States and Canada, as well as in Latin America. The globalization process plays a key role. During the last two decades, a migration process has started not only from Central and South America toward the United States but also among the different South American industrial countries. It has been apparent that migration processes cause a state of acculturation, in which behavioral aspects have a great relevance.

Among cultural processes, substance abuse—including alcohol abuse—is one of the most predominant and poses difficulties for diagnosis and treatment as a consequence of the cultural characteristics of the migrating groups. The presenters analyze the main problems of different migrating groups, with particular focus on epidemiologic factors, psychosocial problems, impact on the family, and problems related to treatments.

This presentation is intended to stimulate participants to investigate biopsychosocial aspects of addiction.

REFERENCES:

1. Ruiz P: The role of culture in psychiatric care. Am J Psychiatry 1998; 155:1763–1765.
2. Musacohio A: Education in psychiatry, in Advances in Psychiatry. Edited by Christodoulou D. Athens, Beta Publishers, 2002, pp 51–57.

Issue Workshop 35
THE CLINICAL IMPACT OF TREATING CIVIL AND CRIMINALLY-MANDATED PSYCHIATRIC PATIENTS

Co-Chairpersons: Merrill R. Rotter, M.D., *Department of Psychiatry, Bronx Psychiatric Center, 1500 Water Place, Bronx, NY 10461,* Ali Khadivi, Ph.D., *Bronx Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456*
Participants: Scott D. Rogge, M.D., Patricia Mourilhe, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the clinical issues and challenges involved in treating both violent and nonviolent mandated patients.

SUMMARY:

Mandated treatment of psychiatric patients as an alternative to incarceration and as a public safety measure has received considerable attention in recent years. However, little is known about the impact of treating such patients in the clinical interactions that are part of assessment and treatment. The purpose of this workshop is to explore the clinical challenges and opportunities involved in assessing, monitoring, and treating mandated psychiatric patients. The workshop focuses on three forms mandated treatments: the New York State Assisted Outpatient Treatment (AOT) initiative, a civil outpatient commitment program; the Bronx Mental Health Court Diversion Service, a program involving diversion into court-mandated treatment for patients with criminal justice involvement; and a program for patients acquitted by reason of insanity and court-ordered to be in treatment. The workshop provides a brief overview of mandated treatment in psychiatry. The presenters discuss the clinical challenges involved in treating both violent and nonviolent mandated patients. Emphasis is placed on problems of engagement and contertransferance reactions, with a special focus on psychological intervention and strategies to enhance treatment. The audience members are invited to discuss their experiences in treating and managing mandated psychiatric patients.

REFERENCES:

1. Swanson JW, Swartz MS, Elbogen EB, et al: Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. Behavioral Sciences and the Law 2003; 21:473–491.
2. Christy A, Boothroyd RA, Pertila J, Poythress N: The reported prevelance of mandated community treatment in two Florida samples. Behavioral Sciences and the Law 2003; 21:493–502.

Issue Workshop 36
USING COGNITIVE THERAPY FOR PSYCHOSIS IN PSYCHIATRIC PRACTICE

Chairperson: David G. Kingdon, M.D., *University of Southampton, Royal South Hants Hospital, Southampton SO14 0YG, England*
Participants: Douglas Turkington, M.D., Shanaya Rathod, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participants should be able to 1) understand which of their patients with schizophrenia may benefit from cognitive therapy and 2) be able to incorporate evidence-based elements of cognitive therapy into their work with patients with schizophrenia.

SUMMARY:

Cognitive behavior therapy (CBT) as an adjunctive therapy for persistent symptoms of schizophrenia is now supported by meta-analyses and 16 published randomized controlled trials. However few training programs exist, and consequently trained therapists are rarely available to accept referrals. In these circumstances, psychiatrists may need to consider if they can adapt their practice to incorporate elements of CBT successfully. They can build on general psychiatric engagement, assessment, and formulation skills with a particular focus on the first episode of psychosis and its antecedents. General understanding of cognitive therapy processes and ways of working can be adapted. Specific work on voices, visions, delusions, thought disorder, and negative symptoms can then be incorporated within the framework of identified clinical groups in clinic, community, and inpatient settings. CBT complements medication management by assisting with understanding and improving compliance with treatment, addressing delusional elaboration sometimes associated with medication, or simply addressing faulty assumptions about the function and purpose of medication. It is also valuable in eliciting risk issues by drawing out connections between thoughts, feelings, and actions, for example, in relation to passivity or command hallucinations. The workshop uses case examples and video interviews and allows opportunity for discussion.

REFERENCES:

1. Kingdon DG, Turkington D: A Casebook Guide to Cognitive Behavior Therapy: Practice, Training and Implementation. Chichester, Eng, Wiley, 2002.
2. Kingdon DG, Turkington D: Treatment Manual for Cognitive Behavior Therapy of Schizophrenia and Psychotic Symptoms. New York, Guilford (in press).

Issue Workshop 37
THE THEATER OF EMOTIONS

Chairperson: Ian E. Alger, M.D., *New York Hospital, Cornell, 500 East 77th Street, #132, New York, NY 10162-0021*
Participants: Ferruccio A. di Cori, M.D., Ferruccio Marotti, M.D., Stefania Papirio, Alessandro Nicolo, Lisa Colosimo, Critstiano Adiutori

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to appreciate the complexity and therapeutic potential of the merging of collaborative artistic and theatrical expression in a therapeutic context.

SUMMARY:

"The Theater of Emotions" is the title of a course created and conducted over the past 10 years by Professor Ferruccio diCori, M.D., in the Department of Literature and Theater, at the University of Rome, La Sapienza. Dr. diCori, well known for his creative teaching and therapeutic work with psychodrama both in America and in Europe, has developed a unique artistic course that involves a dual approach in a collaborative interplay among students and the therapist/dramatist. This workshop features a live, spontaneous demonstration of this method by Dr. diCori and his actual students from Rome. Using role-play techniques, combining the arts with therapeutic psychodrama, Dr. diCori directs the students in role-play and imaginative self-revelatory discourse. This process brings to the foreground primary emotional forces, leading to a recognition by the participants of their ambitions, conflicts, parental influences, frustrations, and ideals. Revelations of this complex "dedalus of life" under the eye of, and through the interaction with an expert therapist/dramatist, promote motivation and enhance the recognition of many underlying conflicts. During this process the individual faces peers, with the "eye" and involvement of the therapist promoting new insight, which combine to help resolve many of the question marks in the individual's life. In this process, it is the individual versus the collective unconscious, and vice versa. A playground is offered by the stage scene, with the student-as-actor. Negative and positive forces are at play and are sustained and/or rechanneled during the process.

REFERENCES:

1. McManus IC: Humanity and the medical humanities. Lancet 1995; 346:1143–1145.
2. Horowitz HW: Poetry on rounds: a model for the integration of humanities into residency training. Lancet 1996; 347:447–449.

Issue Workshop 38
INITIAL PSYCHIATRIC INTERVIEW: A PSYCHODYNAMIC APPROACH TO 90801 American Academy of Psychoanalysis and Dynamic Psychiatry

Chairperson: Gopalakrishna K. Upadhya, M.D., *Medical Psychiatric Practice Inc., 9 Overhill Road, Scarsdale, NY 10583-5307*
Participant: Moitri N. Datta, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize and understand the complex dynamic interplay of the mind and the body during the initial psychiatric evaluation and to formulate a comprehensive treatment plan for the patient.

SUMMARY:

Very frequently patients do not return to therapy after an initial encounter with a psychiatrist. In an era of quick-fix managed care, where different professions compete for the same patient with diverse views on what works and what does not, the psychiatrist's very existence and survival are being threatened. Numerous training programs are not encouraging their residents to seek special competence in psychoanalytic principles in psychopathology, with a misguided notion that psychoanalysis and dynamic psychotherapy are time consuming and impractical.

This intensive and highly interactive workshop is intended to sensitize the participants to the complexities and relevance of psychodynamic issues that are essential in one's understanding of a patient's psychopathology during the initial psychiatric interview (CPT code 90801). It is also an unique opportunity to make use of the session

as a window through which one could look into the mind of the patient. This knowledge can be used to formulate the origins of his or her symptoms and educate a distressed patient about the various therapeutic options that are available to help ease the suffering. This understanding will eventually help both the patient and the therapist establish a positive and productive therapeutic relationship, understand the relevance of transference, and better assess the prognosis of the clinical outcome and compliance.

Several case vignettes are presented and discussed with special emphasis on using the initial psychiatric interview to its maximum potential. Furthermore, psychodynamic principles are discussed as aids in diagnosing, formulating, and treating patients in various clinical settings, such as inpatient, outpatient, and general hospital medical/surgical unit settings.

REFERENCES:

1. Tarachow S: An Introduction to Psychotherapy. New York, International Universities Press, 1963.
2. Marcus ER: Integrating psychopharmacotherapy, psychotherapy, and mental structure in the treatment of patients with personality disorders and depression. Psychiatric Clinics of North America 1990; 13:209–214.

Issue Workshop 39
HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE, PART 1

Co-Chairpersons: William E. Callahan, Jr., M.D., *7700 Irvine Center Drive, Suite 530, Irvine, CA 92618,* Keith W. Young, M.D., *10780 Santa Monica Boulevard, #250, Los Angeles, CA 90025-4749*
Participants: Jacqueline M. Melonas, J.D., Donna Vanderpool, J.D., Martin G. Tracy, J.D., Tracy R. Gordy, M.D., Chester W. Schmidt, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) discuss 10 key tips to avoiding lawsuits and malpractice, 2) discuss the three most frequent reasons why psychiatrists are successfully sued, and 3) understand different types of malpractice insurance and which one is best for the participant.

SUMMARY:

This is Part 1 in a three-part comprehensive course that provides all the information needed to launch a successful private practice. It is composed of two workshops and one symposium, all on one day, and has been offered for the last six years and directed by faculty who have succeeded using this information. Even if the participant is not in private practice, this course offers lots of useful information to assist in launching a career. The material is constantly updated with up-to-the-minute solutions from the faculty, who have thriving practices. Part 1 focuses on risk management, avoidance of malpractice suits, ways to maximize quality, and high-risk issues that must be addressed in private practice. Drs. Callahan and Young are joined by experts in the field Jackie Melonas, J.D., Vice President, Risk Management, Professional Risk Management Services; Martin Tracy, J.D., President/CEO, Professional Risk Management Services; and Donna Vanderpool, J.D., Professional Risk Management Services. Other sessions cover coding for maximum billing, marketing, office location and design, streamlining the practice, and business/financial principles.

REFERENCES:

1. Molloy P: Entering the Practice of Psychiatry: A New Physician's Planning Guide. Roerig and Residents, 1996.
2. Practice Management for Early Career Psychiatrists. Washington, DC, APA Office of Healthcare Systems and Financing, 1998.

Issue Workshop 40
MY NAME IS WALTER JAMES CROSS

Chairperson: David L. Dawson, M.D., *231 Bay Street North, Hamilton, ON L8R 2R1, Canada*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session the participant should be able to recognize and be able to use in their teaching of students and the general public a powerful tool for conveying an accurate and sympathetic depiction of schizophrenia.

SUMMARY:

My Name is Walter James Cross is a 55-minute docudrama written and directed by David Dawson, psychiatrist and novelist/filmmaker. A man makes his way to the stage of an abandoned theater and tells the story of his lifelong struggle with schizophrenia to an imaginary audience of the important people in his life. The production has been highly rated by reviewers, and by people who suffer from schizophrenia and their families, as a powerful, yet honest and accurate depiction of the illness.

REFERENCES:

1. Gabbard GO, Gabbard K: Psychiatry and the Cinema. Washington, DC, American Psychiatric Press, 1999.
2. Dawson D, Blum H, Bartolucci G: Schizophrenia in Focus. Human Sciences Press, 1983.

Issue Workshop 41
ONLINE VIDEO GAMES: PSYCHOPATHOLOGICAL OR PSYCHOTHERAPEUTIC?

Co-Chairpersons: Jeffrey N. Wilkins, M.D., *Department of Psychiatry, Cedars-Sinai Medical Center, 8730 Alden Drive, Suite 301, Los Angeles, CA 90048,* Jack Kuo, M.D., *Cedars-Sinai Medical Center, 8730 Alden Drive, W101, Los Angeles, CA 90048-3443*
Participants: William Huang, M.D., Kimberly S. Young, Ph.D., Kurt Squire, Ph.D., Stephanie M. Stewart, M.D., Maressa H. Orzack, Ph.D., Constance Steinkuehler, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the possible risks and appreciate the potential benefits of the online videogame phenomenon through an interactive, multimedia presentation involving experts on both Internet addiction and videogame development.

SUMMARY:

Experts in treatment of "Internet addiction" and in gaming development critically review the evidence-based research evaluating the possible risks and potential benefits of online videogames. A literature search of MEDLINE, PsychINFO and Internet search engines was performed of articles from 1983 to 2003. Case reports suggest that engagement in online videogames can become "addictive" and may contribute to antisocial behavior, including violence. Selected individuals may manifest behaviors consistent with a dependence process: continual increase in the activity, inability to cut down, substitution of the activity for work and social activities, and continued play despite awareness of associated problems. Yet, the literature also demonstrates that potential benefits of online videogames may far outweigh their risk to some persons. Online videogames have the potential to provide innovative opportunities for cultivating teamwork and supportive social networks. In addition, online videogames are at the earliest stages of development as potential diagnostic and therapeutic tools. A review of the literature reveals a contrast of possible risks with realized and potential benefits. Future development of online videogames may contribute to the understanding of

emotional and cognitive development, as well as provide innovative, interactive means of educating, evaluating, and treating patients.

REFERENCES:

1. Squire K: Cultural framing of computer/video games. International Journal of Computer Game Research 2002; 2(1).
2. Young KS: Cyber disorders: the mental health concern for the new millennium. Cyberpsychology and Behavior 2000; 2:475–479.

Issue Workshop 42
INFERTILITY: A CHRONIC ILLNESS WITH CHRONIC CHALLENGES

Chairperson: Roxanne C. Dryden-Edwards, M.D., *National Center for Children and Families, 6301 Greentree Road, Bethesda, MD 20817*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to 1) recognize the prevalence of infertility, its causes, and traditional and alternative treatment interventions; 2) understand the emotional, interpersonal, spiritual, and financial challenges associated with infertility; and 3) understand ways to support infertility sufferers in clinical practice.

SUMMARY:

Infertility is a chronic condition defined as an inability to conceive and/or carry a fetus to term after trying to do so for more than one year. It affects 10% of adults of childbearing age or about 8 million people in the United States alone. Of those individuals, 40% will experience emotional distress with long-term impact. When the partners of affected individuals are considered, infertility influences the lives of one of every five couples. Given the myriad of medical emotional, spiritual, interpersonal, and financial stresses this condition can produce, it is important for mental health professionals to be knowledgeable about infertility and ways to support its sufferers. Dr. Dryden-Edwards describes medical conditions that cause infertility and the treatments involved. The highly debated issue of using alternative medical interventions is discussed. The various morbidities associated with the conditions and their treatment are presented in detail. The presentation concludes with specific guidance to mental health professionals regarding interventions for infertile individuals and their families.

REFERENCES:

1. Dryden-Edwards RC: Infertility From Both Sides of the Stethoscope: A Guide From a Doctor Who's Been There. Bethesda, Md, National Center for Children and Families, 2003.
2. Wesson N: Alternative Infertility Treatments. London, Vintage/Ebury, 1997.

Issue Workshop 43
VALUES-BASED TREATMENT OF RELATIONAL DISORDERS

Co-Chairpersons: Glenn N. Siegel, M.D., *Elmhurst Healthcare, 183 North York Road, Elmhurst, IL 60126,* Mary Pittman, M. S., *Elmhurst Healthcare, 183 North York Road, Elmhurst, IL 60126*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to 1) describe the values-based approach to the treatment of personality disorders, 2) implement the use of this model in his/her own clinical setting, and 3) address severe destructive behaviors in patients according to this values-based model.

SUMMARY:

The presenters' extensive experience in the programmatic treatment of personality disorders has led them to reconceptualize this diagnostic category as disorders of relationship. The common denominator in all relational disorders is varying degrees of disconnection from self and others. This state of disconnection is expressed through psychiatric symptoms, interpersonal disruption, and self-destructive behaviors. An innovative treatment model based on relational values has been developed and successfully implemented to guide individuals with relational disorders toward developing authentic connection to self and others. The model is discussed in depth, with an example of a case history application. The simplicity of the paradigm demystifies the therapeutic process and creates a culture of collaboration between patient and therapist(s). The content of this workshop is expected to stimulate discussion and reevaluation of traditional therapeutic approaches to the treatment of personality disorders.

REFERENCES:

1. Leichsenring F, Leibing E: The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: a meta-analysis. Am J Psychiatry 2003; 160: 1223–1232.
2. Rice AH: Interpersonal problems of persons with personality disorder and group outcomes. Int J Group Psychotherapy 2003; 53:155–175.

Issue Workshop 44
ORAL BOARDS BOOT CAMP

Co-Chairpersons: Elyse D. Weiner, M.D., *SUNY Downstate, 113 University Place #1010, New York, NY 10003,* Eric D. Peselow, M.D., *Department of Psychiatry, New York University School of Medicine, 32 Bassett Avenue, Brooklyn, NY 11234*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session the participant should be able to begin developing a comprehensive personal strategy for studying and taking the oral boards examination in psychiatry.

SUMMARY:

Oral Boards Boot Camp is a comprehensive, interactive approach to making oneself into an attractive boards candidate. The chairpersons present a comprehensive strategy for boards preparation, including a study timeline, how to practice, doing the interview, and fielding questions. This presentation is detailed oriented and includes tips such as how to relate to both patients and examiners, how to make the travel experience more comfortable, and how to dress. Diplomates are invited to attend the workshop and share their stories. Candidates are encouraged to ask questions throughout the presentation. Through this intensive shared experience, candidates have the opportunity to develop their own individual strategy. A long-term personal strategy that candidates can further develop over the months prior to taking the boards allows confidence to increase and anxiety to decrease. Oral Boards Boot Camp provides a structured setting with lively discussion for future examinees to make themselves into perfect boards candidates.

REFERENCES:

1. Morrison J, Munoz RA: Boarding Time: A Psychiatry Candidate's Guide to Part II of the APBN Examination. Washington, DC, American Psychiatric Press, 1996.
2. Strahl NR: Clinical Study Guide for the Oral Boards in Psychiatry. Washington, DC, American Psychiatric Press, 2001.

Issue Workshop 45

STEROID ABUSE: GROWING PROBLEM FOR ADOLESCENTS AND A HIDDEN PROBLEM FOR ADULTS

Collaborative Session With the National Institute on Drug Abuse

Chairperson: Donald R. Vereen, Jr., M.D., *NIDA, NIH, DHHS, 6001 Executive Boulevard, #5274, MSC 9581, Bethesda, MD 20852-3831*
Participants: Gary I. Wadler, M.D., Harrison G. Pope, Jr., M.D., Linn Goldberg, M.D., Diane L. Elliot, M.D.

EDUCATIONAL OBJECTIVE:

At the end of this workshop session, the participant should be able to recognize the signs, symptoms, and extent of steroid abuse; identify the motivations for steroid abuse and the psychiatric consequences; recognize the importance of screening for abnormal perceptions of body image in steroid abuse; and identify research-based interventions for preventing initiation and escalation of steroid abuse.

SUMMARY:

The abuse of anabolic steroids is a hidden and growing drug abuse problem in the United States. According to an epidemiology study funded by the National Institute on Drug Abuse, steroid abuse among high school seniors has doubled in the last 10 years. Recent research suggests that the motivation for the abuse of illicitly obtained steroids may not be limited to the enhancement of muscle bulk, strength, or athletic performance. In addition to these motivations, abnormal perceptions of body image and related obsessive thinking may play a role in steroid abuse for adolescents, as well as young and middle-aged adults. This workshop is intended to engage participants with thought-provoking questions at the beginning of each presentation. These questions are answered during the discussion and review of the 1) types of abused steroids, including those available over the counter; 2) epidemiology of steroid abuse, emphasizing the increased incidence of abuse by adolescents (in particular girls) and other populations such as adult body builders; 3) underlying motivations for use, especially motivations concerning distorted body image; 4) psychiatric consequences of use, including "roid rage" and psychiatric issues related to body disfigurement; and 5) research on successful efforts to prevent initiation and escalation of steroid and related drug abuse among student athletes.

REFERENCES:

1. Goldberg L, MacKinnon DP, Eliot D, Moe E, Clarke G, Cheong J: The adolescents training and learning to avoid steroids program: preventing drug use and promoting health behaviors. Arch Ped Adol Med 2002; 154:332–338.
2. Pope HG, Kouri EM, Hudson, MD: Effects of supraphysiologic doses of testosterone on mood and aggression in normal men. Arch Gen Psych 2000; 57:133–140, 2000.

Issue Workshop 46

ENGAGING THE HOMELESS IN TREATMENT STRATEGIES AND RESULTS

Chairperson: John S. McIntyre, M.D., *Department of Psychiatry, Unity Health System, 81 Lake Avenue, 3rd Floor, Rochester, NY 14608*
Participants: Kevin McIntyre, M.D., Linda Morgan, Ph.D., Odysseus Adamides, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) recognize major issues involved in engaging homeless persons in mental health and chemical dependence treatment, 2) understand useful strategies and programs for the care of these individuals, and 3) understand strategies for evaluation of these programs.

SUMMARY:

The number of homeless individuals and families is rising in most urban settings. It has been clearly documented that at least 25% of individuals who have recurring episodes of homelessness have a serious mental illness. Several studies have demonstrated the need for integrated mental health and substance abuse treatment for this population. Effective mental health services for the homeless require a broader base of knowledge and social system expertise than is traditionally required of the mental health professional. Although diagnostic and traditional treatment expertise are necessary for success, professionals also need knowledge and understanding of the special needs and challenges of the homeless mentally ill in order to provide effective treatment. The Assertive Community Treatment (ACT) model has been demonstrated to be effective in engaging this population in treatment and in continuing treatment. In this workshop, a program in Rochester, New York, that uses this model is discussed, and some of the lessons learned are described. Also, a program in Boston that involves a rotation for psychiatric residents is reviewed.

REFERENCES:

1. Dixon L, Wieden P, Torres M, Lehman A: Assertive community treatment and medication compliance in the homeless mentally ill. Am J Psychiatry 1997; 154:1302–1304.
2. Drake RE, McHugo GJ, Clark RE, Teague GB, Xie H, Miles K, Ackerson TH: Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: a clinical trial. Am J Orthopsychiatry 1998; 68:201–215.

Issue Workshop 47

NEW TECHNOLOGIES FOR THE ASSESSMENT OF ADHD

Co-Chairpersons: Martin H. Teicher, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478,* Gianni L. Faedda, M.D., *Lucio Bini Mood Disorder Center, 245 East 50th Street, Suite 2A, New York, NY 10022*
Participants: Carl M. Anderson, Ph.D., F. Xavier Castellanos, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to discuss and understand new technologies being used to study ADHD and should have an appreciation of their potential clinical utility.

SUMMARY:

New techniques that provide objective measures of behavior and brain function are being used to assess children with attention-deficit hyperactivity disorder (ADHD). Four of these technologies are introduced, and evidence is provided regarding their utility and applicability. Actigraphy and biological rhythm analysis are described, and data are presented on their potential to discriminate between children with early-onset bipolar disorder and children with classic ADHD. Near-infrared motion analysis coupled with continuous performance testing is described as a means of monitoring the onset, time-course, and duration of stimulant effects in children with ADHD. T2-relaxometry-based functional magnetic resonance imaging is described as a means of assessing steady-state medication effects on regional cerebral blood flow in pediatric patients with ADHD. Dynamic near-infrared optical tomography is explained and introduced as a novel tool that uses laser light to monitor moment-to-moment changes in cortical oxy- and deoxyhemoglobin levels (functional brain activity) using equipment that could reside in a practitioner's office. After these technologies have been introduced, their limitations, current

availability, clinical applicability, and future role in the evaluation and monitoring of children with ADHD are discussed.

REFERENCES:

1. Teicher MH: Actigraphy and motion analysis: new tools for psychiatry. Harvard Review of Psychiatry 1995; 3:18–35.
2. Anderson CM, Polcari A, Lowen SB, Renshaw PF, Teicher MH: Effects of methylphenidate on functional magnetic resonance relaxometry of the cerebellar vermis in children with ADHD. American Journal of Psychiatry 2002; 159:1322–1328.

Issue Workshop 48
EMERGING PHARMACOTHERAPIES FOR TREATMENT OF STIMULANT DEPENDENCE Collaborative Session With the National Institute on Drug Abuse

Chairperson: Francis J. Vocci, Ph.D., *NIDA/NIH/HHS, 6001 Executive Boulevard, Room 4123, Bethesda, MD 20892-9551*
Participants: Steven Shoptaw, Ph.D., Kyle M. Kampman, M.D., Frances R. Levin, M.D., Stephen L. Dewey, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the current state of the science in the pharmacotherapy of stimulant dependence.

SUMMARY:

The development of pharmacotherapies for stimulant dependence is the highest priority of the Division of Treatment Research and Development of the National Institute on Drug Abuse. One approach is to translate basic science findings into clinical testing. Stimulant drugs of abuse differ from opiates in their administration patterns. Abuse of stimulant medications, rather than producing satiation, actually "primes" the user to administer more of the drug. Blockade of the "priming response" is thus seen as an appropriate medications target to interrupt the priming and prevent binge use. The preclinical evidence for the GABA (B) receptor as a pharmacological target for stimulant medications, including antagonism of priming, is presented by Stephen Dewey. Steve Shoptaw reviews the results obtained with baclofen, a GABA B agonist, in cocaine-dependent patients. Another approach involving clinically-based rationales with already marketed medications in appropriate stimulant-dependent subpopulations has started to yield positive results. Two examples of this approach are given. Frances Levin discusses clinical study results of potential medications in cocaine abusers with comorbid adult attention-deficit/hyperactivity disorder. Kyle Kampman discusses clinical study results with topiramate, a marketed antiepileptic medication, in cocaine-dependent patients.

REFERENCES:

1. Ashby CR, et al: Implication of the GABA (B) receptor in gamma vinyl-GABA's inhibition of cocaine-induced increases in nucleus accumbens dopamine. Synapse 1999; 31:151–153.
2. Levin FR, et al: Bupropion treatment for cocaine abuse and adult attention-deficit/hyperactivity disorder. J Addict Dis 2002; 2:1–16.

Issue Workshop 49
UPDATE ON HEPATITIS C AND PSYCHIATRIC ISSUES

Co-Chairpersons: Andrew F. Angelino, M.D., *Johns Hopkins University, 4940 Eastern Avenue, A4C-461A, Baltimore, MD 21224,* Glenn J. Treisman, M.D., *Johns Hopkins University, 600 North Wolfe Street, Meyer 4-119, Baltimore, MD 21287*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to demonstrate an understanding of the natural history, routes of transmission, and treatment of hepatitis C infection, as well as the psychiatric issues that complicate treatment and propagate the epidemic.

SUMMARY:

Hepatitis C infection has an estimated prevalence of nearly 6 million cases in the United States. Psychiatric patients are vulnerable to acquiring hepatitis C infection. Treatments for hepatitis C infection containing alpha interferon lead to new or worsening psychiatric symptoms in many patients. This workshop presents an update on medical information about hepatitis C virus; their epidemiology, transmission, and the natural history of the infection; and the treatment algorithm. The presenters discuss the comorbidities of psychiatric disorders and substance use disorders as barriers to effective treatment and present the consensus on management of psychiatric complications in hepatitis C/interferon treatment. At the end of this presentation, participants are given the opportunity to discuss the psychiatric management of patients infected with hepatitis C and the recommendations regarding the timing and nature of interferon therapy.

REFERENCES:

1. Angelino AF, Treisman GJ: Psychiatric factors affecting HIV/HCV coinfected patients. HIV/HCV Coinfection Monthly 2002; 1(7):1, 4–9.
2. Straits-Tröster KA, Sloan KL, Dominitz JA: Psychiatric and substance use disorder comorbidity with hepatitis C. Psychiatric Annals 2003; 33:362–366.

Issue Workshop 50
FIBROMYALAGIA: CURRENT UNDERSTANDING AND FUTURE DIRECTIONS

Chairperson: Alan Z.A. Manevitz, M.D., *Payne Whitney New York Psychiatric Hospital, 525 East 68th Street, New York, NY 10022*
Participant: James P. Halper, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to diagnose fibromyalgia, to be aware of approaches to current and future clinical treatment of fibromyalgia, and to understand the pathophysiology of fibromyalgia and new research on fibromyalgia.

SUMMARY:

Fibromyalgia syndrome (FMS) is a common, chronically painful, frequently disabling disorder of unknown origin. Epidemiologic data indicate that FMS affects at least 2% of the general population in the United States (approximately 5 million persons). Six percent to 10% of all individuals in a medical physician's waiting room may have FMS. In addition to meeting the pain classification criteria, FMS patients report a variety of other clinical symptoms, including psychiatrically relevant anxiety, depression, headaches, and dysfunctional sleep. Fibromyalgia is associated with high rates of disability, increased health care utilization, frequent psychiatric consultations, and a high number of lifetime psychiatric diagnoses. More and more patients with this frustrating disorder present themselves or are referred to psychiatrists and/or even receive a diagnosis for the first time from a psychiatrist and are treated with psychotropic medication. In the past there was a common perception that FMS was just a manifestation of depression. According to current estimates, the prevalence of depression in FMS is about 40%. The pain associated with FMS appears to involve many physiologic components of nociception, and the earlier perception that patients were psychosomatic malingerers has been replaced by the recognition of neurophysiological abnormalities such as abnormal brain imaging findings and abnormal levels of CSF substance P. This presentation gives presenters and audience members the opportunity to share cases of psychiatric

disorder and abnormal pain so the participants will 1) be better able to recognize and diagnose FMS, 2) learn up-to-date clinical approaches to treatment of this complex disorder, and 3) learn about new research findings that indicate FMS is a primary CNS disorder and thus may be better treated by psychiatrists than by rheumatologists.

REFERENCES:

1. Leventhal LJ: Management of fibromyalgia. Ann Intern Med 1999; 131:850–858.
2. Staud R: Domingo M: Evidence of abnormal pain processing in fibromyalgia syndrome. Pain Medicine 2001; 2:208–245.

Issue Workshop 51
THE ART OF THE UNCONSCIOUS: SHAKESPEARE, POETRY, FILM, AND PSYCHIATRY

Co-Chairpersons: Steven E. Pflanz, M.D., *Department of Psychiatry, U.S. Air Force Base, 4348 Prestwick Road, McGuire AFB, NJ 08641,* Charles R. Joy, M.D., *4406 Sunnydale Boulevard, Erie, PA 16509-1651*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand that the various forms of art are windows into the human unconscious and examine both literature and the performing arts for the connection between art and the unconscious.

SUMMARY:

Theater, film, literature, and poetry are forms of expression that allow artists and their audiences to explore the compelling issues of their lives. On a very basic level, the various forms of art are windows into the emotions and impulses that populate the human unconscious. In a real sense, art, both in its creation and its enjoyment, can be as healing for the psyche as psychotherapy. This workshop examines the role of drama and literature in both the professional and personal lives of psychiatrists. The themes explored in literature help in understanding from a different perspective the difficult issues that patients grapple with in therapy. The films, poems, and plays that we find most gripping or poignant tell us something about our own unconscious world and help us reach a greater degree of self-understanding. In creating our own poetry or performing in theater, we are revealing something of ourselves to others that is important for us to share. In this workshop, the audience members listen to readings of poetry, view short film clips, and discuss each piece as it is presented. The material chosen contains universal themes touching on human lives. The poetry readings include selections from the presenters' writings as well as from the presenters' favorite poets. A short performance of a classic scene from Shakespeare is provided by the two facilitators. Throughout the workshop, opportunities are provided for the audience to participate in a lively discussion exploring the connection between art and the unconscious for both psychiatrists and their patients.

REFERENCES:

1. Joy CR: What if Lashika. The Pharos 1999; 1:8.
2. Pflanz SE: Winter's Ill Wind. West Virginia Medical Journal 2000; 96:573.

Issue Workshop 52
THE IMPACT OF 9/11 ON PSYCHIATRIC RESIDENTS AND TRAINING PROGRAMS

Chairperson: Renato D. Alarcon, M.D., *Department of Psychiatry, Mayo Clinic Medicine School, 200 First Street, SW, GE-M-W, Rochester, MN 55905*
Participants: Nyapati R. Rao, M.D., Maria A. Oquendo, M.D., Milton Kramer, M.D., Anne O'Connell, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to assess and recognize the emotional/psychological effects of 9/11 on the personal and professional experience of psychiatric trainees and on the role, structure, and operations of their training programs.

SUMMARY:

The impact of the September 11, 2001, attacks has been multidimensional in all layers, groups, and communities across American society. Psychiatric residents are in a unique position regarding this phenomenon, both due to their cultural diversity (high numbers of international medical graduates, for instance) and to the stage of their personal and professional trajectories. In this workshop the presenters discuss the variety of psychological, emotional, and sociocultural issues explored through 1) the clinical and professional experience of the participants, 2) "town hall" meetings with residents of three Northeastern residency training programs, and 3) a survey aimed at assessing the impact of 9/11 on the same residents' self-perceptions and interactions with patients, peers, supervisors, and the public at large. Some of these results are compared with findings from resident groups in other parts of the country. The audience is given the opportunity to comment on the results and eventual corrective or management interventions.

REFERENCES:

1. McFarlane AC: Posttraumatic stress disorder: a model of the longitudinal course and the role of risk factors. J Clin Psychiatry 2000; 61:15–20.
2. Alarcon RD: Trastorno por estrés post-traumático: estudios en veteranos de guerra norteamericanos y su relevancia para America Latina. Rev Chil Neuro-Psiquiat 2002; 40:35–47.

Issue Workshop 53
IMPLEMENTING THE INSTITUTE OF MEDICINE REPORT: FOSTERING RESEARCH CAREERS VIA RESIDENCIES

Chairperson: Joel Yager, M.D., *Department of Psychiatry, University of New Mexico, School of Medicine, 1 University of New Mexico, Albuquerque, NM 87131-5326*
Participants: Wayne S. Fenton, M.D., Regina S. James, M.D., John F. Greden, M.D., Joel J. Silverman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to discuss plans of major stakeholders (including the NIMH, APA, Residency Review Committee, and American Association of Chairmen of Departments of Psychiatry) for implementing the Institute of Medicine's recommendations regarding increasing psychiatric research careers via residency training and beyond.

SUMMARY:

The Institute of Medicine's report on integrating research into residency training appeared in the fall of 2003, offering a number of specific recommendations to the field designed to improve the recruitment, training, and retention of psychiatric residents involved in careers devoted to patient-oriented research. This workshop focuses on disseminating and implementing these recommendations.

To start, the major recommendations are presented. Panelists representing the primary stakeholders and consumers of the report, including adult and child areas of the National Institutes of Mental Health, the Council of Research of the American Psychiatric Association, the Residency Review Committee of the Accreditation Council for Graduate Medical Education, and the American Association of Chairmen of Departments of Psychiatry, describe how their organizations and constituents view the recommendations and how they plan to respond and implement the recommendations.

REFERENCES:

1. Abrams MT, Patchan KM, Boat TF (eds): Research Training in Psychiatry Residency: Strategies for Reform. Washington, DC, National Academies Press, 2003.
2. Kupfer DJ, Hyman SE, Schatzberg AF, Pincus HA, Reynolds CF 3rd: Recruiting and retaining future generations of physician scientists in mental health. Arch Gen Psychiatry 2002; 59:657–660.

Issue Workshop 54
A SHARED-CARE MODEL FOR TREATING THE HOMELESS MENTALLY ILL

Chairperson: Samuel Packer, M.D., *Centre for Addiction and Mental Health, 1001 Queen Street West, Toronto, ON M6J 1H4, Canada*
Participants: Carol Zoulalian, M.A., Sharon Gazely, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should have an understanding of the organization and function of a team that addresses the physical and psychiatric needs of the homeless mentally ill.

SUMMARY:

To its advantage, the shared care model of health care delivery offers the flexibility to address mental health issues in marginalized populations. The Shared Care Service at the Centre for Addiction and Mental Health (CAMH) in Toronto provides care to a portion of the homeless population in the downtown core of this large metropolitan city. In several shelters, drop-ins, and a housing program for the homeless, a mental health team consisting of a family physician, a psychiatric nurse, and mental health worker assess and treat patients. Psychiatrists act as consultants to these teams, making regular visits to the community sites for direct and indirect consultation, and are available by telephone at other times. This model offers the opportunity to address mental health needs in the context of what may be more readily accepted visits to a family physician. One obvious advantage is that physical ailments that may affect mental health may be more readily addressed in what is usually a more comfortable environment, lacking the formality of a hospital or a doctor's office.

This workshop provides participants with an opportunity to discuss the organization of the team and its relationship to its partners, how the team functions, and the role of the psychiatric consultant.

REFERENCES:

1. Craven MA, Bland R: Shared mental health care: a bibliography and overview. Can J Psychiatry 2002; 47(2 Suppl 1):iS–viiiS, 1S–103S.
2. Goldberg D, Jackson G, Gater R, et al: The treatment of common mental disorders by a community team based in primary care: a cost-effectiveness study. Psychol Med 1996; 26:487–492.

Issue Workshop 55
GROUP INTERVENTIONS WITH ADOLESCENTS IN OUTPATIENT, INPATIENT, AND SCHOOL SETTINGS

Chairperson: Fady Hajal, M.D., *Stony Lodge Hospital, 40 Croton Dam Road, Ossining, NY 10562*
Participant: Saul Scheidlinger, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize and utilize the special motivational forces operative in adolescent groups toward change and growth, prepare individual adolescents for a group treatment experience, organize and conduct adolescent groups, and know when to introduce additional treatment modalities.

SUMMARY:

Designed for persons with at least one year's experience in group work with adolescents, this workshop focuses on current conceptual and technical issues in the group treatment of adolescents in clinical and in high school settings. Long- and short-term traditional therapy groups are contrasted with expressive-supportive and cognitive behavior models. The differential needs of early and of late adolescents are considered. Selection and preparation of group members are discussed, together with appropriate leadership behaviors applicable to the nature of the target population and of the treatment context. Special attention is given to groups designed for trauma and loss and to the development of social skills, as well as to alcohol and nicotine abuse. The pros and cons of co-leadership and of adding other treatments (i.e., individual, family, drug interventions) are also considered. The workshop's format is designed to encourage the sharing of work experiences and of participants' questions.

REFERENCES:

1. Aronson S, Scheidlinger S: Group therapy for adolescents, in The Hatherleigh Guide to Child and Adolescent Therapy. New York, Hatherleigh Press, 1996.
2. Kymissis P, Halperin AD (eds): Group Work with Children and Adolescents. Washington, DC, American Psychiatric Press, 1996.

Issue Workshop 56
ADDICTION RESEARCH AS A CAREER CHOICE IN PSYCHIATRY
Collaborative Session With the National Institute on Drug Abuse

Chairperson: Ivan D. Montoya, M.D., *NIDA, 6001 Executive Boulevard, Room 4145, Bethesda, MD 20892-9651*
Participants: Herbert D. Kleber, M.D., Douglas M. Ziedonis, M.D., Ronald L. Cowan, M.D., Nathalie Maullin, M.D., Kathleen T. Brady, M.D., Charles P. O'Brien, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the opportunities and challenges of pursuing a career in addiction research psychiatry.

SUMMARY:

The purpose of this workshop is to discuss issues related to the opportunities and challenges in developing a career in addiction research in psychiatry. During this workshop, psychiatrists who are at different stages of career development in the field of addiction research will discuss some of their reasons for choosing a career in addiction psychiatry, opportunities and challenges faced by addiction research psychiatrists, the training and funding opportunities available, and the vision of the future for career development and new and innovative research in this field. The workshop is designed to

provide ample time for questions and an interactive discussion between the workshop participants and the speaker panel. The workshop is expected to be attended by clinicians interested in pursuing a career in addiction psychiatry research as well as junior and mid-career investigators exploring opportunities in addiction research.

REFERENCES:

1. Montoya ID, Herbeck DM, Svikis DS, Fitek DJ, Marcus SC, Pinus HA: Demographic and practice characteristics of psychiatrists who primarily treat patients with substance use disorders. Am J Addict 2003; 12:181–192.
2. Karam-Hage M, Nerenberg L, Brower KJ: Modifying residents' professional attitudes about substance abuse treatment and training. Am J Addict 2001; 10:40–47.

Issue Workshop 57
IT DOESN'T HAPPEN TO US: EXPLORING TRAUMA AND RESILIENCY IN MINORITIES

Co-Chairpersons: Napoleon B. Higgins, Jr., M.D., *Department of Psychiatry, Bay Pointe BHS, Inc., 412 Stockbridge Lane, Dickinson, TX 77539,* Lacresha L. Hall, M.D., *University of Miami, 17440 N.W. 67th Place, Miami, FL 33015-5843*
Participants: Jean-Marie E. Alves-Bradford, M.D., Eric R. Williams, M.D., Aruna S. Rao, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to 1) recognize minority coping mechanisms to stress and trauma in African American, Latino, Asian, and refugee communities in the United States; 2) be aware of unique perceptions and expressions of trauma in minority communities; and 3) enhance outreach efforts to improve care for the minority patient.

SUMMARY:

The purpose of this workshop is to present a novel minority perspective on issues regarding trauma and resiliency. The presenters specifically focus on the views of African American, Latino, Asian, and refugee communities in the United States. Currently, psychiatry is focusing on cross-cultural differences and disparities in treatment, assessment, and diagnosis in minority groups. What makes this talk unique is that it distinctively concentrates on resiliency and coping mechanisms in minority communities and on how they view trauma, communicate symptoms, and resist acceptance of mental illness. The presenters discuss obstacles in seeking treatment, including cultural and language barriers, as well as difficulties in the therapeutic alliance between the patient and physician. Many cultures deny that mental illness occurs in their population and often believe that it is a "white American majority" problem that does not affect them. By the end of this workshop, the participant should know how to identify resilient factors within minority groups, coping mechanisms, and cultural barriers to treatment and how to facilitate exchange between mental health professionals and the minority community. The goal of this workshop is to advance effective intervention, education, and advocacy for minority populations.

REFERENCES:

1. Ziguras S, Klimidis S, Lewis NS, Stuart G: Ethnic matching of clients and clinicians and use of mental health services by ethnic minority clients. Psychiatric Services 2003; 54:535–541.
2. Barbarin OA: Coping and resilience: exploring the inner lives of African American children. Journal of Black Psychology 1993; 9:478–492.

Issue Workshop 58
CUTTING-EDGE MANAGEMENT OF TOURETTE'S DISORDER AND ITS COMORBIDITIES

Co-Chairpersons: Cathy L. Budman, M.D., *Department of Psychiatry, North Shore—LIJ Health System, 400 Community Drive, Manhasset, NY 11030,* John T. Walkup, M.D., *Department of Psychiatry, Johns Hopkins School of Medicine, 600 North Wolfe Street, CMSC 314, Baltimore, MD 21287-3325*
Participants: Anthony L. Rostain, M.D., Fred Penzel, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion, the participant will be able to diagnose and treat affective disorders, including mood disorders, non-OCD anxiety disorders, and explosive outbursts that are common comorbidities in Tourette's disorder. Exploration of complex cases, specific targeted polypharmacological strategies, and impact on tics will be discussed.

SUMMARY:

A major clinical challenge in treating Tourette's disorder is the diagnosis and management of its common psychiatric comorbidities. Affective disorders, obsessive-compulsive disorder (OCD), non-OCD anxiety disorders, and attention-deficit hyperactivity disorder (ADHD) occur at significant frequency among most Tourette's disorder populations, often causing greater, more persistent morbidity than the primary tic disorder. Some of these disorders subtly differ phenomenologically when they present with comorbid tics and pose special treatment challenges. Underrecognition of these comorbidities and concern about exacerbating the underlying tic diathesis contribute to inadequate treatment of debilitating symptoms that can be effectively targeted by using modern management strategies with both medication and cognitive behavior interventions. The purpose of this workshop is to highlight recent advances in diagnosis and treatment of affective disorders, OCD, and ADHD in patients with comorbid tic disorders. A review of recent literature, rating scales, and actual cases by clinicians with expertise in the treatment of complicated Tourette's disorder are presented to enable the participant to appreciate the significance of psychiatric comorbidity in Tourette's disorder and to identify appropriate medication and cognitive behavior treatment options.

REFERENCES:

1. Walkup JT: The psychiatry of tourette syndrome. CNS Spectrums 1999; 4:54–61.
2. Budman C, Feirman L: The relationship of Tourette's syndrome with its psychiatric comorbidities: is there an overlap? Psych Ann 2001; 31:541–548.

Issue Workshop 59
APPROACHING MORAL ISSUES IN MENTAL HEALTH TREATMENT

Chairperson: John R. Peteet, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 02115*
Participants: Martha Jurchak, Ph.D., Leigh C. Bishop, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize moral challenges inherent in clinical work and the usefulness of a paradigm based on moral functioning for approaching these challenges.

SUMMARY:

Psychiatrists often struggle to understand their role in patients' moral lives. How much should a therapist intervene with an individual who is harming herself or others? How can therapists help patients

who are deciding whether it is right for them to divorce, or how much to sacrifice for an aging parent? How should therapists deal with the person who is convinced that the state owes him a living? Clinicians have increasingly recognized the need to look beyond the ethics of autonomy and neutrality for answers to these questions. While attempting to avoid paternalism, they have begun to articulate other therapeutic ideals and to examine the clinical relevance of ethical reasoning, forgiveness, and evil. This workshop considers how moral functioning may provide a framework for addressing moral issues that arise in treatment. After briefly reviewing basic moral capacities, participants use case material to explore approaches to clinical challenges involving caring, ethical dilemmas (e.g. concerning confidentiality, dual relationships, and responsibilities toward victims of personality disordered individuals), unfair pain, guilt/shame, and the phenomena of moral growth and transformation. Panelists with backgrounds in psychiatry, philosophy, and bioethics facilitate discussion designed to clarify the skills necessary for practicing in an optimally integrated way.

REFERENCES:

1. Peteet JR: Doing the Right Thing: An Approach to Moral Issues in Mental Health Treatment. Washington, DC, American Psychiatric Publishing, (in press).
2. Doherty WJ: Soul Searching: Why Psychotherapy Must Promote Moral Responsibility. New York, Basic Books, 1995.

Issue Workshop 60
THE PORTRAYAL OF PSYCHIATRY IN RECENT AMERICAN FILM

Chairperson: Steven E. Pflanz, M.D., *Department of Psychiatry, U.S. Air Force Base, 4348 Prestwick Road, McGuire AFB, NJ 08641*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to critically examine contemporary films with mental health content 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 psychiatrists' profession, it is necessary to examine the images of mental illness and the mentally ill in commercially successful films. In this workshop, the audience discusses the portrayal of psychiatry in contemporary films from the past five years, including *A Beautiful Mind, K-Pax, The Hours, Unfaithful, Antwone Fisher, Analyze That, Mumford,* and *About Schmidt.* Each of these films achieved a certain degree of both critical acclaim and box office success and was seen by millions of Americans. To generate discussion, short film clips from these movies are shown. The majority of the session is devoted to audience discussion of these and other films and of how contemporary film influences the image of psychiatry in America.

REFERENCES:

1. Gabbard GO, Gabbard K: Psychiatry and the Cinema, 2nd Edition. Washington, DC, American Psychiatric Press, 1999.
2. Hesley JW, Hesley JG: Rent Two Films and Let's Talk in the Morning: Using Popular Films in Psychotherapy. New York, Wiley, 1998.

Issue Workshop 61
HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE, PART 2

Co-Chairpersons: William E. Callahan, Jr., M.D., *7700 Irvine Center Drive, Suite 530, Irvine, CA 92618,* Keith W. Young, M.D., *10780 Santa Monica Boulevard, #250, Los Angeles, CA 90025-4749*
Participants: Tracy R. Gordy, M.D., Chester W. Schmidt, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) understand the use of codes for insurance to accurately reflect work with patients, 2) understand documentation requirements consistent with the codes, and 3) know where to go to get updated information on coding throughout his or her career.

SUMMARY:

This is part 2 in a three-part comprehensive course that provides all the information needed to launch a successful private practice. It is composed of two workshops and one symposium, all on one day. It has been offered for the last six years and is directed by faculty who have succeeded by using this information. Even for psychiatrists who are not in private practice, this course offers lots of useful information that will assist them in launching their careers. The material is constantly updated with up-to-the-minute solutions from the faculty, who have thriving practices. Part 2 focuses on the complexities of using the insurance industry's procedure codes to accurately reflect work with patients. Even in a fee-for-service, cash-based practice, many patients require "superbills" for insurance so they can get reimbursed. There are documentation requirements for each code, and not understanding them and following them can lead to prosecution for fraud. Drs. Callahan and Young are joined by two nationally recognized experts on coding, who work with APA and AMA to make these codes and guidelines work. (Chester Schmidt, M.D. and Tracy Gordy, M.D.)

REFERENCES:

1. Practice Management for Early Career Psychiatrists. Washington, DC, American Psychiatric Association, Office of Healthcare Systems and Financing, 1998.
2. Logsdon L: Establishing a Psychiatric Private Practice. Washington, DC, American Psychiatric Press, 1985.

Issue Workshop 62
USING ART AND POETRY: FROM MEDICATION MANAGEMENT TO COUNTERTRANSFERENCE

Chairperson: Charles R. Joy, M.D., *4406 Sunnydale Boulevard, Erie, PA 16509-1651*
Participant: Stuart A. Copans, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize a simple art technique designed to provide important information regarding the patient, appreciate the effectiveness of poetry as an aid to introspection in the therapeutic process, and understand the utility of art and poetry in evaluation and treatment.

SUMMARY:

Among the methodological arrows in the psychiatrist's therapeutic quiver, art and poetry are two to consider when tracking that elusive

quarry, Good Outcome, across the unity of mind and brain. This highly interactive and experiential workshop presents two examples of the use of art and poetry in psychiatry. For art, a practicing artist and child psychiatrist (Dr. Copans) shares the Squiggle Game, a classic technique developed by D.W. Winnicott, and then facilitates an exercise demonstrating the utility of the Squiggle Game in medication management. For poetry, a practicing poet and child psychiatrist (Dr. Joy) presents original poetry drawn from the psychiatric experience, then leads an exercise in which participants themselves experience the power of poetry as a shaft of light, instead of death, piercing the darkness of countertransference, when they have the opportunity to consider their own experience with psychiatry through writing a poem. Additional time is provided for questions and interactions as the group reflects on the vivid affects and sharp cognitions engendered by this consideration of using art and poetry in psychiatry.

REFERENCES:

1. Winnicott DW: Therapeutic Consultation in Child Psychiatry. London, Hogarth Press, 1971.
2. Joy C: Attending psychiatrist. The Pharos 2001; 64(3):28.

Issue Workshop 63
PSYCHIATRIC REHABILITATION AND PSYCHODYNAMICS

Co-Chairpersons: Anand Pandya, M.D., *NYU School of Medicine, 462 First Avenue, 20th Floor Adept PR, New York, NY 10016,* Grace Otto, R.N., *Bellevue Hospital Center, First Avenue & 27th Street, New York, NY 10016*
Participants: Veronica Popoiu, M.S.N., Eric Leventhal, C.S.W., Manuel Trujillo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to identify three psychodynamic techniques/principles that are useful in psychiatric rehabilitation and discuss the limitation of psychodynamic principles in psychiatric rehabilitation.

SUMMARY:

The report of the President's New Freedom Commission on Mental Health has identified the recovery model of psychiatric rehabilitation as an important paradigm for the treatment of severe mental illness. Although much of the recovery and psychiatric rehabilitation literature focuses on atheoretical skills training and cognitive behavior interventions, some clinicians have integrated psychodynamic principles within the daily practice of vocational, prevocational, and social rehabilitation for individuals with severe mental illness. To explore the applicability of psychodynamics in this work, clinicians discuss brief anecdotes of how they conceived and executed such interventions. The audience members are encouraged to consider the "model fidelity" of these interventions to both psychiatric rehabilitation and psychodynamic psychiatry. The audience is also encouraged to suggest other areas where psychodynamic theory or technique fits with the rehabilitation model and to identify risks of such an integrative approach. Finally, the discussant, a senior psychiatrist with exceptional experience in public psychiatry and dynamic therapy, offers his insights on the comments by the panel and the audience.

REFERENCES:

1. Lehman AG, Seinwachs DM: Evidence-based psychosocial treatment practices in schizophrenia: lessons from the Patient Outcomes Research Team (PORT) project. Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry 2003; 31:141–154.
2. Kates J, Rockland LH: Supportive psychotherapy of the schizophrenic patient. Amer J Psychother 1994; 48:543–561.

Issue Workshop 64
MANAGEMENT OF DIFFICULT SCHIZOPHRENIA

Chairperson: Michael Y. Hwang, M.D., *Department of Psychiatry, East Orange VA Medical Center, 385 Tremont Avenue (116A), East Orange, NJ 07018-1095*
Participants: Edward Kim, M.D., Faiq Hameedi, M.D., David P. Folsom, M.D., Samuel G. Siris, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium the participant will be familiar with the current state of knowledge in common and challenging conditions in schizophrenia and able to assess and manage these conditions.

SUMMARY:

Schizophrenia has long been recognized as a spectrum disorder with diverse clinical phenomena and treatment outcomes. Studies suggest diverse neurobiological abnormalities, pharmacological treatment response, and poor psychosocial interaction that challenges clinicians and patients. Emerging evidence suggests that individualized psychosocial treatment approaches result in optimal outcome in schizophrenia. However, clinical, pharmacological, and psychosocial diversities such as comorbid psychiatric conditions, impulsive-aggressive behaviors, and homelessness further challenge clinicians. The workshop reviews recent clinical and research advances and discusses management of some common and challenging problems in schizophrenia. Dr. Siris discusses current research and clinical evidence in management of schizophrenia with severe depression. Dr. Hwang presents neuropsychological and clinical findings in schizophrenia with comorbid anxiety disorders and suggests an optimal treatment strategy. Dr. Hameedi discusses the management of adverse metabolic effects of the new atypical antipsychotic medications, and Dr. Kim reviews and discusses psychosocial interventions in homeless and poorly adherent patients with schizophrenia. Workshop participants are encouraged to participate in discussion at the end of the presentations.

REFERENCES:

1. Hwang MY, Bermanzohn PC (eds): Schizophrenia and Comorbid Conditions. Washington, DC, American Psychiatric Press, 2001.
2. Hwang MY (guest editor): Management of Schizophrenia With Comorbid Disorders. Psychiatric Annals 2000; 30(1).

Issue Workshop 65
THE APPLICATION OF BEDSIDE EXECUTIVE-FUNCTION MEASURES

Chairperson: Jeffrey A. Cordes, M.D., *Department of Psychiatry, UTHSCSA, 7703 Floyd Curl Drive, San Antonio, TX 78229*
Participants: Jason E. Schillerstrom, M.D., Kaustubh G. Joshi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the impact executive function has on clinical care, administer an executive clock-drawing task, and recognize the utility of other executive measures and how to apply them in clinical practice.

SUMMARY:

Executive function is the ability to plan, initiate, sequence, monitor, and stop complex behavior. Executive impairment is generally associated with dementia. However, patients with schizophrenia, major depression, and bipolar disorder also have executive impairment that may be as debilitating as dementia-associated deficits. Functional deficits associated with executive impairment include

poor capacity to consent, poor medication compliance, and poor performance of activities of daily living. However, executive function often is not assessed by clinicians, perhaps because of a perceived lack of convenient executive-function measures. This workshop, which is intended for general adult psychiatrists, introduces the use of the EXIT25 and CLOX. The EXIT25 highly correlates with other executive measures such as the Wisconsin Card Sorting Task. CLOX is more sensitive to executive function than similar clock-drawing tasks. Both tests are easy to administer and score. The workshop begins with a brief overview of the clinical significance of executive function. Copies of the CLOX are distributed to the audience. The audience is invited to participate in an executive clock-drawing task. An interactive video of patients taking the EXIT25 is shown.

REFERENCES:

1. Royall DR, Mahurin RK, Gray KF: Bedside assessment of executive cognitive impairment: the Executive Interview. Journal of the American Geriatrics Society 1992; 40:1221–1226.
2. Royall DR, Cordes JA, Polk M: CLOX: an executive clock drawing task. Journal of Neurology, Neurosurgery, and Psychiatry 1998; 64:588–594.

Issue Workshop 66

THE PSYCHIATRY RESIDENT AS EDUCATOR: A PROPOSAL FOR CURRICULUM AND SUPERVISION

Co-Chairpersons: Ruth M. Lamdan, M.D., *Department of Psychiatry, Temple University School of Medicine, 1316 West Ontario Street, Jones Hall, Philadelphia, PA 19140,* Autumn Ning, M.D., *Temple University School of Medicine, 1316 West Ontario Street, Philadelphia, PA 19140*
Participants: Karriem L. Salaam, M.D., Diane B. Gottlieb, M.D., Edward A. Volkman, M.D., Roya Lewis, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to discuss the existing medical education literature on the role of residents as teachers and design a curriculum to enhance the skills of resident educators.

SUMMARY:

The literature shows that residents spend approximately 20% of their time teaching medical students and junior house staff. The ACGME, in addition to the skills and attributes outlined in the core competencies, has developed guidelines requiring that psychiatry residents have teaching opportunities. Residents are expected to be instructed in appropriate methods of teaching and to have ample opportunity to teach students in the health professions. The standards, process, and outcome measures by which this is to be accomplished remain unclear. The workshop faculty and residents present a series of 15-minute talks/vignettes about the role of the residents in the education of undergraduate and graduate trainees, including 1) residents as teachers of preclinical medical students, 2) residents as supervisors for medical students during their clinical rotations, and 3) senior resident mentorship and supervision of junior house staff. In the remaining time, the audience has the opportunity to discuss the role of residents at their medical schools as well as at affiliate or community teaching hospitals. The workshop allows participants to explore development of a consensus on an educational curriculum for all residents, as well as a proposal for a "chief resident for education."

REFERENCES:

1. Morrison EH, Jafler JP: Yesterday a learner, today a teacher too: residents as teachers in 2000. Pediatrics 2000; 105:238–241.
2. Kaji A, Moorehead JC: Residents as teachers in the emergency department. Annals of Emergency Medicine 2002; 39:316–318.

Issue Workshop 67

INTERFACE BETWEEN PSYCHIATRY AND OBSTETRICS: COMPREHENSIVE PERINATAL CARE

Chairperson: Johannes Bitzer, M.D., *Department of Obstetrics and Gynecology, University Women's Hospital, Spitalstrasse 21, Basle 4031, Switzerland*
Participants: Maria F. Hofecker-Fallahp, M.D., Werner Tschan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize typical perinatal psychiatric and obstetrical problems and make use of multidisciplinary strategies and of systemic approaches in perinatal care of mothers with mental disorders.

SUMMARY:

Mental health issues in pregnancy and the postpartum period are often neglected by obstetricians, just as the puerperal period is foreign to psychiatrists. This places women at risk for undiagnosed mental disorder. At Basle University a comprehensive care program with close cooperation between obstetricians and psychiatrists has been established. In this workshop, Prof. Johannes Bitzer, M.D., head of the Division of psychosomatic obstetrics and gynecology at the Women's Hospital, Basle, discusses the role of the obstetrician in detecting mental disorders in pregnant women. The focus is on instruments for obstetricians to use to detect mental disorders. Examples discussed include posttraumatic stress disorder, affective disorders, personality disorders, and wish for primary caesarian section. The role of the psychiatrist in early perinatal care is discussed by Maria Hofecker, M.D. of the Psychiatric Outpatient Department, University of Basle. The focus is on psychiatric treatment, crisis intervention, parenting assessment, and rehabilitation. Psychiatric follow-up care of the patient, the newborn, and the partner is discussed by Werner Tschan, M.D., a psychiatrist in private practice. The focus is on outpatient care in the community, treatment of the psychiatric disorder, networking, systemic care involving the family, and experiences and techniques in medium-term and long-term care. The workshop includes substantial opportunity for discussion and brief case presentations to enhance practical applicability.

REFERENCES:

1. Tschan W: PTSD in der hausärztlichen Praxis: erkennen-verstehan-behandein. Swiss Medical Forum (in press).
2. Riecher-Roessler A, Hofecker Fallahpour M: Postpartum depression: do we still need this diagnostic term? Acta Psych Scand (in press).

Issue Workshop 68

CLOSING A PSYCHIATRIC PRACTICE: CLINICAL AND RISK-MANAGEMENT ISSUES

Chairperson: Robinette Bell, M.D., *4550 Cherry Creek South Drive, #2309, Denver, CO 80246*
Participants: Donna Vanderpool, J.D., Denny Rodriguez, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to 1) discuss the elements involved in termination of the psychiatrist-patient relationship, 2) recognize the potential professional liability risks involved in closing a psychiatric practice, and 3) develop risk management strategies for managing the clinical and legal risks when closing a practice.

SUMMARY:

Closing a psychiatric practice because of retirement, relocation, a change in employment, or some other reason has many ramifications for the psychiatrist and the patients involved. The clinical issues of terminating the psychiatrist-patient relationship must be managed as well as administrative, business, and legal details. This workshop explores both the clinical impact and the potential professional liability risks inherent in closing a practice. Risk management strategies for minimizing these risks are provided. During this workshop one psychiatrist discusses her personal experience of managing all aspects of closing a clinical practice. The responsibility of the psychiatrist to successfully manage the process of termination for patients who experience this event as unexpected and upsetting is explored. Sharing this experience and discussing the problems that arose can help other psychiatrists who must close a practice. In addition, the psychiatrist and two health care attorneys discuss clinical risk management issues that are part of closing a practice, including but not limited to issues of when to inform patients, documentation of the termination and referral process, contents of a termination letter, managing referrals and medications, storing and securing records after practice closure, and decisions about professional liability insurance coverage. The focus of the workshop is to provide practical solutions for minimizing clinical and legal risks.

REFERENCES:

1. Hickson GB, Federspiel CF, Pichert JW, Miller CS, Gauld-Jaeger J, Bost P: Patient complaints and malpractice risk. JAMA 2002; 287:2951–2957.
2. Termination of the psychiatrist-patient relationship. Rx for Risk 2000; 8(2):1–5.

Issue Workshop 69
REHABILITATING TRAUMATIZED GIRLS IN RESIDENTIAL JUVENILE-JUSTICE SETTINGS

Chairperson: Cheryl D. Wills, M.D., *Department of Psychiatry, Tulane University, 1440 Canal Street, TB53, New Orleans, LA 70112*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the rehabilitative needs of traumatized delinquent girls.

SUMMARY:

In November 2001, Louisiana was at risk of being sued on behalf of the girls residing in its juvenile corrections facilities, based on conditions of confinement, gender equity, and service delivery. This workshop reviews how these concerns were successfully addressed, including how the problem of self-injurious behavior in delinquent adolescent girls decreased from a "public health nightmare" to "virtually nonexistent" within a period of 7 months. The gender-specific movement in juvenile justice is explored, along with information about collaborating with and consulting to juvenile detention and corrections facilities, as well as employee retention, stress management, and program design. The training of mental health and other corrections professionals is reviewed. Participants are encouraged to ask questions, offer suggestions, and share their experiences so that the audience has the opportunity to explore the rehabilitation question from a variety of perspectives and experience levels.

REFERENCES:

1. Al-Mateen CS: Effects of witnessing violence on children and adolescents, in Principles and Practice of Child and Adolescent Forensic Psychiatry. Edited by Schetky DM, Benedek EP. Washington DC, American Psychiatric Publishing, 2002, pp 213–224.
2. Connor DF: Aggression and Antisocial Behavior in Children and Adolescents: Research and Treatment. New York, Guilford Press, 2002.

Issue Workshop 70
THE OUT-OF-THE-SHADOW PROJECT

Co-Chairpersons: Edward F. Foulks, M.D., *Tulane University, School of Medicine, 1430 Tulane Avenue, SL 97, New Orleans, LA 70112-2699,* Susan E. Smiley, *NAMI, 4156 Neosho Avenue, Los Angeles, CA 90066*
Participants: Suzanne E. Vogel-Scibilia, M.D., Stephen M. Goldfinger, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to educate residents and others about the devastating vicissitudes of isolation, loss of productivity, and problems with housing experienced by persons with a severe and persistant mental illness and their families.

SUMMARY:

The *Out of the Shadow Project* is a documentary film, with accompanying educational materials designed to inform psychiatrists and other mental health providers about the emotional complexities and often painful and bewildering realities of living with someone with schizophrenia. It is fully endorsed by the National Alliance for the Mentally Ill (NAMI) and is being developed as a workshop for NAMI and its affiliates. Spanning four years, professional documentary producer Susan Smiley filmed her mother Millie, who suffers from paranoid schizophrenia, following her on a journey through the public mental health system. Viewers are taken inside the home, private family gatherings, and the hospital to witness how one patient and her family have made sense out of chaos and tremendous stigma and ultimately learned to collaborate with mental health professionals to make recovery possible. But this is difficult to accomplish when the impact of the disease on the patient's sense of self and on critical social supports must be observed in order to teach effective interventions. This film intimately shows what it is like to be someone afflicted with schizophrenia and shows how the person, illness, and treatments are experienced by loved ones. It can inform mental health trainees in ways that textbooks, lectures, and clinical rounds cannot. Audience discussion with the presenters links sections from the film to information on evidence-based practices, such as interventions with families designed to optimize treatment compliance, psychoeducation, and effective collaborations between mental health professionals and family caregivers.

REFERENCES:

1. Foulks E: Advocating for persons who are mentally ill: a history of mutual empowerment of patients and profession. Administration and Policy in Mental Health 2000; 27:353–367.
2. Sokas P: Rapidly growing NAMI becomes influential advocate for mentally ill. Hosp Comm Psychiatry 1986; 37:88–89.

Issue Workshop 71
PSYCHOGENIC SEIZURES: A PROTOTYPE OF SOMATOFORM DISORDER

Chairperson: Selim Benbadis, M.D., *University of South Florida, 4 Columbia Drive, Suite 730, Tampa, FL 33606*
Participant: Francisco Fernandez, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium, the participant should be able to recognize the manifestations of epileptic seizures and under-

stand the clinical features and diagnosis of psychogenic seizures and other psychogenic symptoms.

SUMMARY:

Psychogenic symptoms are common. It is estimated that at least 10% of all medical services are provided for psychogenic symptoms. In addition, psychogenic symptoms represent an uncomfortable and frustrating challenge, both in diagnosis and in management. Among psychogenic symptoms, psychogenic nonepileptic seizures (PNES) are unique in several ways. They are particularly common and have been extensively studied since the advent of EEG-video monitoring. Unlike most other psychogenic symptoms, they can be diagnosed with near certainty. Because almost everything that applies to PNES applies to other psychogenic symptoms, PNES provide a good framework for studying psychogenic symptoms in general. This presentation reviews important features about PNES, extends them to the study of other psychogenic symptoms in neurology, and discusses psychogenic symptoms in the more general context of medicine. First, the neurologic aspects are discussed. Specifically, the diagnosis of PNES and psychogenic symptoms are reviewed, using video illustrations. Difficult issues about the diagnosis of psychogenic symptoms are discussed, including coexisting organic disease, disability, and diagnostic uncertainties. Second, the psychiatric aspects are covered, including the various psychiatric diagnoses that are applicable, their management, and their outcome. Ample time is allowed for interactive discussions.

REFERENCES:

1. Benbadis SR, Tatum WO IV, Vale FL: When drugs don't work: an algorithmic approach to medically intractable epilepsy. Neurology 2000; 55:1780–1784.
2. Benbadis SR: Provocative techniques should be used for the diagnosis of psychogenic nonepileptic seizures. Arch Neurol 2001; 58:2063–2065.

Issue Workshop 72
CLINICAL EFFECTS OF SEXUAL ABUSE BY CATHOLIC PRIESTS: A FORENSIC PERSPECTIVE

Chairperson: Allan S. Nineberg, M.D., *307 Concord Ave, Cambridge, MA 02138-1207*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) recognize the long-term clinical effects of sexual abuse, mostly in boys, by Catholic priests, 2) understand family dynamics and demography associated with such abuse, and 3) understand the principles of forensic evaluation of victims who have brought suit and whose sexual molestation may have occurred decades earlier.

SUMMARY:

There has been extraordinary publicity regarding the abuse of children, mostly boys, by Catholic priests. However, much of this relates to controversy surrounding the Catholic Church, and less relates to the specific long-term clinical effects of this abuse on individuals. Much is known in psychiatry about the sexual abuse of children, but much less about the abuse of boys by Catholic priests. Data on some 20 individuals interviewed are presented regarding family dynamics, demography, and clinical symptoms as well as a discussion of the varying forms that the abuse took. A victim who has decided to file a civil suit concerning a set of events that may have occurred decades earlier faces certain legal challenges. The workshop reviews some of the case law and clinical principles regarding memory and harmfulness that help to guide the forensic examiner in these cases.

REFERENCES:

1. Lisak D: The psychological impact of sexual abuse. Journal of Traumatic Stress 1994; 7: 525–548.
2. Ross v. Garabedian (2001) Supreme Judicial Court of Massachusetts SJC-08626, 1-7.

Issue Workshop 73
PROBLEMS IN THE PSYCHIATRIC EDUCATION OF INTERNATIONAL MEDICAL GRADUATES

Chairperson: Milton Kramer, M.D., *Maimonides Hospital and Medical Center, 4802 10th Avenue, Brooklyn, NY 11219*
Participants: Nyapati R. Rao, M.D., Brunhild Kring, M.D., Jeffrey Goldberg, D.O., Nalini V. Juthani, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the challenges that international medical graduates (IMGs) face in learning to be a psychiatrist in the United States and the problems that IMGs from various parts of the world experience in attaining psychiatric skills during residency.

SUMMARY:

International medical graduates (IMGs) are playing a significant role in meeting psychiatric manpower needs in the United States. IMGs make up some 40% of the first-year residents in psychiatry. Unfortunately they have a significantly lower pass rate on the oral aspect of the psychiatric board examination. This is an unacceptable outcome, given the vital role IMGs play in providing psychiatric treatment to populations in great need. The American Board of Psychiatry and Neurology has acknowledged the problem and has encouraged training centers to develop programs to assist IMGs to prepare for the oral boards. The literature commenting on the problems of IMGs has been directed at issues of bias in selection for training and employment. The special educational challenges and problems of IMGs have been limited to suggestions about assisting in cultural adaptation, fostering mastery of the new language, and providing a mentor in the training program. There is no systematic attention given to the specific educational needs of IMGs during their training and how they should be addressed. The workshop briefly reviews the general problems that all IMGs encounter. It focuses primarily on the particular learning problems of IMGs from particular countries or areas and how they were ameliorated. The participants are given an opportunity to share their experiences with IMGs and what they have found to be helpful.

REFERENCES:

1. Rao NR: International medical graduates, in Handbook of Psychiatric Education and Faculty Development. Edited by Kay J, Silberman EK, Pessar L. Washington DC, American Psychiatric Association, 1999, pp 125–141.
2. Weintraub W: International medical graduates as psychiatric resident: one training director's experience, in International Medical Graduates in the United States: Challenges and Opportunities. Edited by Husain SA, Munoz RA, Balon R. Washington DC, American Psychiatric Press, 1997, pp 53–64.

Issue Workshop 74
DRUGS AND OTHER ADDICTIONS: DOES ONE SIZE FIT ALL?
Collaborative Session With the National Institute on Drug Abuse

Chairperson: Steven J. Grant, Ph.D., *NIDA/NIH/DHHS, 6001 Executive Boulevard, Bethesda, MD 20857*
Participants: Linda Cottler, Ph.D., Nathan A. Shapira, M.D., Nancy M. Petry, Ph.D., Marc N. Potenza, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the similarities and differences between addictions to

drugs and non-drug addictions with regard to diagnosis, treatment, and underlying neurobiological dysfunctions, and to be able to demonstrate knowledge of the controversies and gaps in present understanding of these disorders.

SUMMARY:

It has been a longstanding controversy whether the concept of addiction is only appropriate to substance abuse or whether it extends to other pathological conditions characterized by excessive or compulsive consummatory behaviors. This controversy recently resurfaced with the rise of problematic gambling, Internet usage (especially related to pornography), shopping, and eating. In addition, emerging evidence from brain imaging studies suggests that diverse clinical manifestations of addictive behaviors may be secondary to a common brain dysfunction. This workshop focuses on the comparison of substance abuse with problematic gambling and Internet use. In brief presentations, the speakers outline similarities and differences in the diagnosis, epidemiology, treatment, and brain function across these disorders, with an emphasis on comorbidity with other addictive disorders and other psychiatric illnesses. The speakers cover existing knowledge and also identify gaps in our present knowledge. Audience members are provided with ample opportunity to share their clinical observations and research experience, as well as to discuss challenges for future research and treatment development. The workshop is intended for both practitioners and researchers in the field of addiction psychiatry.

REFERENCES:

1. Potentza M, et al: Gambling urges in pathological gambling: a functional magnetic resonance imaging study. Archives of General Psychiatry 2003, 60:828–836.
2. Shapira N: Problematic Internet use: proposed classification and diagnostic criteria. Depression and Anxiety 2003, 17:207–216.

Issue Workshop 75

STRESS, TRAUMA, AND DRUG ABUSE
Collaborative Session With the National Institute on Drug Abuse

Chairperson: Nancy Pilotte, Ph.D., *National Institute on Drug Abuse/NIH, 6001 Executive Boulevard, Room 4282 MSC 9555, Bethesda, MD 20892-9555*
Participants: Paul Plotsky, Ph.D., Martin H. Teicher, M.D., Dean Kilpatrick, Ph.D., Lisa M. Najavits, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to understand how trauma and stress are risk factors for substance abuse and comorbid psychiatric illnesses and should be aware of a promising therapy for co-occurring PTSD and substance abuse.

SUMMARY:

Trauma (e.g., being the victim of or witnessing violent acts or natural or manmade disasters) or stress (e.g., child neglect and maltreatment, severe illness) can have persistent effects on the brain and subsequent behavior. Severe early stress and maltreatment has the potential to alter brain development through a cascade of events involving the stress-induced programming of the glucocorticoid, noradrenergic, and vasopressin-oxytocin stress response systems, followed by effects on gene expression, neurogenesis, synaptic overproduction and pruning, and myelination during specific sensitive periods, resulting in alterations in brain structure and function. These alterations provide the neurobiologic framework through which early abuse increases the risk of developing posttraumatic stress disorder (PTSD), depression, borderline personality disorder, and substance abuse. PTSD is a risk factor for substance abuse and dependence, and many women in need of drug treatment have been victims of aggravated assault or rape and have comorbid PTSD. The speakers address 1) the underlying neurobiology of trauma and early stress; 2) functional outcomes in terms of drug abuse; 3) describe "Seeking Safety," a cognitive behavior psychotherapy for PTSD and substance use disorder; and 4) consider treatment challenges, including clinician training and adaptation to special populations.

REFERENCES:

1. Najavits LM: Clinicians' views on treating posttraumatic stress disorder and substance use disorder. J Subst Abuse Treat 2002; 22:79–85.
2. Teicher MH, Andersen SL, Polcari A, Anderson CM, Navalta CP, Kim DM: The neurobiological consequences of early stress and childhood maltreatment. Neurosci Biobehav Rev 2003; 27:33–44.

Issue Workshop 76

CHILDREN AND FAMILIES FACING TERRORISM, DISASTERS, AND COMPLEX EMERGENCIES

Chairperson: Howard J. Osofsky, M.D., *Department of Psychiatry, LSU Health Sciences, 1542 Tulane Avenue, New Orleans, LA 70112-2865*
Participants: Richard F. Mollica, M.D., Sandra J. Kaplan, M.D., Arieh Y. Shalev, M.D., Eric Noji, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize risk factors and provide clinical consultations and ongoing mental health services for children and families impacted by terrorism, disasters, and complex emergencies.

SUMMARY:

Mental health efforts are needed in enhancing readiness for terrorism, disasters, and complex emergencies; providing support, as needed, during the response; and providing services and consultation to help with recovery. Emphasis should be placed on enhancing coping responses and resiliency while recognizing risk factors, addressing early behavioral reactions, and recognizing and treating mental health symptoms. Training of traditional and nontraditional responders is crucial. It is important to take into account availability of resources, mental health system capacity, skill levels of providers, training that is most effective for different responder groups, and on-site and telecommunication consultations. Needs and concerns of responders and their families must receive attention. Consideration needs to be placed on issues of cultural sensitivity, family, community, and religious support; other sources of help; and psychosocial medical, and socioeconomic risk factors that affect short- and long-term adaptation. Consideration should be given to needs of special populations, for example, the elderly, those requiring relocation, and those in isolated rural locations. Brief presentations on these topics are followed by interactive discussions concerning effective mental health efforts during preparation, response, and recovery.

REFERENCES:

1. Mollica RF, Cardoza BL, Osofsky HJ, Raphael B, Ager A, Salama P: Scientific overview of the role of mental health in complex humanitarian emergencies. The Lancet (in press).

2. Hoven CW: Effects of the World Trade Center Attack on NYC Public School Students. Execution Summary. Initial report to the New York City Board of Education. May 6, 2002.

WEDNESDAY, MAY 5, 2004

Issue Workshop 77
MIRROR, MIRROR ON THE WALL: AMBITION AND THE TEACHING PSYCHIATRIST
Association for Academic Psychiatry

Co-Chairpersons: Susan Lieff, M.D., *Department of Psychiatry, Baycrest Hospital—University of Toronto, 3560 Bathurst Street, North York, ON M6A 2E1, Canada,* Philip R. Muskin, M.D., *Department of Psychiatry, Columbia University, 622 West 168th Street/MB 427, New York, NY 10032-3874*
Participant: Josepha A. Cheong, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participants should be able to discuss a conceptual framework for the consideration of ambition in the teaching psychiatrist, discuss potential benefits and limitations of teacher ambition for student learning and development, and consider the relevance of this framework for the monitoring of their own ambition in the context of their teaching.

SUMMARY:

Ambition is a desire for achievement and success, based on healthy narcissism. We assume that all psychiatrists who teach have healthy ambition for themselves and for their students. When teacher ambition and student learning resonate, there is a tremendous potential for productivity and education. When the teacher's ambition is misaligned with student learning, ambition has the potential to suppress learning. This workshop focuses on reaching a deeper understanding of the role of ambition in teaching. In the ideal, teacher ambition resembles Oedipal "joy" as described by Kohut, i.e., the teacher (parent) takes joy in the child's (trainee's) accomplishments, without an experience of competition. At the other extreme, the ambition of the teacher uses the student to further his or her own needs, or the teacher is threatened by the accomplishments of the student. When the teacher seeks to augment his/her chances for promotion by using the student, or when the supervisor's expectations of clinical outcome are unrealistic, ambition corrupts the supervisory process. Illustrations of this extreme come from parts of Shakespeare's play, *Julius Caesar*, particularly the speeches of Brutus and Antony. The workshop reviews the ways ambition enhances or corrupts the supervisory process. Interactive discussion with the audience is intended to help academic psychiatrists monitor ambition and improve their synergy with the educational needs of their trainees.

REFERENCES:

1. Davis LL, Little MS, Thornton WL: Mentoring: the art and the angst. Academic Psychiatry 1997; 21 (suppl 2):61–71.
2. Muslin H, Val E: Supervision and self-esteem in psychiatric teaching. Am J Psychother 1980; 24 (suppl 4):545–555.
3. Davis H: "They Like Me, They Really Like Me!" Critically examining my desire to be loved by my students. Philosophy of Education 2000; 346–353.

Issue Workshop 78
THE TRAUMA OF MEDICAL MISTAKES: AN EXPERIENTIAL WORKSHOP

Co-Chairpersons: Michael F. Myers, M.D., *Department of Psychiatry, University of British Columbia, 2150 West Broadway, Suite 405, Vancouver, BC V6K 4L9, Canada,* Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville, School of Medicine, 3006 Dunraven Drive, Louisville, KY 40202*
Participants: Rabbi Goldie Milgram, Barry Bub, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to face and integrate medical errors with honesty, understanding, and forgiveness.

SUMMARY:

Discovering that one has made a medical mistake is one of the most traumatic and universal experiences for physicians in practice. Often this event triggers an acute stress reaction with panic, shock, guilt, fear, and shame, which for some can evolve into PTSD. After brief introductory remarks by psychiatrists Drs. Dickstein and Myers, the workshop is conducted by Dr. Barry Bub and Rabbi Goldie Milgram. Participants are involved in a carefully designed sequence of experiences that facilitate facing the trauma and effecting its integration in a way that reclaims life-energy, self-esteem, and learning. Ritual is used to transition attendees into a learning community that reconnects them to their lineage as members of a noble and honorable profession. This model of conscious ritual is contrasted to time-consuming and obsolete unconscious rituals common in medicine. A passage in Leviticus that reveals an ancient communal healing ritual for leaders who have made unintentional errors is studied. Participants are given a period of contemplation to identify emotions experienced in the face of error and the opportunity to share with a study partner. After closing with a powerful communal ritual, participants are invited to engage in an interactive discussion.

REFERENCES:

1. Christensen JF, Levinson W, Dunn PM: The heart of darkness: the impact of perceived mistakes on physicians. Journal of General Internal Medicine 1992; 7:424–431.
2. Wu AW, McPhee SJ, Christensen JF: Mistakes in medical practice, in Behavioral Medicine In Primary Care: A Practical Guide. Edited by Feldman MD, Christensen JF. East Norwalk, Conn, Appleton & Lange, 1997, pp 299–306.

Issue Workshop 79
THE PORTRAYAL OF ECT ON TELEVISION, FILM, AND THE INTERNET

Chairperson: Patrick Ying, M.D., *Department Psychiatry, NYU School of Medicine, 530 First Avenue, #7D, New York, NY 10016*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be aware of the portrayal of electroconvulsive therapy in the media, understand the origins of preconceived notions, and discuss strategies to combat them.

SUMMARY:

Electroconvulsive therapy (ECT) is a safe and effective treatment for depression and other psychiatric conditions. However, despite an increase in acceptance by the psychiatric community in recent years, the portrayal of ECT in the media, especially on television, film, and the Internet, remains primarily inaccurate and/or negative. Segments of older depictions of ECT, including scenes from *The*

Snake Pit and *One Flew Over the Cuckoo's Nest,* are shown, followed by more recent portrayals of ECT, including scenes from *Requiem For a Dream* and *Oz.* A review of available information on the Internet is also presented. Audience members are encouraged to discuss their reactions to the depictions and describe their experience with the impact of these depictions on patients' and policymakers' attitudes. The discussion focuses on trends in the portrayal of ECT and ways to combat preconceived notions that patients may have developed after seeing these depictions. This session is suitable for all participants, although psychiatrists with exposure to ECT may have special interest.

REFERENCES:

1. McDonald A, Walter G: The portrayal of ECT in American movies. J ECT 2001; 17:264–274.
2. Walter G, McDonald A, Rey JM, Rosen A: Medical student knowledge and attitudes regarding ECT prior to and after viewing ECT scenes from movies. J ECT 2002; 18:43–46.

Issue Workshop 80
PSYCHODYNAMIC TREATMENT OF DEPRESSION

Chairperson: Fredric N. Busch, M.D., *Department of Psychiatry, Weill Cornell Medical College, 10 East 78th Street, Suite 5A, New York, NY 10021*
Participants: Marie G. Rudden, M.D., Theodore Shapiro, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to assess the role and value of psychodynamic psychotherapy in the treatment of depression, understand indications and contraindications for this treatment, identify dynamic constellations that are significant in depressive disorders, and recognize the use of psychodynamic clinical techniques as they are adapted for depression treatment.

SUMMARY:

Psychodynamic approaches are frequently employed in the treatment of depression, but they have undergone little in the way of systematic study. Given the increasing focus on remission of depressive symptoms, it is important to clarify the role and value of psychodynamic psychotherapy for depression treatment. The presenters describe the types of depression for which psychodynamic psychotherapy should be considered, indications and contraindications for this treatment, and the integration of psychodynamic psychotherapy with medication treatment. By using information derived from psychodynamic theorists, clinical experience, and systematic studies, a set of specific dynamics of depression is described, including narcissistic vulnerability, conflicted reactive anger, a severe superego, idealization and devaluation, and the employment of specific defense mechanisms. Use of clinical techniques as they relate to treatment of depression, including interpretation and use of the transference, is described. Case vignettes are used to illustrate both the specific dynamics and the use of psychodynamic techniques. Audience participation is encouraged to assess whether these dynamics match with the clinical experience of the participants. The potential use of this specific dynamic approach for more systematic study of the psychodynamic treatment of depression is described.

REFERENCES:

1. Rudden MG, Busch FN, Milrod BL, Singer M, Aronson A, Roiphe J, Shapiro T: Panic disorder and depression: a psychodynamic exploration of comorbidity. International Journal of Psychoanalysis. 2003; 84:997–1015.
2. Busch FN, Rudden MG, Shapiro T: Psychodynamic Treatment of Depression. Washington, DC, American Psychiatric Publishing (in press).

Issue Workshop 81
WHEN USUAL TREATMENTS FAIL: ANTIPSYCHOTIC STRATEGIES FOR REFRACTORY SCHIZOPHRENIA

Chairperson: Jean-Pierre Lindenmayer, M.D., *Manhattan Psychiatric Center, Wards Island, NY 10035*
Participants: John W. Rosenberger, M.D., Robert R. Conley, M.D., Richard P. Brown, M.D., Leslie L. Citrome, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be familiar with the evidence for successful pharmacological treatment strategies for treatment-refractory schizophrenia.

SUMMARY:

Treatment resistance in schizophrenia is a problem of substantial proportions. While 30%–45% of patients with treatment-resistant schizophrenia respond to clozapine or at times to other atypical antipsychotics, the remaining 55%–70% of patients respond only partially or not at all. These patients represent not only a pharmacological treatment challenge but also a public mental health problem, as they use a high degree of mental health services. A number of augmentation strategies have been suggested for patients whose symptoms have failed to respond to clozapine. However, there are few controlled studies in this area. Most studies include small numbers of patients with various definitions of partial response and are open label. In the absence of controlled data, most clinicians choose an augmentation strategy without a clear pharmacological rationale, by targeting the prevailing residual symptoms or by a trial-and-error strategy. This workshop addresses the evidence for the effectiveness of different pharmacological treatment strategies in this group of patients, the development of an overall treatment strategy of sequential treatment trials with monitoring by objective measures, the therapeutic use of novel potential treatment mechanisms, and data from empirical treatment trials. The audience is encouraged to contribute case material and successful treatment approaches for this difficult-to-treat group of patients.

REFERENCES:

1. Volavka J, Czobor P, Sheitman B, Lindenmayer JP, Citrome L, McEvoy JP, Cooper TB, Chakos M, Lieberman JA: Clozapine, olanzapine, risperidone, and haloperidol in patients with chronic schizophrenia and schizoaffective disorder. Am J Psychiatry 2002; 159:255–262.
2. Lindenmayer JP: Treatment-refractory schizophrenia. Psychiatric Quarterly 2000; 71:373–384.

Issue Workshop 82
TREATMENT OF PATIENTS WITH DRUG DEPENDENCE AND PSYCHIATRIC ILLNESS
Collaborative Session With the National Institute on Drug Abuse

Co-Chairpersons: Wilson Compton III, M.D., *NIH/NIDA, 6001 Executive Blvd MSC5153, Bethesda, MD 20892-9589,* Roger D. Weiss, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478-9106*
Participants: Edward V. Nunes, M.D., Alan S. Bellack, Ph.D., Joy M. Schmitz, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the diagnostic approach and pharmacologic and psychosocial treatment strategies for patients with dual diagnoses of drug dependence and psychiatric illness.

SUMMARY:

The evaluation and treatment of patients with co-occurring drug dependence and psychiatric disorders offers an opportunity for clinicians to integrate the treatment of this population in two major ways. First, the integration of pharmacotherapy and behavioral treatment approaches is critical in this population. An emphasis on medication adherence, which is typically quite erratic in dually diagnosed patients, is an important component in treating this population. A second challenge involves the integration of psychiatric and addiction treatment models. A number of different approaches have recently been developed in an attempt to integrate these two models of care, which have often been delivered separately in the past. This workshop presents various methods of integrating pharmacologic and psychosocial treatment, as well as mental health and addiction treatment, for patients with dual diagnoses of drug dependence and either schizophrenia, major depressive disorder, or bipolar disorder. The presenters offer various models of integrated treatment and engage the audience in discussion of the specific challenges inherent in treating dually diagnosed patients and of the treatment models and techniques that audience members have used successfully with this challenging population.

REFERENCES:

1. Westermeyer JJ, Weiss RD, Ziedonis DM (ed): Integrated Treatment for Mood and Substance Use Disorders. Baltimore, Johns Hopkins University Press, 2003.
2. Drake RD, Mercer-McFadden C, McHugo GJ, Mueser KT, Rosenberg SD, Clark RE, Brunette MF (eds): Readings in Dual Diagnosis. Columbia, Md, International Association of Psychosocial Rehabilitation Services, 1998.

Issue Workshop 83
KUNDALINI YOGA MEDITATION TECHNIQUES FOR PSYCHIATRIC DISORDERS

Chairperson: David Shannahoff-Khalsa, B.A., *University of California SD, 9500 Gilman Drive, Mail 0402, La Jolla, CA 92093-0402*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand specific meditation techniques for treating obsessive-compulsive disorder (OCD), anxiety disorders, depression, grief, fear, and anger and be familiar with clinical results that indicate the efficacy of a protocol for treatment-resistant OCD, and as adjuncts to medication/behavior therapy.

SUMMARY:

A short review of a randomized clinical trial using Kundalini yoga meditation techniques is presented. The trial showed a 70% mean group improvement on the Yale-Brown Obsessive Compulsive Scale. The participants are then taught to personally implement and experience select breathing techniques from this protocol that are highly efficacious in the treatment of OCD and other anxiety-related disorders, as well as a 3-minute technique to help learn to manage fears and an 11-minute technique specific for anger. In addition, the participants have the opportunity to practice two meditation techniques that are specific for the treatment of depression (one for 11 minutes and the other requiring 15 minutes), and an 8-minute technique for grief. The participants are also taught how to formulate short protocols for patients that want to include these techniques in their treatment as either a complement to medication, for those electing to forgo the use of medication, or for those with symptoms that are resistant to standard treatments. Ample time is given to answer questions and to discuss participants' personal experiences of the techniques. No previous background or experience in meditation or yoga is required of the participant, and all of the techniques can be conveniently practiced while sitting in standard meeting room chairs.

REFERENCES:

1. Shannahoff-Khalsa DS: Kundalini yoga meditation techniques in the treatment of obsessive compulsive and OC spectrum disorders. Brief Treatment and Crisis Intervention 2003; 3:369–382.
2. Shannahoff-Khalsa D: An introduction to Kundalini yoga meditation techniques that are specific for the treatment of psychiatric disorders. Journal of Alternative and Complementary Medicine (in press).

Issue Workshop 84
PTSD IN THE NEW YORK FIRE DEPARTMENT: BODIES AND MINDS

Chairperson: Kevin V. Kelly, M.D., *FDNY-Counseling Service Unit, 85 East End Avenue, Apt. 1G, New York, NY 10028-8026*
Participants: Kristina L.N. Jones, M.D., Claire Cammarata, C.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to demonstrate an understanding of modifications of standard PTSD treatment necessary when treating uniformed service personnel, be familiar with medication compliance problems in this group, recognize body recovery duty as a specific trauma, and gain psychodynamic skills useful in treating trauma connected with September 11th.

SUMMARY:

The Counseling Service Unit of the FDNY has provided mental health treatment to more than 7,000 firefighters and their families since 9/11/01. Two psychiatrists and a clinical social worker discuss treatment planning and outcomes to date. Presenters emphasize the unique stressors experienced by this uniformed service population: not only a near-death experience for many but also a massive bereavement for all. The body recovery work, which continued for many months, required innovative treatment approaches to this unusual form of trauma—exposure to body parts and death on a massive scale. Case vignettes from individual and group interventions are discussed, with a focus on the themes of coping strategies (such as altruism and denial), countertransference, and compliance with medication. A comparison is made between those individuals who were collapse survivors and those who were involved in the rescue, recovery, and identification efforts, in order to illustrate the need for various treatment approaches. Presenters discuss the ways in which this clinical material challenges current conceptions of PTSD. A discussion period is provided to allow the audience to contribute their own experiences as clinicians treating traumatized patients and as individuals coping with the ongoing effects of September 11th.

REFERENCES:

1. Ursano RJ, McCarroll JE: Exposure to traumatic death: the nature of the stressor, in Individual and Community Responses to Trauma and Disaster: The Structure of Human Chaos. Edited by Ursano RJ, McCaughey BG, Fullerton CS. New York, Cambridge University Press, 1994, pp 46–71.
2. Thompson J: Psychological impact of body recovery duties. J R Soc Med 1993; 11:628–629.

Issue Workshop 85
WOMEN'S MENTAL HEALTH IN TIMES OF TURMOIL: AN INTERNATIONAL PERSPECTIVE
Association of Women Psychiatrists

Chairperson: Sylvia W. Olarte, M.D., *Department of Psychiatry, New York Medical College, 25 East 83rd Street, Apt 9D, New York, NY 10028*
Participants: Marta B. Rondon, M.D., Unaiza Niaz, M.D., Ana E. Campo, M.D., Marian I. Butterfield, M.D.

EDUCATIONAL OBJECTIVE:

At the end of this session the participant should be able to recognize, diagnose, and treat the mental health sequelae of political or social turmoil in the life of women.

SUMMARY:

Environmental turmoil with either political or natural causes can rapidly interrupt the political and economic fabric of entire populations, creating physical and psychological trauma often compounded by minimal accessibility to resources to address such disruptions. Women and children in such chaotic circumstances are often the object of abuse and/or are traumatized by witnessing violence against their families or those around them. The short- and long-term sequelae of such physical and psychological trauma in the lives of women and children—and indirectly in the fabric of society—are experienced for decades to come. Two psychiatrists from two countries where environmental turmoil is either chronic or of a magnitude difficult to comprehend in industrialized and stable societies present their clinical experience in working with such political, economic, and social realities and the consequence to the mental health of women. A psychiatrist working with women who have migrated to the United States because of political turmoil presents her experience in helping these women adapt to the new environment while coping with the chronic mental health issues related to their personal history of political abuse. Clinical vignettes are used to facilitate interaction with the audience.

REFERENCES:

1. Butterfield MI, Becker M, Marx CE: Post-traumatic stress disorder in women: current concepts and treatments. Current Psychiatric Rep 2002; 4:474–486.
2. Herman JL: Trauma and Recovery: The Aftermath of Violence—From Domestic Abuse to Political Terror. New York, Basic Books, 1992.

Issue Workshop 86
MIGRATION AND PROFESSIONAL IDENTITY EXPERIENCE OF ORGANIZING RUSSIAN-AMERICAN PSYCHIATRY

Chairperson: Nelly Katsnelson, M.D., *Montifoipe Medical Center, 111 East 21st Street, Bronx, NY 18920*
Participants: Rozaliya Vernikov, M.D., Michael L. Melamed, M.D.

EDUCATIONAL OBJECTIVE:

The participants will develop an appreciation of the impact of immigration on psychological functioning of individuals in American society.

SUMMARY:

This workshop focuses on challenges in the professional development of immigrant psychiatrists in the United States. For any individual, doctor and patient alike, migration is a major life event with massive impact on life and psyche. Few studies have examined how distress and coping are affected by negotiating the psychological tasks of migration. Immigrant physicians as well as their patients undergo a parallel process of identity transformation though stages of cross-culturation, ideally resulting in formation of a bicultural identity. The idea of RAPA was a joint collaboration of many psychiatrists who needed to introduce a common conceptual framework in helping colleagues integrate their personal and professional experience of cross-culturation and facilitate greater integration with mainstream professional organizations. Russian-American psychiatrists present their experience using the framework discussed. Issues of particular relevance to clinical work with immigrant patients are examined, including identification and loyalty with both parent and host cultures, conflict of values and its resolution, availability of support systems, coping with losses, ability to mourn, and opportunities for growth.

REFERENCES:

1. Grinberg L, Grinberg R: Psychoanalytic Perspectives on Migration and Exile. New Haven, Conn, Yale University Press, 1989.
2. Akhtar S: A third individuation: immigration, identity, and the psychoanalytic process. Journal of American Psychoanalytic Association 1994; 43(3):4–31.

Issue Workshop 87
VASCULAR DEMENTIA: ASSESSMENT, IMAGING, AND TREATMENT

Chairperson: F. Moises Gaviria, M.D., *Department of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, MC913, Chicago, IL 60612*
Participants: Neil H. Pliskin, Glenn T. Stebbins, Ph.D., Christopher C. Duros, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to demonstrate understanding of the following aspects of vascular dementia care: early recognition; appropriate use of cognitive screening, physical examination, laboratory, and neuroimaging tests; management of psychiatric complications; and family guidance.

SUMMARY:

Vascular dementia (VAD) is currently considered to be the second most common cause of dementia in Europe and in the United States behind dementia of the Alzheimer's type (DAT). However in Asia and many developing countries the incidence of VAD exceeds that of DAT. This workshop reviews the consensus regarding diagnostic algorithms for dementia, the evaluation of these patients, current data obtained from neuropsychology, and relevant new developments in the area of brain imaging. The emphasis of the workshop is not to debate the unknown aspects of vascular dementia. Rather, the intent is to help the practicing clinician effectively assess and treat patients suffering from this condition. Importance is placed on accurately differentiating the spectrum of vascular dementia from other cognitive disorders, effective use of neuropsychological testing and neuroimaging, strategies for pharmacological and psychosocial interventions, and approaches to prevent further cognitive deterioration in these patients. After four short presentations of emerging issues in the diagnosis and treatment of vascular dementia, participants are engaged in discussion and inquiry regarding practical application of recent findings in caring for patients with this challenging disorder.

REFERENCES:

1. Scheltens P, Hijdra AH: Diagnostic criteria for vascular dementia. Haemostasis 1998; 28:151–157.
2. Gaviria M, Lis C, Disayalanish C, Furmaga K: Neuropsychiatric aspects of ischemic cerebrovascular disease, in Clinical Neuropsychiatry. Edited by Jobe T, Gaviria M. New York, Blackwell Science, 1997, pp 123–159.

Issue Workshop 88
MEDICAL TRAINING FOR PSYCHIATRISTS: WHAT DO WE NEED TO KNOW?

Chairperson: Peter Manu, M.D., *Department of Psychiatry, Hillside Hospital Medical Services, 75-59 263rd Street, Glen Oaks, NY 11004*
Participants: Raymond E. Suarez, M.D., James L. Levenson, M.D., Bruce R. Levy, M.D., Roger G. Kathol, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize that the most common medical problems of psychiatric patients are side effects of psychotropic drugs, pain symptoms, metabolic syndrome, and common infections and should be able to challenge residency programs to develop a realistic curriculum for medical training in psychiatry.

SUMMARY:

At least 50% of psychiatric patients have somatic complaints and active medical disorders that are often underrecognized, misdiagnosed, or suboptimally treated. Although psychiatry residents are required to complete four months of medical training, the knowledge objectives of this experience have not been specified. The goal of the workshop is to define these knowledge objectives and the best training modalities. The workshop starts with what is happening now, as seen from the vantage point of a resident (10 minutes) and a residency program director (10 minutes). A consultation-liaison psychiatrist (10 minutes) and a psychiatrist/internist (10 minutes) discuss the outcome of medical training. These comments are followed by a question-and-answer period (10 minutes). The presenters review the result of a study assessing the medical problems of 1,000 psychiatric patients (10 minutes). The audience is invited to discuss their experience with the most common medical problems identified in the study: side effects of psychotropic drugs (e.g., falls, hypotension, leukopenia, neutropenia), delirium, pain symptoms, common infections, hypertension, and diabetes (15 minutes). In the final segment, the panel and the audience interact in an open forum on developing programs for medical training of psychiatrists (15 minutes).

REFERENCES:

1. Kick SD, Morrision M, Kathol RG: Medical training in psychiatric residency. Gen Hosp Psychiatry 1997; 19:259–266.
2. ACGME. Program requirements for residency training in psychiatry, 2003 (http:/www.acgme.org/).

Issue Workshop 89
THE SISSY DUCKLING: THE PERILS OF CHILDHOOD GENDER VARIANCE

Co-Chairpersons: Edgardo J. Menvielle, M.D., *Department of Psychiatry, Children's Hospital, 111 Michigan Ave NW, Washington, DC 20010-2916,* Catherine Tuerk, R.N., *2605 Northhampton Street, NW, Washington, DC 20015*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to 1) recognize risks and protective factors in children with gender-variant behaviors and 2) discuss issues of stigma and tolerance with children.

SUMMARY:

The purpose of this workshop is to inform psychiatrists of a useful resource for working with gender nonconforming children and their families (gender identity disorder). The HBO film *The Sissy Duckling* (directed by Anthony Bell, 1999, USA) is a cartoon retelling of the classic fairy tale, *The Ugly Duckling*. Featuring the voices by Harvey Fierstein and Sharon Stone, this heartwarming tale concerns a duckling averse to rough-and-tumble play and fond of playing with girls who attempts to fit in with the other young ducks in the community and to gain his father's approval. The film depicts the struggles of children who have gender-variant behaviors and the responses of their families, peers, and society and focuses on the resiliency of the main character. After the screening, the presenters and audience discuss the film in the context of working with children with gender-variant behaviors. The presenters often recommend that parents view this video with their young child and engage the child in relevant discussions afterward. This video is a powerful educational tool that can be used with children and adults in a variety of settings. The well-crafted dialogues provide poignant examples of how to talk to patients and siblings about the loaded issues of gender uniqueness and intolerance.

REFERENCES:

1. Menvielle E, Tuerk C: A support group for parents of gender non-conforming boys. Journal of the American Academy of Child and Adolescent Psychiatry 2002; 41:1010–1013.
2. Tuerk C, Menvielle E: If You Are Concerned About Your Child's Gender Behaviors: A Guide for Parents. Washington, DC, Children's National Medical Center, 2003.

Issue Workshop 90
GERIATRIC PSYCHIATRY AROUND THE GLOBE: PRESENT AND FUTURE

Chairperson: Dilip V. Jeste, M.D., *Department of Psychiatry, University of California at San Diego, VA La Jolla Village Drive, 116A-1, San Diego, CA 92161*
Participants: Hugh C. Hendrie, M.D., Kirsten Abelskov, M.D., Alvaro Camacho, M.D., Tonmoy Sharma, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to 1) understand the epidemiology and barriers to care for major psychiatric disorders in old age in different parts of the world, 2) appreciate the upcoming challenges as the numbers of elderly people with mental illness increase substantially, and 3) learn possible ways of meeting those challenges.

SUMMARY:

The numbers of elderly people with mental illnesses are expected to more than double in the United States and Europe in the next 30 years. Comparable increases will occur in developing countries too. This workshop focuses on the epidemiology and barriers to care for older psychiatric patients in the United States and India (Jeste), Africa (Hendrie), Scandinavia (Abelkov), South America (Camacho), and the United Kingdom (Sharma). While there are some cultural differences, there are also several common themes related to geriatric psychiatry, such as negative stereotypes about aging, stigma against mental illness, difficult housing conditions, and poverty. The presenters discuss ways of preparing for the upcoming "silent epidemic" in geriatric psychiatry through education of the lay public and policy makers and through greater emphasis on preventive research. U.S. psychiatry needs to increase its involvement in improving mental health care in developing countries. An ongoing Indianapolis-Ibadan dementia project that includes a psychogeriatric clinic and a caregivers' support group for families of demanted patients may serve as a model. The workshop is highly interactive, and time for discussion involving the audience is provided after each presentation and toward the end of the session.

REFERENCES:

1. Jeste DV, Alexopoulos CS, Bartels SJ, Cummings JL, Gallo JJ, Gottlieb GL, Halpain MC, Palmer BW, Patterson TL, Reynolds CF, Lebowitz BD: Consensus statement on the upcoming crisis in

geriatric mental health: research agenda for the next two decades. Archives of General Psychiatry 1999; 56:848–853.
2. Sokoya O, Baiyewu O: Geriatric depression in Nigerian primary care attendees. International Journal of Geriatric Psychiatry 2003; 18:506–510.

Issue Workshop 91
PREMARITAL COUNSELING: THE FACTS OF LIFE AND MORE

Chairperson: Lawrence Bryskin, M.D., *Albert Einstein College School of Medicine, 157 East 80th Street, New York, NY 10021-0438*
Participants: Rabbi Yaakov Neuberger, B.A., Judy Young, B.A., Sophia Simantov, Peshy Neuberger, B.A., Rabbi Shlomo Gissinger, Sori Teitelbaum, B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be knowledgeable about the experience of premarital counseling, the body of knowledge utilized by such teachers, and how it may address issues such as commitment, intimacy, openness, sharing, sexuality, and love.

SUMMARY:

The institution of marriage is under assault. Sexual problems abound. However, premarital counseling has been left to the admittedly undertrained clergy. Professionally, clergy work with individuals in relation to marital problems but do not have a systemetized body of knowledge to offer young people. For generations, within the Orthodox Jewish world, designated people have been preparing couples for marriage. The religious community feels that this experience is so important for a satisfying marriage, that it is considered a "must" for a prospective mate. Although not formally trained, these teachers carry the wisdom of the culture, the religious tradition, and their own psychological sophistication, together with their personal experience. For this community, sex education is generally deferred, and premarital sexual activity is disapproved of. It is only first addressed during the engagement period. What values do these teachers espouse? How do they approach sexuality? What problems do they encounter? These and other questions are addressed in the workshop. Case presentations are offered. This workshop has relevance for the prevailing society. Preparing young people for marriage is crucial. This topic should interest everyone working with individuals contemplating marriage, married couples, and those having marital problems.

REFERENCES:

1. Greenberg D, Witztam E: Sanity And Sanctity. New Haven, Conn, Yale University Press, 2001.
2. Heilman SC: Defenders Of The Faith: Inside Ultra-Orthodox Jewry. New York, Schocken, 1992.

Issue Workshop 92
PSYCHOTHERAPY ISSUES THROUGHOUT THE LIFE CYCLE IN ASIAN WOMEN

Chairperson: Albert C. Gaw, M.D., *Department of Psychiatry, University of California, 88 King Street, #401, San Francisco, CA 94107*
Participants: Alice C. Tso, M.D., Nalini V. Juthani, M.D., Norma C. Panahon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to demonstrate competence in modifying application of Ericksonian life stages in forming a culturally competent diagnostic formulation in psychotherapy in Asian women.

SUMMARY:

An understanding of Erickson's life stages is crucial for any clinician providing psychotherapy. However, the Western paradigm of life stage conflict resolution may not be fully applicable in Asian women because of Eastern philosophical and cultural differences. A cross-cultural Asian focus must be applied and understood in the context of the Ericksonian life stages in order to form an accurate culturally competent working diagnostic formulation for therapy. Through clinical vignettes, this workshop examines and discusses 1) the unique psychosocial stressors and cross-cultural issues that affect Asian women throughout the life cycle and in psychotherapy, 2) similarities and differences of such psychotherapeutic and life stage issues among Chinese, Asian Indian, and Philippine women, and 3) how to apply Erickson's life stages in the context of these cross-cultural differences for a culturally competent clinical formulation for therapy. The presenters cover the following ethnic groups: Dr. Alice Tso, Chinese women; Dr. Nalini Juthani, Asian Indian women, and Dr. Norma Panahon, Philippine women.

REFERENCES:

1. Newton PM, Newton DS: Theories of personality and psychopathology, psychoanalysis, section 6.2: Erik H. Erickson, in Comprehensive Textbook of Psychiatry. Edited by Kaplan HI, Saddock BJ. Baltimore, Williams & Wilkins, 1995, pp 478–486.
2. Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Appendix I: Outline for Cultural Formulation and Glossary for Culture Bound Syndromes. Washington, DC, American Psychiatric Association, 1994, pp 843–849.

Issue Workshop 93
PRACTICAL MANAGEMENT OF MOOD DISORDERS

Co-Chairpersons: Gary E. Miller, M.D., *ASN, 530 Wells Fargo Drive, Suite 110, Houston, TX 77069-3338,* Richard L. Noel, M.D., *ASN, 530 Wells Fargo Drive, #110, Houston, TX 77090-4026*
Participant: Georgia Gaiser, PA-C

EDUCATIONAL OBJECTIVE:

At the conclusion of the workshop, participants will have gained an improved understanding of practical and theoretical issues in the management of mood disorders and will be able to recognize diagnostic clues for discerning the presence of bipolarity in patients presenting with depression or psychosis.

SUMMARY:

The workshop is directed toward practicing psychiatrists and other clinicians involved in the diagnosis and treatment of mood disorders. The moderators are a psychiatric physician assistant with 12 years of experience in the diagnosis and treatment of psychiatric patients in inpatient and outpatient settings and two practicing psychiatrists who have treated more than 12,000 adults, adolescents, and children over the last 10 years. They present vignettes of actual patients, each illustrating a diagnostic conundrum facing clinicians: Is it unipolar or bipolar depression? Is it "first break" schizophrenia or a psychotic initial presentation of bipolar disorder? Is it "postpartum psychosis" or a psychotic bipolar episode? Is it severe attention-deficit/hyperactivity disorder, bipolar disorder, or both? The moderators have observed that patients with bipolar spectrum disorders frequently receive an incorrect diagnosis of unipolar depression (major depression), schizophrenia, or other psychotic disorders. Since the treatment flowing from such misdiagnosis can adversely affect clinical outcomes, the workshop emphasizes the diverse presentations of bipolar spectrum disorders, diagnostic clues for detecting the pres-

ence of bipolarity, and appropriate pharmacological management of these patients. In the interest of promoting a lively discussion among participants, the moderators do not intend to use audiovisual materials; instead, a handout containing clinical vignettes is distributed.

REFERENCES:

1. Hirschfeld RMA, Calabrese JR, Weissmann MM, Reed M, Davies MA, Frye MA, Keck PE, Lewis L, McElroy SL, McNulty JP, Wagner KD: Screening for bipolar disorder in the community. J Clin Psychiatry 2003; 64:53–59.
2. Blanco C, Laje G, Olson M, Marcus SC, Pincus HA: Trends in the treatment of bipolar disorder by outpatient psychiatrists. Am J Psychiatry 2002; 159:1005–1010.

Issue Workshop 94
DISSOLVING THERAPEUTIC BARRIERS: SPIRITUALITY GROUP WORK WITH PSYCHIATRIC STAFF

Chairperson: C. Paul Yang, M.D., *Department of Psychiatry, UC San Francisco, 1001 Potrero Avenue, Unit 7C, San Francisco, CA 94110*
Participants: Hendry Ton, M.D., Heather M. Hall, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participants should be able to acquire tools for cultivation of empathic love and enhance their ability to integrate spirituality into patient care.

SUMMARY:

There is growing evidence to suggest that empathic love may be related to positive treatment outcomes, possibly mediated through an enhanced therapeutic relationship. The presenters have been conducting spirituality groups for psychiatry staff at the UCSF–San Francisco General Hospital to facilitate the cultivation and integration of empathic love into patient care. Group members have practiced mindfulness meditation, read and discussed relevant literature, and shared their experiences and insights gained from the clinical practice of empathic love. This workshop is designed to be both didactic and experiential. In the didactic part, the presenters share their experiences in conducting staff spirituality groups over the past three years. In the experiential portion of the workshop, the presenters create a clinician spirituality group in a supportive context. Participants are invited to share their experience of integrating spirituality into their clinical practice. The presenters describe meditation and guide participants through a session of meditation. This workshop is designed for clinicians who are interested in incorporating spirituality into patient care. Through sharing and discussion, the participants have the opportunity to learn ways to cultivate and apply empathic love in the clinical setting. The workshop is nondenominational, and no special religious or spiritual background is required for participating.

REFERENCES:

1. Davis MH: Empathy: A Social Psychological Approach. Boulder, Col, Westview Press, 1996.
2. Post SG: Unlimited Love: Altruism, Compassion, and Service. Radnor, Pa, Templeton Foundation Press, 2003.

Issue Workshop 95
GUIDELINE DEVELOPMENT FOR THE ASSESSMENT OF COMPETENCY

Chairperson: Thomas S. Zaubler, M.D., *Psychiatry Department, Morristown Memorial Hospital, 100 Madison Avenue, Morristown, NJ 07962-1956*
Participants: Peter M. Bolo, M.D., Cynthia N. Hoen, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to identify the clinical, legal, and ethical dimensions of competency assessment; recognize different methods for assessing decision-making capacity; and understand the benefits and challenges of developing guidelines to standardize these assessments.

SUMMARY:

The assessment of decision-making capacity to determine competency to consent to treatment is a frequent request for psychiatrists working in a hospital setting. There is, however, very little consistency among psychiatrists in making these determinations. While methods and scales have been developed to assist psychiatrists with these assessments, they are often time consuming and difficult to operationalize in the clinical setting. This workshop focuses on the development and implementation of guidelines and documentation templates used by both psychiatrists and other physicians for the assessment of decision-making capacity in three general medical hospitals in Northern New Jersey. The discussion begins with a brief overview of the clinical, ethical, and legal dimensions of competency assessments and various methods for performing these assessments in the clinical treatment setting. Then the guidelines developed for the three hospitals are discussed, and the challenges and successes of implementing these guidelines are reviewed. Audience members have the opportunity to share their own experiences of conducting competency assessments and any attempts that have been made to standardize this process.

REFERENCES:

1. Ganzini L, Volicer L, Nelson W, Derse A: Pitfalls in assessment of decision-making capacity. Psychosomatics 2003; 44:237–243.
2. McKinnon K, Cournos F, Stanley B: *Rivers* in practice: clinicians' assessments of patients' decision-making capacity. Hosp Community Psychiatry 1989; 40:1159–1162.

Issue Workshop 96
INNOVATIONS IN ACADEMIC EMERGENCY PSYCHIATRY

Co-Chairpersons: William R. Dubin, M.D., *Department of Psychiatry, Temple University Hospital, 100 East Lehigh Avenue, Philadelphia, PA 19125,* Henry W. Weisman, M.D., *Department of Psychiatry, Temple University Hospital, 100 East Lehigh Avenue, Philadelphia, PA 19125*
Participants: Brook E. Zitek, D.O., Mahrukh S. Khan, M.D., Robert O'Brien, Harris Strokoff, Margaret A. Minehart, M.D., Carolyn Ulmer, M.S.W., Marcella Maguire, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to appreciate the academic potential of the psychiatric emergency service (PES), appreciate the diversity of viewpoints that can enrich the PES experience and inform excellent patient care, appreciate the unique opportunities that the PES provides in teaching core competencies to medical student trainees and psychiatric residents, and recognize the opportunities to increase his/her own skills in working with patients in the acute setting, as well as the opportunities for psychiatric residents to acquire core psychiatric competencies, per the Accreditation Council for Graduate Medical Education (ACGME).

SUMMARY:

Psychiatric emergency services (PES) have grown tremendously in the last 20 years. This workshop focuses on the development of the Temple University Crisis Response Center into a multidisciplinary academic environment with many clinical, educational, and research capabilities. Academic innovations include case-based learning, psychopharmacology, forensic and consultation-liaison curriculum development, research supervision, and the development of a liaison with the university's anthropology department and the city's Behavioral Health Services Administration. Trainee achievement of core

psychiatric competencies is emphasized. Faculty present a case and a series of brief presentations emphasizing multiple viewpoints on the presented case. The panel is chaired by Dr. Weisman, the Medical Director of Temple PES, and includes the viewpoints of trainees (a medical student and a 4th-year psychiatry resident) an attending psychiatrist in CRC/forensic psychiatry, an anthropologist, a social worker, and a psychiatrist from the Medicaid behavioral health system of Philadelphia. This topic should have broad appeal to an audience that includes attending psychiatrists, residents, medical students, and others with emergency psychiatry interests. Dr. William Dubin, expert in violence and the management of agitation and Chief Medical Officer of Temple University Hospital—Episcopal Campus, serves as discussion moderator.

REFERENCES:

1. Currier G, Allen M: Organization and function of academic psychiatry emergency services. General Hospital Psychiatry 2003; 25:124–129.
2. ACGME Core competencies (www.acgme.org/outcome/).
3. The Health Care Communication Group: Writing, Speaking, and Communication Skills for Health Professionals. New Haven, Conn, Yale University Press, 2001.

Issue Workshop 97
ADDICTION PSYCHIATRY: SCIENCE, CRAFT, AND SPIRITUALITY

Chairperson: Richard J. Frances, M.D., *200 East End Avenue, Apt. 9B, New York, NY 10128-000*
Participants: Sheila B. Blume, M.D., Avram H. Mack, M.D., Marc Galanter, M.D., Sheldon I. Miller, M.D., Robert B. Millman, M.D., Edgar Nace, M.D., Lionel P. Solursh, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand that addictive disorders span the biological, psychological, and social areas of study.

SUMMARY:

This will be the 37th year of the Ewing Workshop. This year's topic is Addiction Psychiatry—Science, Craft and Spirituality, and the workshop consists of five-minute presentations by several experts in the addiction field, with lots of interchange with the audience. The presenters discuss advances in addiction treatment, new directions, and ways to integrate clinical experience, 12-step approaches, and spirituality with cutting-edge science. Skillful therapists integrate a variety of approaches in order to tailor treatment to the specific needs of individual patients. How best to target the right treatment to the right patient is currently an art as much as it should be based on the state of our scientific knowledge. Input from experienced leaders in the field in an informal workshop format promotes a good learning experience for attendees.

REFERENCES:

1. Frances RJ, Franklin JE Jr: Concise Guide to Treatment of Alcoholism and Addictions, 2nd ed. Washington, DC, American Psychiatric Press, 1989.
2. Frances RJ, Miller SI (eds): Clinical Textbook of Addictive Disorders, 2nd ed. New York, Guilford, 1998.

Issue Workshop 98
UNDERSTANDING AND TREATING COMPULSIVE SEXUAL BEHAVIOR

Chairperson: Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, One Gustave Levy Place, Box 1230, New York, NY 10029*
Participants: Eli Coleman, Ph.D., Jon Morgenstern, Ph.D., Frederick Muench, M.A., Jeffrey Parsons, Ph.D., Milton L. Wainberg, M.D.

SUMMARY:

During the last two decades there has been a growing interest in understanding and treating compulsive sexual behavior (CSB). CSB is characterized by sexual fantasies and behaviors that increase in frequency and intensity so as to interfere with personal, interpersonal, or vocational pursuits. Numerous articles and books have been published on the topic including ones on clinical descriptions (e.g., Goodman, 2000), studies of comorbidity (e.g., Black, 1997), psychosocial interventions (e.g., Carnes, 2000), sexual risk taking (e.g., Benotsch, Kalichman, & Kelly, 1999), and pharmacological treatments (e.g., Kafka, 1994). Despite advances in knowledge about CSB, there continues to be limited empirical information on this problem and the effectiveness of different treatments. This workshop highlights the current state of knowledge regarding CSB, including descriptive features, nosological controversies, axis I and II comorbidity, underlying psychological processes and correlates, public health implications, and current psychopharmacological treatments. The target audiences for this workshop are researchers and practitioners currently working with or studying CSB, those interested in public health concerns related to increased sexual behavior, those interested in off-label uses of medications, and those interested in diagnosis, nosology, and spectrum disorder theories. An interactive question-and-answer session follows the presentations.

REFERENCES:

1. Black DW: The epidemiology and phenomenology of compulsive sexual behavior. CNS Spectrums 2000; 5:26–35.
2. Kafka MP, Prentky RA: Preliminary observations of DSM-III-R axis I comorbidity in men with paraphilias and paraphilia-related disorders. Journal of Clinical Psychiatry 1994; 55:481–487.

Issue Workshop 99
KENDRA'S LAW BECOMES REALITY: ASSISTED OUTPATIENT TREATMENT IN MANHATTAN

Co-Chairpersons: Andrew M. Kleiman, M.D., *Psychiatry Department, Bellevue Hospital, 462 First Avenue, 21W24, New York, NY 10016,* Gary R. Collins, M.D., *Department of Psychiatry, New York University, Bellevue Hospital, 462 First Avenue, 21W24, New York, NY 10016*
Participant: Jennifer Correale, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to demonstrate a basic understanding of the Manhattan Assisted Outpatient Treatment Program, its history and current implementation, its possible benefits to the severely mentally ill person and the community, and its psychiatric and legal challenges.

SUMMARY:

In November 1999, New York State enacted Kendra's Law, legislation that provides for court-ordered assisted outpatient treatment (AOT) to ensure that individuals with mental illness and a history of hospitalizations or violence secondary to noncompliance participate in and receive community-based services appropriate to their needs. Manhattan's AOT program is the largest in New York State and is based in Bellevue Hospital Center. A careful examination of

the history of outpatient commitment in Manhattan reveals the various goals of the current legislation and of the AOT program itself, specifically in Manhattan. Specific psychiatric and legal criteria for Kendra's Law are examined, as well as the details and components of the AOT program administration in Manhattan. The patient population of the Manhattan AOT program is described. The possible benefits of Manhattan's AOT program to its clients, including increased psychiatric services and outcomes focused on rehospitalization rates, are examined. Finally, the future of Manhattan AOT is discussed, taking into consideration current psychiatric successes and challenges, as well as legal challenges and ethical considerations.

REFERENCES:

1. Swanson JW, Swartz MS, Borum R, et al: Involuntary outpatient commitment and reduction of violent behavior in persons with severe mental illness. British Journal of Psychiatry 2000; 176:324–331.
2. Kendra's Law: An Interim Report on the Status of Assisted Outpatient Treatment. Albany, NY, New York State Office of Mental Health, January 1, 2003.

Issue Workshop 100
SEXUAL SATISFACTION AND MENTAL HEALTH IN ORTHODOX JEWISH WOMEN

Co-Chairpersons: Rachel Yehuda, Ph.D., *Department of Psychiatry, Mount Sinai School of Medicine, 130 West Kingsbridge Road, #116A, Bronx, NY 10468,* Michelle E. Friedman, M.D., *Mount Sinai School of Medicine, 205 West End Avenue, New York, NY 10023*
Participants: Talli Rosenbaum, P.P.T.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the risk factors for sexual problems in Orthodox Jewish women and how they relate to mental health symptoms; learn the prevalence of childhood molestation, domestic violence, sexual dysfunction in this group; and understand how to work with patients with specific cultural sexual mores and attitudes about mental health and its treatment.

SUMMARY:

According to Jewish law, married women refrain from sexual relations during menstruation and for the following week and only resume sexual contact following immersion in a ritual bath (i.e., mikva). Thus, couples adhering to this practice refrain from sexual contact for nearly 2 weeks out of every month. Jewish law also proscribes sexual contact before marriage, and social mores of modesty discourage open discussions of sexuality in this population. The latter has resulting in a paucity of data about sexuality in Orthodox Jewish women (OJW). Following the 1999 report of Laumann et al., which described sexual dysfunction and concomitant emotional problems in 43% of women in the United States, the presenters undertook a similar investigation among married OJW describing themselves as regular users of the mikva. The impact of molestation, mental health problems, and infertility on sexual functioning in this cohort was also examined. This workshop presents survey data collected from 382 women ranging in age from 19 to 58 years (mean = 36, SD = 9), and discusses issues related to psychotherapy with this culturally unique sample. Relative to the results of Laumann et al., a high number of OJW (70%) indicated overall sexual satisfaction, with 36.2% of couples cohabitating between three and six times per week (six to 12 times per month). Yet, 82% reported the experience of lacking interest in sex in the past year, and 42.7% felt they could have been better prepared for their married sexual life.

REFERENCES:

1. Laumann EO, Pik A, Rosen RC: Sexual dysfunction in the United States: prevalence and predictors. JAMA 1999; 281:537–544.
2. Bancroft J, Loftus J, Long JS: Distress about sex: a national survey of women in heterosexual relationships. Arch Sex Behav 2003; 32:193–208.

Issue Workshop 101
TREATMENT OF ADULT ADHD: COMBINING COGNITIVE AND MEDICAL APPROACHES

Co-Chairpersons: Anthony L. Rostain, M.D., *Department of Psychiatry, University of Pennsylvania Health System, 3535 Market Street, Philadelphia, PA 19104,* J. Russell Ramsay, Ph.D., *University of Pennsylvania, 3535 Market Street, #2027, Philadelphia, PA 19104-3309*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the symptoms of attention-deficit hyperactivity disorder (ADHD) in adult patients, to summarize the current research and clinical literature regarding ADHD in adults, and to develop a treatment plan that combines pharmacotherapy and cognitive therapy.

SUMMARY:

Attention-deficit/hyperactivity disorder (ADHD) is a complex neurobehavioral disorder with widespread effects on behavior, learning and cognition, and social-emotional functioning. While it was previously thought to be strictly a childhood disorder, recent longitudinal studies have shown that clinically significant problems related to ADHD persist into adulthood for more than 50% of child patients. Moreover, many patients develop significant comorbid psychiatric disorders in addition to their core ADHD symptoms, and for others their symptoms may go undiagnosed and untreated. The purpose of this workshop is to discuss the assessment and treatment of ADHD in adult patients. The workshop includes a review of the neurobehavioral and psychological functioning of adults with ADHD, diagnostic and assessment issues, and a discussion of a combined treatment model (medications and cognitive therapy). Data from a pilot study at the presenters' clinic are shared. The data indicate that combining medication with cognitive therapy improves the functional status of adult patients with ADHD. This workshop is designed for practicing clinicians who treat adults with ADHD. The workshop format combines lecture with slides, case examples, and questions and cases from the audience.

REFERENCES:

1. McDermott SP: Cognitive therapy for adults with attention-deficit/hyperactivity disorder, in Attention Deficit Disorders and Comorbidities in Children, Adolescents, and Adults. Edited by Brown TE. Washington, DC, American Psychiatric Press, 2000, pp 569–606.
2. Weiss M, Murray C: Adults with attention-deficit/hyperactivity disorder: current concepts. J Psychiatric Pract 2002; 8:99–111.

Issue Workshop 102
IMPLEMENTING PSYCHOSOCIAL TREATMENTS IN REAL-WORLD SETTINGS

Chairperson: Edward Kim, M.D., *Department of Behavioral Healthcare, Robert Wood Johnson University, 671 Hoes Lane, Piscataway, NJ 08855-1392*
Participants: Elizabeth Vreeland, M.S.N., Anna Marie Toto, M.Ed.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to 1) recognize the importance of psychoeducation as a best practice

and 2) understand aspects of effective implementation of new programming.

SUMMARY:

One of the current challenges in health care is translating empirical evidence into real world clinical practice. Mental health systems that deliver care to severely mentally ill persons are confronted by limited resources and a patient population plagued by stigma, social impairment, and cognitive deficits. These systemic and clinical factors present major obstacles to implementing effective practices to treat the patients who can most benefit from them. The presenters describe a unique program for disseminating and implementing patient and staff educational programs that is used in more than 70 mental health agencies nationwide. This program has led to the successful rapid implementation of clinical programming in more than 90% of agencies trained. Workshop participants have the opportunity to learn how to overcome multiple barriers to implementation that are frequently encountered in resource-limited clinical settings. Faculty-audience interactions allow open discussions regarding the clinical and organizational change strategies that were successful in driving implementation and how to apply these strategies within diverse care settings.

REFERENCES:

1. Rosenbeck R: Strategies in the implementation of innovate clinical programs in complex organizations. J Nerv Ment Dis 2001; 189:812–821.
2. Corrigan PW, Steiner L, McCracken SG, Blaser B, Barr M: Strategies for disseminating evidence-based practices to staff who treat people with serious mental illness. Psychiatric Serv 2001; 52:1598–1606.

Issue Workshop 103
CRIMINAL JUSTICE SYSTEM AND SERIOUS MENTAL ILLNESS: PROBLEMS AND SOLUTIONS

Co-Chairpersons: Joseph R. Calabrese, M.D., *Department of Psychiatry, University Hospital of Cleveland, 11400 Euclid Avenue, Suite 200, Cleveland, OH 44106,* Janet Berry, J.D., *Washoe Court, 2nd District, 75 Court Street, Reno, NV 89501*
Participants: Omar Elhaj, M.D., Sol Wachtler, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand how the U.S. criminal justice system adjudicates patients with serious mental illness (in particular, bipolar disorder), the personal experiences of Saul Wachtler, J.D. (author of *After Madness: A Judge's Own Prison Memoir*), and preliminary results from the Ottawa County Jail Mental Health Screening Project.

SUMMARY:

The criminal justice system and the penal institutions of the United States have become the single largest provider of mental health treatment in the country. Judges, lawyers, law enforcement officers, and prison officials are confronted daily with cases involving mentally ill offenders. The criminal justice system, historically, has not been equipped to provide treatment, resources, or innovative sentencing programs to mentally ill offenders. Mental health courts are the latest innovation in the criminal justice system. Currently six mental health courts are operating the United States. The goals of this workshop are to 1) increase awareness of the implications of shifting the burden of caring for the mentally ill to the criminal justice system, 2) present the experience of the judicial system with the mental health court, and 3) present and discuss preliminary data from the Ottawa County jail project to assess the prevalence of severe mental illnesses and substance-related disorders in the prison community. The format is an interactive workshop in which the speakers each briefly present their respective segments, followed by an open forum for questions and answers between the audience and the panel, moderated by the workshop chairs.

REFERENCES:

1. Calabrese JR, et al: Impact of bipolar disorder on a US community sample. J Clin Psychiatry 2003; 64:425–432.
2. Wachtler S: After the Madness: A Judge's Own Prison Memoir. New York, Random House, 1997.

Issue Workshop 104
INNOVATIVE METHODS OF PROMOTING USE OF EVIDENCE-BASED PSYCHOPHARMACOLOGY

Chairperson: David N. Osser, M.D., *Department of Psychiatry, Taunton State Hospital, 60 Hodges Avenue Extension, Taunton, MA 02780*
Participants: Carole C. Upshur, Ed.D., Robert D. Patterson, M.D., Kenneth O. Jobson, M.D., Richard C. Hermann, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant will have learned methods of 1) getting information about evidence-supported medication treatment approaches into the hands of practitioners and 2) assessing whether this knowledge is being applied in their clinical decisions.

SUMMARY:

Evidence-based medicine and quality improvement efforts are some of the ways through which physicians have the potential to regain control of medical practice and influence government and private organizations whose management of medical care has placed cost-cutting considerations above clinical concerns. This workshop focuses on efforts to influence practitioners in different settings to adopt prescribing practices that produce the best outcomes in the most cost-effective way. Panelists describe educational initiatives and outreach with group-practice-based primary care physicians (who prescribe most antidepressants), a U.S.-based web site that provides interactive psychopharmacology consultation on difficult clinical problems, and an international consensus group associated with the International College of Neuropsychopharmacology that is developing a set of guidelines and algorithms that will have multiple language versions and will take into account local costs and availability of pharmaceutical products. Finally, an expert discusses how to measure clinicians' use of evidence-based practices in the context of quality improvement activities. Ample time is provided for presenters to interact with attendees, with particular focus on whether mental health care effectiveness is really influenced by these efforts.

REFERENCES:

1. Suppes T, Rush AJ, Dennehy EB, et al: Texas medication algorithm project, phase 3 (TMAP-3): clinical results for patients with a history of mania. J Clin Psychiatry 2003; 64:370–382.
2. Sim I, Gorman P, Greenes RA, et al: Clinical decision support systems for the practice of evidence-based medicine. J Am Med Inform Assoc 2001; 8:527–534.

Issue Workshop 105
WHEN PSYCHIATRISTS HAVE SUFFERED A MENTAL ILLNESS: THEIR STORIES AND INSIGHTS
National Alliance for the Mentally Ill

Co-Chairpersons: Michael F. Myers, M.D., *Department of Psychiatry, University of British Columbia, 2150 West Broadway, Suite 405, Vancouver, BC V6K 4L9, Canada,* Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville, School of Medicine, 3006 Dunraven Drive, Louisville, KY 40202*
Participants: Elizabeth A. Baxter, M.D., Marian Fireman, M.D., Raymond M. Reyes, M.D., Suzanne E. Vogel-Scibilia, M.D., Francine Cournos, M.D., Kay R. Jamison, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand some of the myriad issues faced by psychiatrists who have had a mental illness.

SUMMARY:

This workshop, a collaborative effort with the National Alliance for the Mentally Ill, builds upon narratives and feedback from previous presentations at annual meetings of the American Psychiatric Association. After brief opening remarks by Drs. Myers and Dickstein, the following psychiatrists give presentations: Dr. Elizabeth Baxter addresses issues in recovery and the importance of celebrating achievements; Dr. Marian Fireman speaks about practical ways of coping with illness, getting treatment, and navigating obstacles such as medical licensing boards; Dr. Raymond Reyes discusses the important theme of psychotherapy for the psychiatrist-patient; Dr. Suzanne Vogel-Scibilia, a member of the NAMI board, provides information about managing one's practice and one's illness, hospital privileges, coverage of one's patients, and more, and Dr. Francine Cournos, author of the memoir *City of One,* discusses the influence that her own experience with antidepressants, psychotherapy, and psychoanalysis have played in her conviction about the power of our treatments. Dr. Kay Redfield Jamison, clinician, researcher, author, and tireless advocate, is the discussant. During the 30-minute discussion period, the audience has the opportunity to participate by posing questions, providing commentary, and sharing their own stories if they choose.

REFERENCES:

1. Cournos F: City of One: A Memoir. New York, WW Norton & Company, 1999.
2. Jamison KR: An Unquiet Mind: A Memoir of Moods and Madness. New York, Alfred A Knopf, 1995.

Issue Workshop 106
WILL OUTCOMES EVALUATION AND RESEARCH INITIATIVES SAVE THE THERAPEUTIC COMMUNITY?

Chairperson: Gregory C. Bunt, M.D., *Department of Psychiatry, New York University Medical School, 550 First Avenue, New York, NY 10016*
Participants: Charles Devlin, George DeLeon, Ph.D., Britta Muehlbach, M.A., Marc Galanter, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to 1) estimate the effectiveness of Therapeutic Community (TC) treatment for different subpopulations, 2) distinguish between treatment progress variables and outcomes of substance abuse treatment, and 3) identify current issues in substance abuse and TC research.

SUMMARY:

This workshop is designed for mental health professionals who would like to learn about the effectiveness of Therapeutic Community (TC) treatment for drug addiction and understand current TC research and evaluation. The TC treatment model has been evaluated for its effectiveness in helping patients initiate and maintain recovery from drugs and alcohol. National studies have demonstrated that the TC model achieves positive outcomes, in both the short and the long term. In addition, TCs continue to lend their treatment setting and population to research studies directed at deepening the understanding of the addiction process and successful treatment. In recent years, evaluation and research have become more process oriented, illuminating those aspects of treatment and patient change that may lead to stable long-term outcomes. This workshop offers an overview of outcomes studies that have established the effectiveness of TC treatment in terms of abstinence, reduced legal involvement, employability, etc. The presenters provide data from studies that correlate treatment process with retention and outcomes and discuss research on the effect of new clinical interventions and special aspects of TC treatment on overall treatment success. While the presenters provide salient information in these areas, the questions and interests of the audience are given strong consideration.

REFERENCES:

1. DeLeon G: The Therapeutic Community: Theory, Model, and Method. New York, Springer, 2000.
2. Metrikin AS, Galanter M, Dermatis H, Bunt G: Somatization, anxiety, and depression in a drug-free residential therapeutic community. Am J Addict 2003; 12:60–70.

Issue Workshop 107
NEGATIVE-SYMPTOM SPECTRUM DISORDERS: RESPONSE TO PHARMACOTHERAPY OF ASPERGER'S DISORDER

Chairperson: Elizabeth Sirota, M.D., *Department of Psychiatry, Medical College of Georgia, 1515 Pope Avenue, Augusta, GA 30912*
Participants: Donna L. Londino, M.D., Jeffrey L. Rausch, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to consider the presence of negative symptoms in a range of disorders and the use of pharmacological treatment of negative symptoms in Asperger's disorder.

SUMMARY:

A systematic review of DSM-IV criteria indicates that there are a number of disorders that have negative symptoms. This workshop contrasts Bleuler's observation that negative symptoms were the primary symptoms of schizophrenia with the observation that there are several other diagnoses, in addition to schizophrenia, that have clusters of negative symptoms. The presenters review the utility of considering such diagnoses as "negative symptoms spectrum disorders." In addition to schizophrenia, these may include schizoid personality disorder, schizotypal personality disorder, autism, and Asperger's disorder. Although treatments for negative symptoms of schizophrenia are available, the notion that diagnoses other than schizophrenia would respond to agents that are effective for negative symptoms has been largely untested. The presenters examined this question with respect to the study of Asperger's disorder. Patients with Asperger's disorder present with impairment in social interaction, a lack of spontaneous sharing, a lack of emotional reciprocity, a restricted pattern of interests, and deficits in nonverbal behavior. The presenters review new data from their open trial testing the hypothesis that an atypical neuroleptic, risperidone, is effective for treatment of the negative symptoms of Asperger's disorder.

REFERENCES:

1. Asperger H: Die 'Autisitic Psychopathen' im Kindesalter. Arch Psychiatr Nervenkr 1944; 117:76–136.
2. Frith U: Elective affinities in schizophrenia and childhood autism theory, methodology, and practice, in Social Psychiatry. Edited by Bebbington P. New Brunswick, NJ, Transaction Publishers, 1991.

Issue Workshop 108

SOMETIMES IT IS ABOUT YOU: THE USE OF SELF IN ENGAGING AND TREATING HOMELESS INDIVIDUALS

Chairperson: Marvin A. Nierenberg, M.D., *PPOH, Box 876, Bowling Green Station, New York, NY 10274-0876*
Participants: Amy Cohen, N.P., Dillon C. Euler, M.D., Van Yu, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the unique treatment needs of homeless mentally ill persons and understand that the clinician's conscious use of self is a significant factor in engaging and treating this population. Participants will also develop an understanding of treatment in community-based programs.

SUMMARY:

The problem of homelessness, particularly among individuals with mental illness, continues to challenge mental health practitioners. It is estimated that between one-third and one-half of the homeless population is mentally ill. Many mentally ill homeless persons have had negative experiences with the mental health system and have come to believe that it has little to offer them. Still others are suffering from untreated illnesses that cause them to be too paranoid, too disorganized, or perhaps even too grandiose to utilize the services of a traditional mental health clinic. This workshop describes services provided by the Project for Psychiatric Outreach to the Homeless, Inc. (PPOH) in New York City. PPOH practitioners take an active part in engaging their clients in the community and use themselves consciously and creatively in the process. Case examples are presented to illustrate the effectiveness of interventions in which the clinician uses him- or herself actively as part of the treatment. Workshop participants are asked to share their own case examples and to participate in discussion regarding the clinical and ethical implications of this type of intervention, as well as its usefulness in other treatment sortings.

REFERENCES:

1. Susser E, Goldfinger SM, White A: Some clinical approaches to the homeless mentally ill. Community Mental Health Journal 1990; 26:463–479.
2. Lawrence M: Psychoanalytic psychotherapy among poverty populations and the therapist's use of self. Journal of the American Academy of Psychoanalysis 1982; 10:241–255.

Issue Workshop 109

MULTIPLE PERSPECTIVES ON THE PATHOLOGICAL FEAR RESPONSE: INTEGRATION OF PSYCHOTHERAPEUTIC AND PSYCHOPHARMACOLOGIC THERAPIES

Co-Chairpersons: David Steinman, M.D., *Department of Psychiatry, University of Pennsylvania, 191 Presidential Boulevard, Suite 111-B, Bala Cynwyd, PA 19004-1263,* Jennifer M. Bonovitz, Ph.D., *Psychoanalytic Center of Philadelphia, 191 Presidential Boulevard, Suite 111-A, Bala Cynwyd, PA 19004-1263*

EDUCATIONAL OBJECTIVE:

At the end of the workshop, participants should be able to 1) describe the neurobiological pathways that are important in the affect of fear, 2) identify maladaptive defenses that are often manifest in in adults with dysregulation of the fear system, 3) increase skill recognizing the impact of early childhood trauma on adult psychopathology, and 4) understand how psychopharmacologic and psychotherapeutic interventions can be integrated to maximize treatment outcomes.

SUMMARY:

This workshop describes the long-term consequences of repeated exposure to fear-inducing experiences in early childhood. In depth clinical material from several adult patients is used to demonstrate how the elements of the childhood stressors and their effect on subsequent psychic functioning emerge in treatment. Emphasis is given to the interplay of the biological and psychological processes that mediate the affect of fear. Memory systems, perception, and ways of being with the other are also addressed. Neuroscientific and contemporary psychoanalytic theories are employcd to show how the presenters worked collaboratively to develop strategies to treat both the dysregulated neurotransmitter systems and the patients' maladaptive defense mechanisms. The presenters address some special considerations in the diagnosis and treatment of adult patients who are highly sensitized to environmental cues that are reminiscent of early childhood fearful situations. It is the intention of the presenters to demonstrate that the state of the art in modern psychiatry is to address dysregulated fear systems simultaneously from two perspectives: the subjectivity of the mind and the chemistry of the brain.

REFERENCES:

1. LeDoux J: Emotional circuits in the brain. Annual Review of Neuroscience 2000; 23:155–184.
2. Yovell Y: Affect theory and the neurobiology of affect dysregulation. Journal of the American Academy of Psychoanalysis. 2000; 28:467–481.

Issue Workshop 110

THE DAY I DIED: A NEAR-DEATH DOCUMENTARY AND THE MIND-BRAIN BARRIER

Chairperson: B. Jason MacLurg, M.D., *1120 Cherry Street, Suite 240, Seattle, WA 98104–2023*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize and better understand the near-death experience (NDE), to know that the NDE is not a psychotic episode necessitating medication or hospitalization, and to more compassionately treat patients and family who, having had such experiences, may wonder if they are "going crazy."

SUMMARY:

It is estimated that more than 8 million Americans have had a near-death experience (NDE). Prospective studies document that 6% to 12% of cardiac arrest survivors report memories consistent with an NDE that occurred during their period of unconsciousness. Near-death-like experiences can occur in persons who arc not actually in the process of imminent physical death. Yet, this relatively common phenomena remains incompletely understood. Attempts to dissolve the "mind-brain barrier" will necessitate a more thorough investigation of NDE. *The Day I Died,* produced and directed by Kate Broome of the BBC, is an excellent documentary that takes viewers into the lives of several NDE survivors and shows how these experiences have affected their lives, mostly for the better. Established medical researchers such as Bruce Greyson, M.D., Pim von Lommel, M.D., and others are interviewed in depth. Also discussed are the opinions of NDE skeptic Dr. Susan Blackmore. A new explanatory model involving neuronal cell microtubules is presented as a possible vehicle for these subjective experiences. Issues raised within the film are directly relevant to consultation-liaison and emergency psychiatrists and others working with trauma survivors, death and dying, suicidal patients, substance abuse, and patients seeking spiritual meaning.

REFERENCES:
1. von Lommel P, et al: Near-death experience in survivors of cardiac arrest: a prospective study in the Netherlands. Lancet 2001; 358:2039–2044.
2. Gabbard G, Twemlow S: Do "near-death experiences" occur only near-death?-revisited. J of Near-Death Studies 1991; 10: 41–47.

Issue Workshop 111
WHAT LOVE HAS TO DO WITH IT: EXPLORING THE ROLE OF LOVE IN MENTAL ILLNESS

Co-Chairpersons: Robert W. Hierholzer, M.D., *Department of Psychiatry, VA Central CA Health Care System (116A), 2615 East Clinton Avenue, Fresno, CA 93703-2286,* Bita Ghafoori, Ph.D., *Department of Psychiatry, VA Central CA Health Care System (116A), 2615 East Clinton Avenue, Fresno, CA 93703-2286*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to identify the types of interpersonal problems seen in combat veterans with PTSD, 2) outline the love theories of Lee, Sternberg, and Sorokin, 3) discuss how love theory might offer a framework for understanding adult psychopathology, and 4) discuss the relationship between love theories and attachment theories.

SUMMARY:

Although scholars from various disciplines such as psychology, social work, and the humanities have acknowledged the importance of love in their writings, the construct of "love" has received little attention in psychiatric literature. Specifically, few studies have explored the love styles and quality of loving in combat veterans, whether with or without posttraumatic stress disorder (PTSD). The lack of attention to this issue is ironic since interpersonal difficulties help define the DSM-IV diagnosis of PTSD, and combat veterans with PTSD often report an inability to love or an inability to successfully negotiate the phases of love. Beginning with a review of studies examining these interpersonal difficulties, this presentation goes on to explore love theories as potential frameworks for investigating adult psychopathology in general, and PTSD in particular. This will entail considering the relationships between attachment and love theory. Participants are encouraged to react to the concept of "love" as an important construct for understanding and treating mental disorders. By drawing upon their own clinical experiences, presenters and participants are encouraged to consider how these love theories might fruitfully inform clinical and research approaches to PTSD. This session is appropriate for any clinician or researcher, especially those working with PTSD.

REFERENCES:

1. Hazen C, Shaver P: Romantic love conceptualized as an attachment process. Journal of Personality and Social Psychology 1987; 52:511–524.
2. Sternberg RJ: A triangular theory of love. Psychological Review 1986; 93:119–135.

Issue Workshop 112
PSYCHIATRY AND HOMELAND SECURITY: AN EXERCISE IN WEAPONS OF MASS DESTRUCTION RESPONSE PLANNING

Co-Chairpersons: Larry H. Pastor, M.D., *U.S. Army Reserve, 10407 Wickens Road, Vienna, VA 22181-3033,* Dickson S. Diamond, M.D., *Los Angeles County Medical Hospital, 937 12th Street, #207, Santa Monica, CA 90403*
Participant: Richard T. Keller, R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize key psychiatric issues arising from incidents involving weapons of mass destruction and demonstrate the ability to initiate a provisional plan for the psychiatric management of casualties of such an event in a community or hospital setting.

SUMMARY:

After a brisk review of both the psychological and medical aspects of a terrorist attack using weapons of mass destruction (WMD) and the anticipated psychiatric sequelae, participants are engaged in an attempt to formulate an initial psychological response plan for a hypothetical terrorist-WMD attack upon a representative U.S. community. Two hypothetical disaster scenarios are presented in detail. Each scenario portrays a realistic event involving a chemical, biological, or radiological agent or other unconventional attack with a significant psychiatric dimension. For each scenario, participants are asked to identify and discuss the key psychiatric issues, the specific role of the psychiatrist, the types of psychological and behavioral casualties anticipated, the needs of the affected community, the initial and follow-up steps that need to be taken, and the resources and mechanisms needed to accomplish the appropriate mental health response. By the conclusion of the workshop, participants should have acquired experience in devising and implementing a plan for the management of psychological casualties of WMD. The intended audience includes psychiatrists and other mental health professionals interested in disaster response and homeland security issues. Resources for further study of the field of psychiatric response to mass disasters and WMD terrorism are identified.

REFERENCES:

1. Hall M, et al: The psychological impacts of bioterrorism. Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science 2003; 1:139–144.
2. Shemer J, Shoenfeld Y: Terror and Medicine: Medical Aspects of Biological, Chemical, and Nuclear Terrorism. Miami, Pabst Science Publishers, 2003.

Issue Workshop 113
FITNESS-FOR-DUTY EVALUATIONS FOR LAW-ENFORCEMENT OFFICERS

Chairperson: Marilyn Price, M.D., *Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906*
Participants: Debra A. Pinals, M.D., Bernice Kelly, Psy.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the role and obligation of the evaluating psychiatrist performing fitness-for-duty evaluations for law enforcement officers.

SUMMARY:

Law enforcement is generally regarded as one of the most dangerous, stressful, and health-threatening occupations. Officers are at risk for physical injury, homicide, and accidents, as well as psychological injury. Psychological harm may result because of exposure to death, human misery, inconsistencies in the criminal justice system, and negative public image. A fitness-for-duty evaluation would be ordered when an officer's conduct, behavior, or circumstances indicate that continued service may be problematic. The workshop addresses guidelines for performing a fitness-for-duty evaluation, including obtaining information from the referral source, disclosing the limits of confidentiality, providing a work function assessment, and making recommendations based on clinical findings and consideration of the demands of the job. The use of psychological and neuropsychological testing as an aid to assessment is discussed. The specific challenges faced by evaluators of law enforcement officers are highlighted through the use of case examples. The cases include those of a suicidal officer and an officer suffering from posttraumatic stress disorder. Participants are encouraged to share concerns and experiences when dealing with law enforcement.

REFERENCES:

1. Mohandle K, Hatcher C: Suicide and violence risk in law enforcement: practical guidelines for risk assessment, prevention, and intervention. Behav Sci Law 1995; 17:357–376.
2. Rivard JM, Dietz P, Martell D, et al: Acute dissociative responses in law enforcement officers involved in critical shooting incidents: the clinical and forensic implications. J Forensic Sci 2002; 17:1093–1100.

Issue Workshop 114
EVALUATING TREATMENT WITH FUNCTIONAL BRAIN IMAGING

Co-Chairpersons: Daniel G. Amen, M.D., *Department of Psychiatry, University of California, Irvine, 4019 Westerly Place, #100, Newport Beach, CA 92660,* Joseph C. Wu, M.D., *University of California, Irvine, Irvine Hall #109 UCI-BIC, Irvine, CA 92697*
Participant: Barton J. Blinder, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should understand the current literature on the effects of successful treatment on brain physiology as seen in functional imaging studies. Participants should also be able to utilize the information from SPECT and PET studies in the treatment process.

SUMMARY:

There are currently more than 300 studies using functional brain imaging, specifically PET and SPECT, that have shown before-and-after effects of effective psychiatric treatment. This workshop evaluates the current literature on the effects of treatment on the physiology of the brain as measured by PET and SPECT. Specifically, the presenters examine the studies of depression, attention-deficit/hyperactivity disorder, and posttraumatic stress disorder and evaluate the effects of medication, specific types of psychotherapy, and stimulating therapies such as transcranial magnetic stimulation and ECT. In addition, they review the literature and use their extensive experience to propose a theory of how to use functional brain imaging studies to help predict treatment response. Several case studies in which imaging was used to help direct treatment are presented. As cases are presented, the audience is invited to predict what treatments were prescribed and which ones were effective.

REFERENCES:

1. Bonne O, Krausz Y, Shapira B, Bocher M, Karger H, Gorfine M, Chisin R, Lerer B: Increased cerebral blood flow in depressed patients responding to electroconvulsive therapy. J Nucl Med 1996; 37:1075–1080.
2. Davies J, Lloyd KR, Jones IK, Barnes A, Pilowsky LS: Changes in regional cerebral blood flow with venlafaxine in the treatment of major depression. Am J Psychiatry 2003; 160:374–376.

Issue Workshop 115
SUICIDE AND SCHIZOPHRENIA: A FAMILY INTERVIEW

Chairperson: Paul A. Kettl, M.D., *Department of Psychiatry, Pennsylvania State University, 500 University Drive, Hershey, PA 17033*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the risk factors of suicide in schizophrenia.

SUMMARY:

Suicide accounts for about 10% of all deaths among persons with schizophrenia, making suicide in this group about eight to nine times more common than in the general population. Risk factors for suicide in schizophrenia have been identified, but predicting suicide risk in any individual remains elusive. In this workshop, a videotape of a patient with schizophrenia and his father is presented. The patient committed suicide months after the interview. In the interview, the young man with schizophrenia cogently discusses his illness, how the disorder and its treatment affected his life, and his view of the mental health care system. His father discusses the effect of schizophrenia on his family, as both his son and wife have had the illness. He also calls on all professionals in mental health to use their gift to care for those affected by severe illness. After the film, the workshop focuses on a discussion concerning not only the risk factors of suicide in an individual with schizophrenia, but also how an individual can become "lost" in the current structure of mental health care.

REFERENCES:

1. Hiroeh U, Appleby L, Mortensen PB, et al: Death by homicide, suicide and other unnatural causes in people with mental illness: a population based study. Lancet 2001; 358:2110–2112.
2. Siris SG: Suicide and schizophrenia. J Psychopharmacol 2001; 15:127–135.

Issue Workshop 116
ETHICAL AND PRACTICAL CHALLENGES IN EMERGENCY PSYCHIATRIC RESEARCH

Co-Chairpersons: Rebecca W. Brendel, M.D., *Department of Psychiatry, Massachusetts General Hospital, 55 Fruit Street, WRN-605, Boston, MA 02114,* Melissa E. Abraham, Ph.D., *Massachusetts General Hospital, 15 Parkman Street, WAC-812, Boston, MA 02114*
Participant: Lawrence T. Park, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to demonstrate knowledge of 1) ethical guidelines governing psychiatric research protocols, 2) challenges inherent in conducting research in the psychiatric emergency setting, and 3) an ethically-informed framework for approaching development of psychiatric emergency research protocols.

SUMMARY:

Emergency research in psychiatry is lagging behind other psychiatric and general emergency services research. Psychiatric research has advanced the diagnosis and treatment of psychiatric disorders, and similarly, attention to research in emergency medicine has informed the provision of acute care. Given these advances, it is notable that psychiatric emergency research has been left largely unexplored. One major concern in developing psychiatric emergency room research protocols is potential harm to a vulnerable population of participants. While protection of research subjects is always paramount, this rationale fails to address the potential harm of delivering care based on anecdotal experience rather than evidence-based data. The presenters' central argument is that research in the emergency setting is necessary to improve emergency psychiatric care and delivery of services. This workshop reviews basic ethical principles of research and the function of institutional review boards in reviewing research protocols. It then addresses actual and perceived barriers to research in psychiatric emergencies through the use of case vignettes. Guidelines are offered to address the inherent challenges in psychiatric emergency research. Ample time is allotted for questions from and discussion with the audience.

REFERENCES:

1. Emanuel EJ, Wendler D, Grady C: What makes clinical research ethical? Seven ethical requirements. JAMA 2000; 283:2701–2711.
2. Roberts LW, Geppert CM, Brody JL: A framework for considering the ethical aspects of psychiatric research protocols. Compr Psychiatry 2001; 42:351–363.

Issue Workshop 117
DEVELOPING A COMMUNITY MENTAL HEALTH RESPONSE TO DISASTERS AND TERRORISM

Co-Chairpersons: John W. Burruss, M.D., *Department of Psychiatry, Baylor College of Medicine, 6655 Travis, #700, Houston, TX 77030,* Jennifer E. Pate, M.D., *Department of Psychiatry, Baylor College of Medicine, 6655 Travis, Suite 700, Houston, TX 77030*
Participant: Meg Crady

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to identify the potential psychological needs of individuals and families who have experienced a catastrophic loss and recognize the need for organized response.

SUMMARY:

Every day in our country, people die from violent crimes or disasters. Unfortunately, disasters and terrorism are part of our modern day life. Few resources exist to help those left behind in the aftermath of a catastrophic loss. Communities must coordinate an organized response to address the immediate short-term and long-term emotional needs surrounding violent death. During this workshop, the presenters discuss the development of a stage-coordinated, culturally and religiously sensitive method for addressing the psychological needs of those experiencing catastrophic loss. They describe a collaboration with state and local officials, emergency management personnel, first responders, clergy, and victim service providers. After this brief presentation, the presenters facilitate a discussion about how mental health professionals are fostering resiliency in their communities in the context of traumatic death.

REFERENCES:

1. Ursano RJ, Norwood AE: Trauma and disaster, responses and management, in Review of Psychiatry, Vol 22. Washington, DC, American Psychiatric Publishing, 2003.
2. From the Centers for Disease Control and Prevention: Psychological and emotional effects of the September 11 attacks on the World Trade Center—Connecticut, New Jersey, and New York, 2001. JAMA 2002, 288:1467–1468.

Issue Workshop 118
JUVENILE-JUSTICE SUCCESS SERIES, CHAPTER 1: MUSICIANSHIP, JAZZ, AND BLUES

Chairperson: Cheryl D. Wills, M.D., *Department of Psychiatry, Tulane University, 1440 Canal Street, TB53, New Orleans, LA 70112*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the importance of the juvenile justice reform movement, including therapeutic interventions, such as music, that lead to successful rehabilitative outcomes for delinquent youth.

SUMMARY:

From 1907–1933, the Colored Waifs' Home was New Orleans's residential conservatory for talented delinquent and orphaned youths of color. This workshop explores the contributions of "Professor" Peter Davis who helped rehabilitate youthful offenders by providing music instruction, mentoring, and supervision for his students. Davis founded the Colored Waifs' Home Brass Band, which he used as a vehicle to encourage musicianship and creativity in his charges. Popularity, recognition, employability, and improved self-esteem were unanticipated outcomes for the young musicians. Many graduates of the program, including Louis Armstrong, became community leaders and innovators of American music, especially jazz and blues. This interactive workshop, suitable for all delegates, examines the development of the Waifs' Home program in the context of the U.S. juvenile justice reform movement. Developmental histories of several accomplished Waifs' Home graduates are reviewed. Lively music is used to illustrate the artistic outcomes of these former delinquent youths. The audience, through discussion and participation, should be able to appreciate why mental health involvement in juvenile justice reform and research is critical.

REFERENCES:

1. Bergreen L: Louis Armstrong: An Extravagant Life. New York, Broadway Books, 1998.
2. Gardner M: Understanding Juvenile Law. New York, Matthew Bender & Company, 2003.

Issue Workshop 119
POLITICS AND PREGNANCY: THE REGINA MCKNIGHT CASE

Chairperson: Andrea G. Stolar, M.D., *Department of Psychiatry, University of South Florida, 8488 35th Avenue North, St. Petersburg, FL 33710-1010*
Participants: David J. McDowell, Ph.D., Lynn M. Paltrow, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session the participant should be aware of recent legal decisions regarding substance abuse and pregnancy and their psychiatric, psychological, and legal ramifications.

SUMMARY:

In South Carolina a woman was convicted of homicide by child abuse when her pregnancy ends in stillbirth and metabolites of cocaine are found on autopsy of the infant. Petitioned to the United States Supreme Court, this case raises critical legal and medical issues of concern to the psychiatrist. The workshop, led by a psychiatrist, a psychologist, and an attorney, begins by reviewing the fetal risk due to cocaine use during pregnancy, as well as the risks associated with other substances of abuse, inadequate prenatal care, malnutrition, poverty, and violence. The implications of altering the physician-patient relationship from that of caregiver to police, the potential deterrent to prenatal care for those women most at risk, and the reality of the cost of prevention and treatment, compared with that of criminalization of substance abusing mothers, are addressed. The legal ramifications of this decision, including privacy and Fourth Amendment rights; the status of pregnant women and fetuses under the law; and issues of consent are reviewed. The workshop concludes with a challenge to the audience to consider their role as psychiatrists and physicians, as educators, caregivers, and advocates for our patients, particularly for those most at risk.

REFERENCES:

1. Harris LH, Paltrow JD: The status of pregnant women and fetuses in US criminal law. JAMA 2003; 289:1697–1699.
2. Curet LB, His AC: Drug abuse during pregnancy. Clinical Obstetrics and Gynecology 2002; 45:73–88.

3. Plambeck CM: Divided loyalties: legal and bioethical considerations of physician-pregnant patient confidentiality and prenatal drug abuse. Journal of Legal Medicine 2002; 23:1–35.

THURSDAY, MAY 6, 2004

Issue Workshop 120
THE HORNS OF A DILEMMA: MYTHS AND REALITIES OF DRUG-INDUSTRY INTERACTION

Chairperson: John W. Burruss, M.D., *Department of Psychiatry, Baylor College of Medicine, 6655 Travis, #700, Houston, TX 77030*
Participants: Woodie M. Zachry, Ph.D., Ali A. Asghar-Ali, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to better appreciate the complex pharmacoeconomic and regulatory issues inherent in interplay between industry and physicians.

SUMMARY:

The debate rages on as to the appropriate manner and depth of interaction between the pharmaceutical industry and psychiatrists. Often the arguments are based solely on personal opinion and "conventional wisdom," and rarely is there representation from the industry itself in the dialogue. In this workshop, the leaders present information that can be used by participants to develop better informed positions on the complex pharmacoeconomic and regulatory issues involved in this controversy. Workshop attendees are presented with some of the more difficult challenges inherent in working with "drug reps" through case discussions with an emphasis on their own personal experiences. This workshop is appropriate for all levels of clinician, from student/trainee through independent practitioner, as well as for nonphysician interested parties.

REFERENCES:

1. Steinman MA, et al: Of principles and pens: attitudes and practices of medicine housestaff toward pharmaceutical industry promotions. Am J Med 2001; 110:551–557.
2. Dana J, Loewenstein G: A social science perspective on gifts to physicians from industry. JAMA 2003; 290:252–255.

Issue Workshop 121
GROUP PSYCHOTHERAPY WITH SUBSTANCE ABUSERS
American Group Psychotherapy Association

Co-Chairpersons: David W. Brook, M.D., *Department of Community and Prevention Medicine, Mt. Sinai School of Medicine, One Gustave Levy Place, Box 1044A, New York, NY 10029,* Henry I. Spitz, M.D., *Department of Psychiatry, Columbia University, 1011 Central Park West, New York, NY 10023-4204*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to 1) understand the developmental, neurobiological, and psychosocial bases for the use of a variety of group psychotherapeutic approaches in the treatment of substance abusers; 2) evaluate which group approaches are most appropriate; and 3) treat substance abusers using a variety of group psychotherapeutic techniques.

SUMMARY:

Group psychotherapeutic approaches form a major method of treatment for substance abusers, and this topic is of critical importance for the treatment of people at risk for substance abuse. Theoretical and technical issues that are relevant to both the evaluation and treatment of substance abusers using a variety of group approaches are presented. Group approaches discussed include multiple family therapy groups, cognitive behavior therapy groups, network therapy, modified psychodynamic group therapy, relapse prevention groups, behavioral-educational groups, harm reduction groups, and self-help groups. A broad overview of the current literature is presented, and a developmental approach is used to examine risk and protective factors and their relationship to group treatment approaches. Issues involving comorbidity are addressed, as are the uses of group approaches in a variety of settings, including inpatient, outpatient, and partial hospitalization. The presenters utilize specific clinical examples and material from group sessions as illustrations. In a brief experiential group, participants are given the opportunity to become familiar with issues and techniques. Active audience participation in the form of questions and answers about specific or general theoretical or treatment issues is encouraged. Participants are asked to present specific clinical examples or problems for discussion. This issue workshop is co-sponsored by the American Group Psychotherapy Association.

REFERENCES:

1. Brook DW, Spitz HI (eds): Group Psychotherapy of Substance Abuse. New York, Haworth Press, 2003.
2. Brook DW (ed): Group Therapy and Substance Abuse (Special Issue). International Journal of Group Psychotherapy 2001; 51:3–122.

Issue Workshop 122
MILIEU THERAPIES IN THE AGE OF MANAGED CARE, REVISITED

Chairperson: C. Deborah Cross, M.D., *Department of Psychiatry, Elmhurst Hospital, 79-01 Broadway, D 10-42, Elmhurst, NY 11273*
Participants: Howard D. Kibel, M.D., Saul Scheidlinger, Ph.D., Janet A. Bezmen, R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the ways in which group therapies in the inpatient milieu, through the use of verbal interventions, enable patients to clarify, understand, and integrate their experiences while in the hospital.

SUMMARY:

Given the short-term stays and rapid turnover that characterize contemporary inpatient units, milieu interventions assumed renewed importance as corollaries to psychotropic treatment. Small psychotherapy groups for higher-functioning patients, groups focused on patient motivation and readiness for change, and therapeutic community meetings all work in concert to assist patients in understanding and integrating their experiences while in the hospital.

This workshop focuses on the value of specific therapist verbal interventions ranging from clarifications through confrontations to interpretations. Unlike such interventions in outpatient contexts, this work is designed to deal with previously avoided ideations with the aim of clarifying for the patients their experiences in the milieu. Often termed "clarifying interpretations," they are designed to elicit and to illustrate the typical patient's distrust of and hostility toward their helpers. Clinical examples from psychotherapy groups, rehabilitation readiness groups, and community meetings are used to illustrate these concepts. The workshop is designed for all levels of psychotherapists, and the audience is invited to share examples of their own group work in inpatient settings.

REFERENCES:
1. Brabender V: (1993) Inpatient group psychotherapy, in Comprehensive Group Psychotherapy, Third Edition. Edited by Kaplan HI, Sadock BJ. Baltimore, Williams & Wilkins, 1993, pp 607–619.
2. Kibel HD: Interpretive work in milieu groups. International Journal of Group Psychotherapy 2003; 53:303–329.

Issue Workshop 123
PSYCHIATRIC CONSULTATION REPORTS IN MINUTES: EXPLORING NEW TECHNOLOGIES

Chairperson: Henry H. Leung, M.D., *Department of Psychiatry, Sault Area Hospital, 969 Queen Street East, Sault Ste Marie, ON P6A 2C4, Canada*
Participant: Anna E. Rogers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand recent technological advances related to the timely completion of psychiatric consultations and learn how these recent changes in technology may allow for powerful database creation, which could be used for inexpensive research, quality control, and utilization assessment.

SUMMARY:

This workshop is designed to explore how a recent convergence of technologies allows psychiatrists to create an individualized, printed psychiatric consultation report within minutes of completion of the consultation. The same technology can allow for the creation of powerful databases of patient information with 10,000 or more variables, without additional time input. The workshop is targeted at psychiatrists who are inundated with paperwork and want to explore how modern technology can reduce time input and increase efficiency. The workshop is appropriate for psychiatrists in all specialties and will also be of interest to research groups as well as administrators. The Tablet PC (a pen-based operating system) and its use during a patient interview are demonstrated, as well as its integration with speech recognition, new handwriting technology, and document-assembly technology. A new program that can write a computer-generated editable psychiatric consultation will be demonstrated. The program's utility as a way to save large amounts of time and create organized legible notes, as an educational and reference tool, as a way to improve accuracy in reporting, as a tool to minimize medico-legal pratfalls, and as a research tool will be discussed.

REFERENCES:

1. Heistein JB, Coffey RA, Buchele BA, Gordillo GM: Development and initiation of computer generated documentation for burn patient care. J Burn Care Rehabil 2002; 23:273–279.
2. Lowe WW, Ciszek TA, Gallaher KJ: Comprehensive computerized neonatal intensive care unit data system including real-time, computer-generated daily progress notes. Pediatrics 1992; 89:62–66.

Issue Workshop 124
A COMPREHENSIVE APPROACH TO THE TREATMENT OF PAIN IN HIV ILLNESS

Chairperson: David G. Krefetz, D.O., *Department of Psychiatry, UMDNJ School of Osteoporosis Medicine, 2250 Chapel Avenue West, #100, Cherry Hill, NJ 08002*
Participants: Richard T. Jermyn, D.O., David M. Kietrys, M.P.T., Maryann Andrews, B.S.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to 1) identify the common etiologies of pain in the HIV-affected individual, 2) understand the need for a comprehensive treatment approach to HIV-associated pain, and 3) understand the role of psychiatry in a multidisciplinary treatment approach to pain in HIV illness.

SUMMARY:

Pain has been demonstrated in 20% to 50% of patients living with HIV infection, yet pain in this population is highly underdiagnosed and undertreated. Expert consensus panels have recommended that the same guidelines that were established for cancer pain be adopted for HIV-related pain. HIV pain may be the direct result of the virus, secondary to the medications used to treat the illness, or due to a comorbid condition. Psychiatric illness and substance abuse may cause barriers to the proper diagnosis and treatment of pain. Proper diagnosis and aggressive treatment of comorbid psychiatric illness is essential to properly treat the pain.

The Comprehensive Pain Center (CPC) was established 5 years ago as a dedicated center to treat HIV-related pain. The panel presents an overview of HIV-related pain and discusses their experiences working as part of a multidisciplinary treatment team. Issues such as using narcotic analgesics in patients with history of substance abuse, treating pain in patients with severe and persistent mental illness, and administering and funding the program are discussed. Case presentations presented by the panel or elicited from the audience are also discussed. Together with the audience, the panel presents novel solutions to common problems.

REFERENCES:

1. Jermyn RT, Janora DM, Douglas BS: HIV Pain Management, in Pain Management in Rehabilitation. Edited by Monga TN, Grabois M. New York, Demos Medical Publishing, 2002, pp 285–318.
2. Breitbart W, Passik S, McDonald M, Rosenfeld B, Smith M, Kaim M, Funesti-Esch J: Patient-related barriers to pain management in ambulatory AIDS patients. Pain 1998; 76:9–16.

Issue Workshop 125
DETECTION OF MALINGERING

Chairperson: Alan R. Hirsch, M.D., *Department of Psychiatry, Rush-Presbyterian, 845 North Michigan Avenue, Suite 990W, Chicago, IL 60611-2201*
Participants: David E. Hartman, Ph.D., Paul Ekman, Ph.D., Carl M. Wahlstrom, Jr., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to utilize techniques to help delineate malingering.

SUMMARY:

In forensic psychiatry, mental health professionals routinely need to assess the truth or falsity of the histories of patients and to weigh their candor or disingenuousness during the physical examination. Yet psychiatrists are only 57% accurate in recognizing deception. This session is designed to teach different methods for detecting both verbal and nonverbal cues of deception in the clinical setting. Methods of determining lying are demonstrated through the use of live audience participation and videotapes of actual examples of lying.

REFERENCES:

1. Hirsch AR, Wolf CJ: Practical methods for detecting mendacity: a case study. J Am Acad Psychiatry Law 2001; 29:438–444.
2. Ekman P, O'Sullivan M, Friesen WV, Scherer KR: Face, voice and body in detecting deceit. J Nonverbal Behav 1991; 15:125–135.

Issue Workshop 126
CAN SOCIAL THEORY BE INTEGRATED INTO THE LIBERATORY GOALS OF PSYCHIATRY?

Co-Chairpersons: Carl I. Cohen, M.D., *Department of Psychiatry, SUNY Downstate, Health Sciences Center, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203,* Kenneth S. Thompson, M.D., *6108 Kentucky Avenue, Pittsburgh, PA 15206-4213*
Participants: Astrid N. Rusquellas, M.D., Bradley E. Lewis, M.D., Sami Timimi

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able 1) to understand four social psychological models that are potentially compatible with the liberatory goals of psychiatry and 2) to synthesize a theoretical perspective that is compatible with the liberatory vision of psychiatry.

SUMMARY:

Pinel's unchaining of the Parisian insane foreshadowed the dual liberatory underpinnings of psychiatry: it can free persons from the oppression of mental illness and it can assist persons to be what they can be (self-realization) and to lead a self-directed life, i.e., psychiatry can help people to be both "free from" and "free to." These goals link psychiatry not only to medicine and science but also to sociopolitical elements. Thus, the focus of psychiatry, the mind, reflects people's brains and their social world. Consequently, oppressive social circumstances can hinder psychological development and contribute to psychopathology. This workshop explores whether there is a social psychological theory that is compatible with the liberatory goals of psychiatry. The presenters explore the strengths and weaknesses of four social psychological perspectives that have been used by psychiatry: 1) "humanism," which posits an a priori human essence (e.g., eros, desire, need); 2) a "decentering" perspective, in which there is no central human essence but rather persons are conceived of as being the product of their social relationships; 3) "post-modernism," which recognizes that language and perspective infuse all ways that we perceive the world, thereby undermining the possibility of universal truths, and which recognizes that, from an individual perspective, "self" consists of multiple, shifting, and self-contradictory identities based on personal experiences of race, class, religion, and culture; and 4) "political economy," which examines the reciprocal effects of the government, the economy, social classes, and status groups, and their impact on the distribution of social goods and well-being (e.g., how social class affects mental and physical health). During this workshop, participants are encouraged to conceptualize a social psychological perspective that is compatible with the liberatory vision of psychiatry.

REFERENCES:

1. Cohen CI: Overcoming social amnesia: the role for a social perspective in psychiatric research and practice. Psychiatric Services 2000; 51:72–78.
2. Double D: The limits of psychiatry. British Medical Journal 2002; 324:900–904.

Issue Workshop 127
TREATMENT-RESISTANT PATIENTS WITH BULIMIA NERVOSA

Co-Chairpersons: Edi Cooke, Psy.D., *Department of Psychiatry and Mental Health, Cedars-Sinai Medical Center, 8730 Alden Drive, Room W101, Los Angeles, CA 90048,* Frampton Gwynette, M.D., *Cedars-Sinai Medical Center, 8730 Alden Drive, Los Angeles, CA 90048*
Participants: Marlene Clark, R.D., Waguih W. Ishak, M.D., Antonia Noble-Ludwig, M.F.T.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand alternative treatment approaches to patients with treatment-resistant bulimia nervosa.

SUMMARY:

Eating disorders cause immeasurable suffering for victims and families. In the United States, there are an estimated 7 million women and 1 million men with eating disorders; 86% report onset of illness by age 20 years, 77% report duration from 1 to 15 years, and 6% of patients with serious cases die due to complications. Cognitive behavior therapy remains the most validated treatment for bulimia nervosa, and many patients respond adequately. At the same time, there remains a percentage of patients who have treatment-resistant disorders or who do not adequately respond to treatment. Research has yet to adequately identify subgroups within the population of patients with treatment-resistant illness. Effective interventions have yet to be matched to these potential subgroups. Individualization of treatment is key in order to optimize the response. The workshop presenters show video clips of difficult-to-treat patients and some of the approaches used to ameliorate their outcome.

REFERENCES:

1. Sands S: Bulimia, dissociation, and empathy: a self-psychological view, in Psychodynamic Treatment of Anorexia Nervosa and Bulimia. Edited by Johnson CL. New York, Guilford Press, 1991, pp 34–50.
2. Fairburn CG, Marcus MD, Wilson TG: Cognitive behavioral therapy for binge eating and bulimia nervosa: a comprehensive treatment manual, in Binge Eating: Nature, Assessment, and Treatment. Edited by Fairburn CG, Wilson GT. New York, Guilford Press, 1993, pp 361–404.

Issue Workshop 128
LEASH ON LIFE: HUMAN ATTACHMENT TO ANIMALS

Chairperson: Debra A. Katz, M.D., *University of Kentucky, 3470 Blazer Parkway, Suite 300, Lexington, KY 40509-1810*
Participants: Jon Katz, Dehra A. Glueck, M.D., Tagalie Heister, M.S.L.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to have a deeper understanding of the significance of human-animal relationships and their utility in understanding an individual's attachment history. The pros and cons of using animals in therapy, psychological reasons for troubled human-animal relationships, and compulsive rescuing will be discussed.

SUMMARY:

Animals have become increasingly important in our emotional lives, and, for many individuals, animals provide uniquely stable and available relationships in an oftentimes unreliable and lonely world. Relationships with pets may illuminate an individual's attachment history and provide important information about early experiences, including separation, nonverbal communication, affective regulation, and nurturing. Attachment theory with its emphasis on the importance and quality of early relationships provides a framework with which to understand pet-human relationships.

This workshop discusses attachment-based issues that unconsciously affect relationships with pets; what makes it difficult to set limits, train, and discipline our pets; how current relationships with pets can be used in treatment to provide valuable information about early relationships; the risks and benefits of using animals in therapy settings; and the psychological, social, and political determinants of rescue fantasies and behavior.

Participants are given the opportunity to explore the meaning of relationships with pets with an author who has written extensively about dogs and their new role in people's lives, a child psychiatrist who has studied the application of attachment theory to pet-human relationships, and a psychiatric resident who has worked with trauma survivors and horses in an equine therapy setting. The workshop utilizes clinical material to illustrate the concepts being discussed and to raise questions about the new emotional work that animals are increasingly asked to perform. Ethical issues regarding the appropriateness of utilizing animals to fulfill humans' emotional needs are examined, along with the benefits and risks to humans who engage in intense and/or exclusive relationships with animals.

REFERENCES:

1. Katz J: The New Work of Dogs: Tending to Life, Love, and Family. New York, Villard, 2003.
2. Podberscek AL, Paul EL, Serpell JA (eds): Companion Animals and Us: Exploring the Relationships between People and Pets. Cambridge, UK, Cambridge University Press, 2000.

Issue Workshop 129
AVOIDING DUAL-AGENCY PITFALLS OF WORK-RELATED NEUROPSYCHIATRIC IMPAIRMENTS

Chairperson: Harold J. Bursztajn, M.D., *Department of Psychiatry, Harvard Medical School, 96 Larchwood Drive, Cambridge, MA 02138-4639*
Participants: Robindra K. Paul, M.D., David M. Reiss, M.D., Christine A. Martone, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize how managed health care restrictions on care and employment-related demand increase psychiatrists' risk of conflict of interest.

SUMMARY:

Both managed health care restrictions on care and employment-related demands of third parties for forensic evaluations increase the risk to the treating clinician of being placed in potential conflict-of-interest situations when asked to perform forensic evaluations. When asked to undertake a forensic evaluation, the treating psychiatrist may avoid potential dual-agency pitfalls by facilitating referral for an independent forensic psychiatric evaluation of the patient. The presenters explore setting-of-care factors that both forensic and general psychiatrists need to be aware of when providing comprehensive work-related claim evaluations. Models for forensic psychiatric analysis and opinion formulation are presented, including an evaluation of whether and how care restrictions have played a role or substantially influenced the prior treatment history, current presentation and impairment of the claimant, recommendations for treatment alternatives, and prognosis. Workshop participants are facilitated in conducting a review and analysis of their own clinical and forensic case experience in treating, referring, and evaluating work-related claims while avoiding dual-agency pitfalls. The workshop is appropriate for all psychiatrists, including those without prior experience with independent medical evaluations.

REFERENCES:

1. Bursztajn HJ, Paul RK, Reiss DM, Hamm RM: Forensic psychiatric evaluation of workers' compensation claims in a managed care context. J Am Acad Psychiatry Law 2003; 31:17–19.
2. Deaton JS, Bursztajn HJ, Brodsky A: The role of the mental health professional in employment litigation, in Mental and Emotional Injuries in Employment Litigation, 2nd ed. Edited by McDonald JJ Jr, Kulick FB. Washington, DC, Bureau of National Affairs, 2001, pp 50–71.

Issue Workshop 130
TEACHING CORE COMPETENCIES: THE CHALLENGE FOR ACADEMIC PSYCHIATRY

Co-Chairpersons: Mary S. Sciutto, M.D., *Department of Psychiatry, Columbia University, 635 West 165th Street, #407, New York, NY 10032,* Mary E. Bongiovi-Garcia, M.D., *New York Psychiatric Institute, 1051 Riverside Drive, Irvington, NY 10032*
Participants: Kareem D. Ghalib, M.D., David A. Lowenthal, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the six core competencies now required for psychiatry training and the tools used by academic clinicians to measure trainee development in these catgories.

SUMMARY:

Psychiatry training programs throughout the United States now must demonstrate resident competence in six core areas: medical knowledge, patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice. Academic medical centers have always had to achieve a fine balance between service needs, financial needs, and training needs. These new requirements to meet certain core competencies put forth by graduate medical education require the academic physician to fine-tune what may seem to be competing allegiances. This workshop focuses of the integration of these resident educational goals and contemporary teaching hospital clinical practices. The presenters assess the clinical experiences required by trainees to demonstrate their mastery of these core areas and describe the tools used by academic clinicians to measure trainee development. The presenters also explore the overall challenges faced by attending physicians and trainees in psychiatry in the evolution of training goals informed by an outcomes-based perspective.

REFERENCES:

1. Beresin E, Mellman L: Competencies in psychiatry: the new outcomes-based approach to medical training and education. Harvard Review of Psychiatry 2002; 10:185–191.

Issue Workshop 131
KEEP IT REAL: PSYCHOLOGICAL PREPAREDNESS AND ACTIVE-COPING GROUP

Chairperson: Paula G. Panzer, M.D., *JBFCS CTPI, 120 West 57th Street, New York, NY 10019*
Participants: Robert H. Abramovitz, M.D., Susan E. Paula, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants should be able to help their patients and community members obtain reliable information about risk of threat; understand the biology of the fear response and its subsequent effects on thinking and functioning; develop strategies for coping with fear; and develop personal, family, and professional safety plans.

SUMMARY:

In the face of war, terrorism, and uncertainty, people have difficulty finding psychological safety. Some don't understand the biology of fear or lack methods to modulate their reactions. Some lose their capacity to accurately evaluate risks or appropriately prepare practical, emotional, and social responses. Resiliency notions are based on strengthening an individual's capacity to cope with subjective reactions of fear, helplessness, confusion, and maladaptive beliefs resulting from threat. Enhancing safety, active coping, self-

care, and mastery may contribute to preventing PTSD. The presenters describe a group training program to help adults prepare for stress and threats. The Keep It REAL© group helps participants build a sense of safety and active coping while experiencing anxiety over war, threats of terrorism, and chronic uncertainty. Critical components of the curriculum are captured in the acronym REAL: risk assessment (obtaining reliable information and reviewing relative threat risk), emotional knowledge (understanding the biology of the fear response and its effects on thinking and functioning), active coping (strategies for living with fear and uncertainty), and life safety plan (developing personal, family, and professional strategies for relative safety). A participatory version of this group is offered, its value discussed, and preliminary evaluation data described.

REFERENCES:

1. LeDoux JE, Gorman JM: A call to action: overcoming anxiety through active coping (editorial). Am J Psychiatry 2001; 188:1953–1955.
2. Chemtob CM, Taylor TL: The treatment of traumatized children, in Trauma Survivors: Bridging the Gap Between Intervention Research and Practice. Edited by Yehuda R. Washington, DC, American Psychiatric Publishing, 2002, pp 75–126.

Issue Workshop 132
PSYCHIATRIC ASPECTS OF TREATING PRIMARY CAREGIVERS OF HOSPICE PATIENTS

Co-Chairpersons: Jay L. Wung, M.D., *Department of Psychiatry, Cedars-Sinai Medical Center, 8730 Alden Drive, W101, Los Angeles, CA 90048,* Robert Taub, M.D., *Cedars-Sinai Medical Center, 8700 Beverly Boulevard, Los Angeles, CA 90048*
Participant: Linda Gorman, R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to diagnose and treat bereavement and major depression in primary caregivers, recognize that a caregiver can have significant loss of quality of life that does not correspond to a DSM-IV category, and demonstrate empathic communication with caregivers.

SUMMARY:

How do we return hope to the hopeless? The lives of hospice caregivers who have lost or are in the process of losing a loved one can be characterized by the absence of hope. The role of psychiatry in aiding caregivers, however, has been unclear. DSM-IV-TR differentiates bereavement from major depressive disorder, yet the diagnosis does not necessarily indicate the amount of suffering experienced or the amount of the quality of one's life lost. Likewise, it is unclear if the best treatment for bereavement-related major depressive episodes is different from those for major depressive disorder. To better understand the special needs of hospice caregivers and to improve their psychiatric care, this workshop reviews the criteria, epidemiology, treatment, and outcome of bereavement and major depressive disorder; presents sample caregiver cases to demonstrate significant loss of quality of life that does not necessarily correspond to a diagnosable DSM-IV category; provides a presentation of the goals of palliative care by a hospice physician, with a videotaped presentation of the functioning of a hospice team; discusses the risks and benefits of treatment by medications, specific psychotherapies, and supportive psychotherapy in the context of the hospice model; and explores these potential interventions in a role-play exercise between participants.

REFERENCES:

1. Reynolds CF 3rd, et al: Treatment of bereavement-related major depressive episodes in later life. Am J Psychiatry 1999; 156:202–208.
2. Schulz R, et al: Involvement in caregiving and adjustment to death of a spouse. JAMA 2001; 285:3123–3129.

Issue Workshop 133
PSYCHIATRY TRAINING FOR PRIMARY CARE PHYSICIANS: WHAT, HOW, AND WHEN?

Chairperson: Hoyle Leigh, M.D., *Department of Psychiatry, University of California, 445 South Cedar Avenue, Fresno, CA 93702*
Participants: Tana A. Grady-Weliky, M.D., Don R. Lipsitt, M.D., Seth M. Powsner, M.D., Deborah C. Stewart, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to identify specific areas of need for psychiatry training in primary care and render an opinion about minimal psychiatric competence for family practice, internal medicine, obstetrics, and pediatrics training programs.

SUMMARY:

A lively and thought-provoking workshop was held during the 2003 Annual Meeting on this issue. This workshop continues the discussion with active audience participation. The moderator of this workshop briefly presents the findings of a follow-up analysis of a survey of directors of training of primary care residencies that show that there are general and specialty-specific differences between those who are satisfied with their psychiatric training and those who are dissatisfied. The following questions are posed: What mental health skills and knowledge are appropriate to which primary care programs? What is the proper role of primary care physicians in diagnosing and treating various psychiatric conditions, such as somatoform disorders and psychiatric emergencies? How much of the training should be done in medical school as opposed to during residency? Are there special psychiatric training needs for pediatrics? Are joint psychiatry-primary care programs useful? Dr. Grady-Weliky discusses her extensive experience in medical education and a joint psychiatry-primary care training program. Dr. Stewart draws from her experience as a pediatrician as well as an associated dean for medical students. Dr. Lipsitt reports on focus group surveys on psychiatric curricula for primary care physicians. Dr. Powsner discusses the interface between primary care and emergency psychiatry. The discussion is expected to stimulate psychiatric educators to develop a set of minimal competencies in mental health for specific primary care training programs and to generate ideas that will lead to the development of more effective and efficient curricular models.

REFERENCES:

1. Hodges B, Inch C, Silver I: Improving the psychiatric knowledge, skills, and attitudes of primary care physicians, 1950–2000: a review. Am J Psychiatry 2001; 158:1579–1586.
2. Horowitz L, Kassam-Adams N, Bergstein J: Mental health aspects of emergency medical services for children: summary of a consensus conference. Academic Emergency Medicine 2001; 8:1187–1196.

Issue Workshop 134
WHOSE RESPONSIBILITY IS IT ANYWAY? THE TREATING PSYCHIATRIST'S?

Chairperson: Bernard J. Arseneau, D.O., *Social Security Administration, 6401 Security Boulevard, Room 4472—Annex, Baltimore, MD 21235-0001*

EDUCATIONAL OBJECTIVE:

At the conclusion of the workshop, participants should be able to define the term "disability" under the Social Security Act, describe

the role of the treating psychiatrist under SSI and SSDI, formulate a more informed perspective of the psychiatrist-patient relationship with regard to these programs, and communicate disability information in a more time-efficient manner.

SUMMARY:

Several circuit courts have found that medical opinions of treating psychiatrists tend to have special intrinsic value in determining whether an individual is disabled and entitled to medical benefits under the Social Security Act. Treating psychiatrists often receive requests for medical documentation and opinions concerning their patients who are filing for disability. Issues concerning the psychiatrist-patient relationship, psychiatrists' understanding of their societal role with regard to disability, and practice time constraints may present challenges to treating psychiatrists who have patients who are filing for SSI or SSDI disability benefits. A fundamental understanding of the Social Security disability programs better prepares treating psychiatrists to formulate a more informed practice approach concerning these patients. This workshop includes a slide presentation (30 minutes), an interactive discussion among attendees (40 minutes), and a question-and-answer session (20 minutes).

REFERENCES:

1. Disability Evaluation Under Social Security, Washington, DC, US Government Printing Office, 2003.
2. Code of Federal Regulations 20 CFR 404.1527(d)(2); 416.927(d)(2).

Issue Workshop 135
"SAD DAYS": A VIDEO OF PSYCHIATRIC PROBLEMS IN AFGHANISTAN AND ITS REFUGEES

Chairperson: Nigel M. Bark, M.D., *Department of Psychiatry, Bronx Psychiatric Center, 1500 Waters Place, Ward 19, Bronx, NY 10461*
Participants: Khalid A. Mufti, M.D., Haroon R. Chaudhry, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the enormous mental health problems facing Afghanis both at home in Afghanistan and as refugees in Pakistan and elsewhere, know what needs to be done to help, and maybe feel compelled to do so.

SUMMARY:

This workshop highlights the mental health problems of Afghanistan and its refugees and what is being done and what should be done to help. Khalid Mufti presents a study of 807 Afghan refugees in Pakistan using the Schedules for Clinical Assessment in Psychiatry (SCAN). Their average age was 35, there were almost equal numbers of men and women, and one-third had no school education, although one-sixth had a university education. They reported a wide variety of traumatic experiences. Two-thirds had mental illness, 40% had depression, and 11% had PTSD. Psychiatric services were provided by a team composed of a psychiatrist, a primary care physician, nurses, social workers, and support workers.

Sad Days is a 12-minute video documentary that presents the current devastated mental health of Afghanis in their homeland in the context of serial traumas due to invasions and civil war. It depicts the miserable situation of women and children especially and highlights the need for urgent help from the international community.

Haroon Chaudhry, who has been training mental health workers in Afghanistan, speaks of his experience, and members of the audience who have experience in Afghanistan are invited to speak. The chairperson leads the discussion through a series of political, practical, diagnostic, and treatment questions.

REFERENCES:

1. Brundtland GH: Mental health of refugees, internally displaced persons and other populations affected by conflict. Acta Psychiatrica Scandinavica 2000; 102:159–161.
2. Kalafi Y, Hagh-Shenas H, Ostovar A: Mental health among Afghan refugees in Shiraz, Iran. Psychol Rep 2002; 90:262–266.

Issue Workshop 136
PROGRAM EVALUATION MADE SIMPLE

Co-Chairpersons: Barbara A. Johnson, M.D., *Community Care, CCBH, One Chatham Center, Suite 700, Pittsburgh, PA 15213-2593,* James A. Schuster, M.D., *Community Care, CCBH, One Chatham Center, Suite 700, Pittsburgh, PA 15219*
Participants: John G. Lovelace, M.S., Frank A. Ghinassi, Ph.D., Mario Cruz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to 1) report at least one reason to perform a program evaluation; 2) define indicator, input, output, outcomes, and logic model; 3) create a sample logic model; 4) identify one low, medium, and high cost data collection method; and 5) list at least one reason it is important to involve stakeholders in the evaluation process.

SUMMARY:

In this era of limited resources, those who provide services and those who fund services need to be able to respond when their stakeholders ask, "What is the evidence that this program works?" (Outcomes)" Program leadership within existing programs and those contemplating adopting the program insist on knowing. "How large an investment is necessary to run such a program?" (Input) Yet other stakeholders want to know "What service do you provide and to how many?" (Output) In this workshop the presenters introduce the language of program evaluation and walk through the steps of developing a program evaluation plan, including how to outline a "logic model" that connects indicators of need to mechanisms of change to the expected short- and long-term outcomes. The presenters discuss types of evaluations, sources and selection of indicators and outcome measures, evaluation costs, and the importance of stakeholder participation in the evaluation process. The steps in an outcome evaluation are illustrated with outcome data from a community treatment team program jointly evaluated by Allegheny County, Community Care Behavioral Health, and the University of Pittsburgh. The audience is encouraged to outline and discuss how they would evaluate their own program.

REFERENCES:

1. Pawson R, Tilley N: Realistic Evaluation. Thousand Oaks, Calif, Sage Publications, 1997.
2. Essock SM, Frisman LK, Kontos NJ: Cost-effectiveness of assertive community treatment teams. Am J Orthopsychiatry 1998; 68:179–190.

Issue Workshop 137
THE STALKING VICTIM: CAUSES, CONSEQUENCES, AND THERAPEUTIC CONSIDERATIONS

Chairperson: Gail E. Robinson, M.D., *Department of Psychiatry, University of Toronto, 200 Elizabeth Street, 8EN-231, Toronto, ON M5G 2C4, Canada*
Participant: Karen M. Abrams, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to treat victims of stalking by acquiring knowledge about the causes

and consequences of stalking, legal and societal responses to stalking, therapeutic techniques, and countertransference issues.

SUMMARY:

Stalking is a serious offense perpetrated by disturbed offenders. It can cause major mental health consequences that are often poorly understood by society. The majority of victims are female. As many as one of 20 women will be stalked during her lifetime. The offenders are usually men who have been in a failed relationship with the victim. Victims may experience anxiety, depression, guilt, helplessness, and symptoms of posttraumatic stress disorder. Victims also suffer from a lack of understanding by family, friends, society, police, and the legal system, all of whom may minimize the behaviour or not enforce laws. Victims may also blame themselves for the stalker's behaviour. Therapists must be aware of many countertransference issues, including fear of taking on the case, an increased sense of vulnerability, defensiveness, and overprotectiveness. This workshop presents overviews of the causes and consequences of stalking, stalking laws, and the problems victims may have with the legal system. Case examples are used to illustrate therapeutic techniques and pitfalls. Participants are given the opportunity to discuss treatment issues and management of their own cases.

REFERENCES:

1. Abrams KM, Robinson GE: Stalking, part 1: an overview of the problem. Can J Psychiatry 1998; 43:473–476.
2. Abrams KM, Robinson GE: Stalking, part 2: victims' problems with the legal system and therapeutic considerations. Can J Psychiatry 1998; 43:477–481.

Issue Workshop 138
DIVERSE CULTURAL EXPRESSIONS AND INTERVENTIONS FOR ANXIETY AND DEPRESSIVE DISORDERS

Chairperson: Nalini V. Juthani, M.D., *Department of Psychiatry, Bronx-Lebanon Hospital Center, 1276 Fulton Avenue, 4 South, Bronx, NY 10456*
Participants: Virginia Contreras, M.D., Kingsley Nwokeji, M.D., Akhtar Hossain, M.D.

EDUCATIONAL OBJECTIVE:

SUMMARY:

Recent projections by the U.S. Bureau of the Census suggest that by the year 2050, 45% of the U.S. population will be composed of people who are Latinos, African Americans, and Asian Americans. Anxiety and depression are universally present in human societies. The meaningful forms in which distress is articulated vary significantly across cultures. These forms include culture-specific idioms that range from somatized expressions to spirits and possession syndrome. In this workshop, Latino, Nigerian African, and Asian clinicians present the culturally based experiences of patients and possible culturally acceptable interventions that can lead to better treatment adherence. The culturally based experiences include infertility, dreams, magical aggression, and witchcraft, which are associated with anxiety and depression. Interventions include *espirito,* religion and spirituality.

REFERENCES:

1. Friedman S: Cross-Cultural Issues in the Treatment of Anxiety. New York, Guilford Press, 1997.
2. Good BJ, Kleinman AM: Culture and anxiety: cross-cultural evidence for patterning of anxiety disorders, in Anxiety and the Anxiety Disorders. Edited by Tuma AH, Maser J. Hillsdale, NJ, Eribaum, 1985, pp 297–324.

Issue Workshop 139
SPIRITUAL AND RELIGIOUS ASSESSMENT IN CLINICAL PRACTICE

Co-Chairpersons: Francis G. Lu, M.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7M, San Francisco, CA 94110,* Christina M. Puchalski, M.D., *GW Institute for Spirituality and Health, 2131 K Street, NW, Washington, DC 20037*
Participant: James L. Griffith, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the workshop, the participant should be able to understand the importance of incorporating history taking and assessment of religious/spiritual issues in clinical work and understand the practical methods of utilizing the assessment in treatment planning.

SUMMARY:

According to the APA Practice Guideline for Psychiatric Evaluation of Adults and the DSM-IV Outline for Cultural Formulation, cultural issues, including religion/spirituality, should be incorporated in history taking, assessment, and treatment planning. Yet clinicians may be unfamiliar with methods of religion/spirituality assessment. This workshop reviews cases that demonstrate methods of interviewing, assessment, and treatment planning. Participants are invited to critique and comment on these cases and use them as a stimulus for discussion of their own clinical work. Specific issues to be discussed include the importance of respect, rapport, the use of the DSM-IV Outline for Cultural Formulation, the DSM-IV diagnosis of religious or spiritual problems, and the use of religious or spiritual consultations and interventions, such as with chaplains.

REFERENCES:

1. Larson D, Lu F, Swyers J: Model Curriculum for Psychiatry Residency Training Programs: Religious and Spiritual Issues. Rockville, Md, NIHR, 1997.
2. Koenig H, McCullough M, Larson D: The Handbook of Religion and Health. New York, Oxford University Press, 2001.

Issue Workshop 140
LONG-TERM CARE INSURANCE DENIALS TO ONE-TIME PSYCHIATRIC PATIENTS

Co-Chairpersons: Rita R. Newman, M.D., *Department of Psychiatry, St. Barnabas Medical Center, 1046 South Orange Avenue, Short Hills, NJ 07078-3131,* Ruth B. Kantor, M.D., *St. Barnabas Medical Center, 212 Short Hills Avenue, Springfield, NJ 07081*
Participants: Lynn Lavendar, Esq., Brenda McElnea, Esq., Mark Wilensky

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants should be able to understand eligibility for long-term care insurance, as standards now exist, and to consider appeals when psychiatric treatment is cited as a reason for denial.

SUMMARY:

Increasing numbers of patients are reporting denial of their applications by long-term care insurance companies, despite appeals. This pattern has become prevalent even in cases of singular psychiatric episodes requiring limited treatment, with no evidence of chronicity at all. Once the individual lists several antidepressants as having been prescribed for concurrent treatment, which is now recommended for efficacious treatment of depression, denial of the application is generally automatic. This outcome suggests that insurance companies are using old guidelines that view use of multiple antidepressants

as a sign of malignancy and chronicity. The use of atypical antipsychotics, which are often used synergistically to enhance action of the primary medication, is also viewed as a sign of malignancy and chronicity. The panel participants review the history of insurance benefits in the psychiatric population and discuss possibilities for a revision of guidelines for insurance companies.

REFERENCES:

1. Shrier DK (ed): Sexual Harassment in the Workplace and Academia: Psychiatric Issues. Washington, DC, American Psychiatric Press, 1995.
2. Jensvold MF: Workplace sexual harassment: the uses of and misuse and abuse of psychiatry. Psychiatric Annals; Dec 1992.

Issue Workshop 141
AN EXTENSION OF THE ANALYSIS OF RESTORATIVE JUSTICE AND THERAPEUTIC JURISPRUDENCE

Co-Chairpersons: Lawrence K. Richards, M.D., *DLFAPA, 714 South Lynn, Champaign, IL 61820* Abraham L. Halpern, M.D., *DLFAPA, 720 The Parkway, Mamaroneck, NY 10543-4299*
Participants: Michael L. Perlin, Bruce J. Winick, Marjorie A. Silver

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to fulfill last year's request for continuation of these discussions, which achieved active full audience participation and an enjoyable exchange of ideas regarding the similarities, dissimilarities, and relationships between psychiatry, restorative justice, and therapeutic jurisprudence.

SUMMARY:

As last year, the primary workshop goal is an enjoyable exchange of ideas, first by stimulating and then expanding on ideas from the audience. The content gives insights into "lawyering" and novel approaches within jurisprudence. The legal presentation includes discussion of new judicial approaches (such as sentencing circles, teen court, and various courts for mental health), juvenile drug dependency, domestic violence, the problem of the revolving door, and the movement from description to prescription, including enhancing problem solving skills, countering denial and minimization, and facilitating motivation to change. Dr. Halpern gives an update on the history and degree of change during the last year. Dr. Richards expands on and adds insights and correlations and bridges matters into the data brought by APA members on jurisprudence. All psychiatrists present may comment on psychological, analytic, and therapeutic aspects of these data. Prof. Perlin discusses the evolution and variety of mental health courts, and Prof. Silver discusses lawyer-client relationships, focusing on psychological mindedness, emotional intelligence, and multicultural competence as aspects of the lawyer's ethical responsibilities. Bruce J. Winick, with Prof. David B. Wexler, is co-founder of the school of social enquiry known as Therapeutic Jurisprudence and a leading national figure and author in these areas.

REFERENCES:

1. Winick BJ, Wexler DB, eds: Judging in a Therapeutic Key: Therapeutic Jurisprudence and the Courts. Durham, NC, Carolina Academic Press, 2003.
2. Winick BJ: Therapeutic jurisprudence defined (www.brucewinick.com).

Issue Workshop 142
CHALLENGING SLEEP PROBLEMS: LOOKING AT SLOW-WAVE SLEEP

Chairperson: Lois E. Krahn, M.D., *Department of Psychiatry, Mayo Clinic Arizona, 13400 East Shea Boulevard, Scottsdale, AZ 85259*
Participants: Peter C. Gleason, M.D., Martin B. Scharf, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify disturbed sleep, explore slow-wave sleep among varied sleep-related problems, differentite features in sleep disturbances, describe limitations of current common treatments, and explore alternatives.

SUMMARY:

The responsibility of the psychiatrist includes accurate diagnosis of sleep complaints and providing appropriate treatment options. Sleep problems may be associated with a wide variety of psychiatric problems such as anxiety/affective disorder and PTSD. In addition to sleep disturbances with underlying psychiatric issues, chronic pain issues such as fibromyalgia may also affect sleep. The presenters explore disturbance in slow-wave sleep across these many sleep-related problems. Restoring normal sleep to patients may be challenging due to the nature of the cause and different patient responses to treatment. It is therefore important for the clinician to seek new and varied approaches in managing challenging sleep cases. Sodium oxybate will be among a number of therapies explored to restore sleep. Proper education about various treatments can enable psychiatrists to understand how to use treatments safely and appropriately in addressing sleep-related symptoms in selected patients. Audience members are invited to participate in discussion of three case presentations and may discuss their own similar difficult cases.

REFERENCES:

1. Wong CG, Bottiglieri T, Snead OC 3rd: GABA, gamma-hydroxybutyric acid, and neurological disease. Ann Neurol 2003; 54(suppl 6):S3–S12.
2. Singareddy RK, Balon R: Sleep in PTSD. Ann Clinical Psy 2002; 14:183–190.

Issue Workshop 143
WORKPLACE BURNOUT IN PSYCHIATRISTS: EVIDENCE FROM THE UNITED KINGDOM

Co-Chairpersons: Alex P. Mears, Ph.D., *College Research Unit, The Royal College of Psychiatrists, 83 Victoria Street, 6th Floor, London SW1H OHW, England,* John Sharkey, M.D., *NHS Jersey Queens House, Route De La Hougue Bie, St. Saviour Jersey JE2 7UW, England*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to appreciate the significant potential for psychiatrists to burnout, to understand how burnout arises, and to understand how to reappraise their working patterns in order to prevent deterioration and allow recovery.

SUMMARY:

Workplace burnout was first described in health care professionals in 1973 by Freudenburger. Since then, several studies have demonstrated a significant and increasing frequency of burnout among doctors. The characteristics of workplace burnout and the principles underlying their development are discussed as a platform to the presentation of research findings. The presenters provide the audience with opportunities and the tools to consider how much burnout

affects their lives and those of their patients. In 2002, a study was devised and executed by the Royal College of Psychiatrists' Research Unit in the United Kingdom. A random sample of 500 psychiatrists practicing in different settings in different parts of the country were sent a questionnaire about themselves and their work patterns, and their burnout profile was measured with using the Maslach Burnout Inventory. Results showed that workplace burnout is a serious issue and demonstrably correlates with working style. The significance of the conclusions from this research are discussed, and ways in which these conclusions may apply to the participants are explored.

REFERENCES:

1. Maslach C, Leiter L: The Truth About Burnout: How Organizations Cause Stress and What To Do About It. San Francisco, Jossey-Bass, 1997.
2. Schaufel W, Maslach C, Marek T: Professional Burnout: Recent Developments in Theory and Research. Florence, KY, Taylor and Francis, 1993.

Issue Workshop 144
REACTIONS AFTER 9/11 IN A PRETRAUMATIZED COMMUNITY IN THE SOUTH BRONX

Co-Chairpersons: Jeffrey M. Levine, M.D., *Bronx Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456,* Andreas Evdokas, Ph.D., *Bronx Lebanon Hospital, 3100 Third Avenue, Bronx, NY 10451*
Participants: Ibet Hernandez, C.S.W., Patrick J. Moynihan

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate the ability to recognize the needs of a pretraumatized population and provide appropriate community-based interventions for trauma-related reactions.

SUMMARY:

In the aftermath of the terrorist attacks in New York City on September 11, 2001, major efforts were undertaken to help local communities cope with trauma. The principal effort, Project Liberty, sponsored through FEMA, was a community mental health outreach strategy based on the philosophy that postdisaster trauma reactions are "normal reactions to abnormal events." However, Project Liberty efforts in the South Bronx frequently confronted a different situation: the community was an already "pretraumatized," psychiatrically vulnerable population, with other than "normal" reactions. The goals of this interdisciplinary workshop are to inform others of the lessons learned and to provide specific suggestions to those considering similar efforts. Topics include a review of relevant trauma/disaster literature, presentation of local demographic and clinical data from one Bronx Project Liberty provider, presentation of data from a study of the subjective experiences of community mental health outreach workers in the Bronx, review of clinical problems involved in adapting to the needs of a pretraumatized community, and methodological issues in organizing such a project. The presentations are interactive, and participants are particularly encouraged to share their thoughts and experiences.

REFERENCES:

1. Galea S, Ahern J, Resnick H, et al: Psychological sequelae of the September 11 terrorist attacks in New York City. New Engl J Medicine 2002; 346:982–987.
2. Schlenger WE, Caddell JM, Ebert L, et al: Psychological reactions to terrorist attacks: findings from the National Study of Americans' Reactions to September 11. JAMA 2002; 288:581–588.

Issue Workshop 145
TREATMENT OF RECENT-ONSET SCHIZOPHRENIA IN COMMUNITY AND RESEARCH SETTINGS

Chairperson: Raman C. Patel, M.D., *Department of Psychiatry, Bronx Lebanon Hospital, 1276 Fulton Avenue, 6th Floor, Bronx, NY 10456*
Participants: Gilbert Robinson, M.D., Rachel Miller, M.S.W., Jose M. Soto, M.D., Beth Lorell, C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the clinical issues and challenges involved in treating patients with first-episode schizophrenia.

SUMMARY:

There is increasing interest in the treatment needs of patients with recent-onset schizophrenia. This workshop explores the clinical challenges involved in treating these patients in community-based treatment settings. Comparison is also made between treatment of these patients in community settings and in research-based settings. The workshop begins with a brief review of clinical research findings relevant to treatment of recent-onset schizophrenia. The next presenter focuses on inpatient treatment and setting up specialized aftercare for these patients. Presenters then discuss the clinical challenges involved in treatment of these patients in the outpatient setting. Emphasis is placed on both psychiatric and psychosocial treatments, with special focus on pharmacological interventions and strategies to enhance adherence to treatment. After the presentation the audience is invited to discuss their experiences in treating recent-onset schizophrenia patients.

REFERENCES:

1. Robinson DG, Woerner MG, Alvir JM, et al: Predictors of relapse following response from a first episode of schizophrenia or schizoaffective disorder. Arch Gen Psychiatry 1999; 56:241–247.
2. Robinson DG, Woerner MG, Alvir JM, et al: Predictors of treatment response from a first episode of schizophrenia or schizoaffective disorder. Am J Psychiatry 1999; 156:544–549.

Issue Workshop 146
EVIDENCE-BASED TREATMENT FOR SCHIZOPHRENIA IN A CORRECTIONAL SETTING

Chairperson: Larry H. Dizmang, M.D., *California Medical Facility, 1600 California Drive, Vacaville, CA 95687*
Participants: John A. Chiles, M.D., Karen Alexander, Ph.D., David Silbaugh, Ph.D., Ira D. Glick, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the main advantages of evidence-based treatment strategies, including benefits received by patients, practitioners, and agencies, and should be able to recognize the common obstacles to implementation and the vast research potential stemming from computerized assessment techniques.

SUMMARY:

The presenters lead a discussion of a broad range of issues surrounding their successful implementation of an evidence-based treatment program at the California Medical Facility (CMF). This program is intended for mental health practitioners who treat schizophrenia patients and especially those who do so within a forensic/correctional environment. California Implementation of Medication Algorithms (CIMA) has the simultaneous benefits of standardizing and improving the overall quality of mental health care while cutting costs. Implementation of the Texas Medication Algorithm

Project (TMAP) was intended to promote consistency of prescription practices, enhance diagnostic accuracy, reduce polypharmacy costs, and quantify treatment outcome. During the past year CMF has implemented this program for patients with psychotic disorders. In this workshop, the process of implementation is described, and workshop participants examine myths and reality regarding algorithms. Does utilization of an algorithm threaten clinical intuition and the "art of prescription?" What happens when prescription practices are examined, including medication preferences, polypharmacy, and medication costs?

REFERENCES:

1. Maples NJ, Bow-Thomas OC, Velligan DI, Miller AL, Chiles JA, Prihoda TJ, Sui DW: The reliability, validity, and sensitivity of brief positive and negative symptom measures in schizophrenia. Schizophrenia Research 2001; 49:17–18.
2. Shores-Wilson K, Biggs MM, Miller AL, Chiles JA, Rush AJ, Crismon ML, Toprac MG, Witte BP, Webster JC: Itemized clinical ratings versus global ratings of symptom severity in patients with schizophrenia. International Journal of Methods in Psychiatric Research 2002; 11:45–53.

ADVANCES IN PSYCHOPHARMACOLOGY

ADVANCES IN PSYCHOPHARMACOLOGY: AN UPDATE FOR CLINICIANS

Alan F. Schatzberg, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Stanford, CA 94305-5717;* Jeffrey A. Lieberman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: identify the major consequences of stress and depression in the immune system; describe how genetic and non-genetic factors influence pharmacokinetics; summarize molecular mechanisms underlying neuronal communication; list common adverse events associated with MAOIs; and outline the risks and benefits of the nerves second generation antipsychotic agents.

SUMMARY:

This symposium features five outstanding scientists who summarize important developments in their respective areas of expertise. Dr. Miller will identify the major consequences of stress and depression on the immune system and will identify behavioral symptoms that may relate to immune activation. Dr. DeVane will describe the principles of pharmacokinetics and pharmacodynamics and how genetic and non-genetic factors influence the effects of medications, including enzyme polymorphisms and drug and herbal interactions. Dr. Manji will review the recent advances in our understanding of the molecular mechanisms underlying neuronal communication and will discuss their implications for psychopharmacological treatment. Dr. Krishnan will summarize the beneficial treatment effects of monoamine oxidase inhibitors (MAOIs) and will outline their potential adverse side effects. Finally, Dr. Lieberman will summarize the mechanism of action, efficacy, adverse events and possible future indications for the second generation antipsychotic agents.

REFERENCES:

1. Schatzberg AF, Nemeroff, CR: The American Psychiatric Publishing Textbook of Psychopharmacology, Third Edition. Washington, DC: American Psychiatric Publishing, 2004.
2. Schatzberg AF, Cole JO, De Battista C: Manual of Clinical Psychopharmacology. Fourth Edition. Washington, DC: American Psychiatric Publishing, 2003.

ADVANCES IN PSYCHOPHARMACOLOGY: INTRODUCTION TO NEUROTRANSMITTERS, RECEPTORS, SIGNAL TRANSDUCTION, AND SECOND MESSENGERS

Husseini K. Manji, M.D., *Laboratory of Molecular Pathophysiology, NIMH, Building 49, 49 Convent Drive, Room B1EE16, MSC4405, Bethesda, MD 20892*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: understand the different mechanisms by which cell to cell communication is undertaken in the central nervous sytem; understand the role of signaling pathways in the mechanisms of action of effective psychotropic medications; and understand strategies being utilized for the development of novel therapeutic agents.

SUMMARY:

The "molecular medicine revolution" has brought to bear the power of sophisticated cellular and molecular biologic methodologies to tackle many of society's most devastating illnesses. The rate of progress has been exciting indeed, and this has allowed the study of a variety of human diseases which are caused by abnormalities in cell to cell communication; studies of such diseases are offering unique insights into the physiologic and pathophysiologic functioning of many cellular transmembrane signaling pathways. Psychiatry, like much of the rest of medicine, has entered a new and exciting age demarcated by the rapid advances and the promise of molecular and cellular biology and neuroimaging. The behavioral and physiological manifestations of the major psychiatric disorders are complex and are likely mediated by a network of interconnected neuronal circuits. Since signal transduction pathways play a critical role in regulating the functional balance between neurotransmitter systems, they represent attractive putative mediators of the therapeutic effects of many of our effective treatments. This lecture will review the recent advances in our understanding of the molecular mechanisms underlying neuronal communication, and discuss their implications for psychopharmacological practice in the future.

REFERENCES:

1. Szabo S, Gould TD, Manji HK: Neurotransmitters, Receptors, Signal Transduction and Second Messengers in Psychiatric Disorders In American Psychiatric Textbook of Psychopharmacology, edited by Nemeroff CB and Schatzberg AF, 2003, in press.

ADVANCES IN PSYCHOPHARMACOLOGY: IMMUNE SYSTEM PATHOLOGY IN PSYCHIATRIC DISEASE

Andrew H. Miller, M.D., *Department of Psychiatry & Behavioral Science, Emory University, School of Medicine, 1639 Pierce Drive, Suite 4000, Atlanta, Georgia 30322*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: describe the major findings demonstrating bidirectional communication between the brain and immune system; identify consequences of stress and depression on the immune system and immune-related disorders including cancer and infectious diseases; and identify behavioral symptoms that may relate to immune activation/ inflammation and describe the nervous system pathways involved and relevant treatment options.

SUMMARY:

Over the past several decades, an immense body of data has been gathered that convincingly demonstrates bidirectional communication between the brain and immune system that can have profound effects on the maintenance of health and the development of disease. Data has demonstrated that immune cells express receptors for transmitters, peptides and hormones derived from and/or regulated by the nervous system. In addition, direct innervation of lymphoid tissue by autonomic nervous system fibers has been described. Alterations in nervous system function brought about by stress and/or depression have been shown to influence immune system activity as well as the development, course and outcome of immune-related disorders including infectious diseases and cancer. Many of the relevant hormonal and neurotransmitter pathways that mediate these effects have been elucidated. Of considerable interest is recent data demonstrating the profound behavioral impact of soluble factors (cytokines) derived from activated immune cells and glia during inflammation. The relative role of these factors in the various psychiatric diseases is an area of active investigation, as is the role of infectious and autoimmune diseases in the pathophysiology of psychiatric disorders. Treatment implications of this work include: 1) alleviation of stress and depression as a way to relieve suffering and improve outcome in patients with immune-related disorders and 2) targeting of pathways by which cytokines influence behavior including corticotropin releasing hormone and monoaminergic neurotransmitters and their precursors. Finally, data suggest that aggressive treatment strategies initiated prior to inflammation-inducing treatments might prevent behavioral alterations, including depression, before they occur.

REFERENCES:

1. Raison CL, Miller AH: The neuroimmunology of stress and depression. Seminars in Clinical Neuropsychiatry, 6(4):277–94, 2001.
2. Musselman DL, Lawson D, Gumnick JF, Manatunga A, Penna S, Goodkin RS, Nemeroff CB, Miller AH: Paroxetine for the prevention of depression induced by high dose interferon-alfa. New England Journal of Medicine, 344:961–966, 2001.

ADVANCES IN PSYCHOPHARMACOLOGY: SECOND GENERATION ANTIPSYCHOTICS

Jeffrey A. Lieberman, M.D., *Department of Psychiatry, University of North Carolina at Chapel Hill, 7025 Neurosciences Hospital, CB#7160, Chapel Hill, NC 27599-7160*

SUMMARY:

This presentation will discuss the comparative effectiveness of antipsychotic drugs and contrast the first and second generation classes of compounds. Clinical differences and efficacy and side effects of short and long-term trials will be described and interpreted in the context of their relevance to clinical practice.

REFERENCES:

1. Lieberman JA, Stroup TS: What can large pragmatic clinical trials do for public mental health care? Schizophrenia Bulletin 2003; 29(1):1–6.

ADVANCES IN PSYCHOPHARMACOLOGY: MAOIs

K. Ranga R. Krishnan, M.D., *Department of Psychiatry, Duke University Medical Center, Box 3018, Durham, NC 27710*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to learn about MAOIs.

SUMMARY:

Monoamine oxidase inhibitors (MAOIs) were first identified as effective antidepressants in the late 1950s. An early report suggested that iproniazid, an antituberculosis agent, had mood-elevating properties in patients who had been treated for tuberculosis. The use of iproniazid soon fell into disfavor because of its significant hepatotoxicity. Other MAOIs, both hydrazina derivatives and nonhydrazine derivatives, were introduced. These MAOIs were not specific for any subtype of MAO enzyme and were irreversible inhibitors of MAO. Their use has been rather limited, because hypertensive crisis by the MAOIs may occur in some patients from potentiation of the pressor effects of amines (such as tyramine) in food. In the last few years, there has been a resurgence of interest in the development of new MAOIs—those that are more specific subtypes of MAO enzyme and those that are reversible in nature. Newer MAOIs, such as an MAO β-inhibitor, have been introduced. After several weeks of treatment, MAOIs produce effects such as a reduction in the number of ββ-adrenoceptors, α1- and α2-adrenoceptors, and serotonin-1 (S-HT1) and serotonin-2 (5-HT2) receptors. These changes are similar to those produced by chronic use of tricyclic antidepressants (TCAs) and other antidepressant treatment. Selegiline hydrochloride is an irreversible MAO-B inhibitor its primary use is in treatment of Parkinson's disease as an adjunct to L-dopa and carbidopa. Selegiline hydrochloride (HCI) undergoes significant first-pass metabolism following oral administration. Transdermal delivery avoids the first-pass effect and provides greater levels of unchanged drug and reduced levels of metabolites compared to the oral regimen. Various MAOIs have been shown to be effective in treating a wide variety of psychiatric disorders, including depression, panic disorder, social phobia, and PTSD. The classic MAOIs are currently used only rarely as first-line medication because of potential dietary interaction and other long-term side effects.

REFERENCES:

1. Krishnan KRR: Monoamine oxidase inhibitors. In: Schatzberg AF, Nemeroff CB (eds), Textbook of Psychopharmacology, Third Edition. American Psychiatric Press, pgs 183–193, 2003.

ADVANCES IN PSYCHOPHARMACOLOGY: PRINCIPLES OF PHARMACOKINETICS

C. Lindsay DeVane, Pharm.D., *Department of Psychiatry, Medical University of South Carolina, 67 President Street, Room 246 North, Charleston, SC 29425-0742*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe how drugs pass through the body beginning with oral dose administration and concluding with elimination and to discuss how genetic and non-genetic factors influence the effects of medications, including enzyme polymorphisms, and drug and herbal interactions.

SUMMARY:

The study of the time course of drugs and their metabolites through the body (*pharmacokinetics*) is complementary to understanding the time course and intensity of pharmacological effects of drugs (*pharmacodynamics*). An explanation of basic principles in these disciplines is presented to aid in individualizing the dose and the frequency of dosing necessary to produce the desired pharmacological response from psychoactive drugs. For the relatively brief time a drug resides in the body, it encounters a variety of host mechanisms to prevent its entry into and to hasten its passage out of the body. Shortly after an oral dosage form is administered, drug in solution is exposed to P-glycoprotein and cytochrome P450 enzymes in the intestinal wall to limit access to the hepatic blood flow. A variety of hepatic enzymes can biotransform drugs into water soluble metabolites for biliary or renal excretion. Once absorbed, most drugs circulate in the blood bound to albumin or lipoproteins. This binding insures a continual re-exposure of drug to hepatocytes for metabolism. Non-protein bound, or free, drug is available to diffuse to target sites to produce pharmacologic effects. Numerous examples of inherited differences in drug effects are due to sequence variants in genes encoding drug-metabolizing enzymes, drug transporters, or drug targets. In addition, the determinants of drug disposition are subject to influence by non-genetic factors and drug interactions. Several essential parameters are used to describe the disposition of drugs. The most useful of these for designing drug dosing regimens and understanding the influence of geuetic and non-genetic variables on drug disposition are clearance and elimination half-life. Examples will be given to illustrate the practical value of these pharmacokinetic variables.

REFERENCES:

1. DeVane CL: Principles of Pharmacokinetics and Pharmacodynamics, In: AF Schatzberg & CB Nemeroff (Eds) American Psychiatric Press Textbook of Psychopharmacology, 3rd edition, 2003 (in press).

ADVANCES IN RESEARCH

FRONTIERS IN THE TREATMENT OF PSYCHIATRIC DISORDERS

Chairperson: Herbert Pardes, M.D., *Co-Chairpersons*: John Greden, M.D., Geetha Jayaram, M.D., *Participants*: Gerald Nestadt, M.D., Anthony Lehman, M.D., John S. March, M.D., Yvette Sheline, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be able to: 1) describe the frequency of personality disorders and their component traits, how they contribute to the burden of disease, their potential linkages with genetics, and potential diagnostic approaches for DSM-5; 2) describe and implement the latest information on evidence-based treatment for schizophrenia most capable of reducing positive symptoms, negative and ancillary symptoms, cognitive impairments, symptom relapse, and functional impairments; 3) describe predictors and possible combinations of predictors that might be useful in determining treatment selections for child/adolescent anxiety and depression, and implement specific steps for different approaches in treatment; and 4) describe how depression is believed to induce brain changes associated with smaller hippocampal and amygdala volumes, and how alterations in neurogenesis are associated with stress, depression, substance abuse, and other variables.

SUMMARY:

Personality disorders and their component traits are relatively common in the general and clinical populations. Their impact and contribution to the burden of disease at individual and societal levels is considerable. Despite this, there remains a limited appreciation of the relationship between personality disorders and normal traits on the one hand with Axis-1 conditions on the other. Dr. Gerald Nestadt, Professor of Psychiatry at Johns Hopkins will present "Personality Disorders: Epidemiology and Diagnosis" and review the latest epidemiologic findings as well as discuss potential diagnostic approaches for DSM-5. Implications for genetic research and treatment will be addressed.

The ultimate application of evidence-based medicine is at the clinical level, enabling decisions about managing critically ill patients. Dr. Anthony Lehman's talk will structure evidence-based treatment for schizophrenia under five levels of intervention:(1) To reduce positive symptoms and symptom relapse; (2) To reduce negative symptoms; (3) To treat ancillary symptoms; (4) To reduce cognitive impairments; and (5) To reduce functional impairments.

In this discussion, Dr. Anthony Lehman, Professor of Psychiatry at the University of Maryland will cover a spectrum of interventions from medications to family and community treatment. Remediation measures that have been proven effective will be discussed. Professor Lehman will talk about future directions for research in this area.

Dr. John March from the Department of Psychiatry, Duke University, North Carolina, addresses a timely clinical question- what have we learned in the treatment of child adolescent anxiety and depression? He will discuss the problem of prediction in treatment outcome studies from the standpoint of definition of terms, using the general linear model of prediction. He will also outline types of studies that may be useful in testing potential predictors and hypothesize possible matrices of predictor variables that might be useful. He will conclude by providing specific suggestions for implementing different approaches in treatment.

REFERENCES:

1. Nestadt G, Romanowski AJ, Samuels JF, Folstein MF, McHugh PR: The relationship between personality and DSM-III Axis I Disorders in the Population: Results from an Epidemiological Survey. American Journal of Psychiatry 1992; 149(9): 1228–1233.
2. March J: Anxiety disorders in children and adolescents. 1995. New York: Guilford Press.

CLINICAL CASE CONFERENCES

1. BOUNDARY ISSUES AND THE CHALLENGE OF THE SOMATIZING PATIENT

James L. Levenson, M.D., *Medical College of Virginia, 1250 East Marshall Street, Richmond, VA 23298,* Catherine C. Crone, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will understand the maladaptive reactions nonpsychiatric physicians may develop in response to patients with sever somatization, and potential interventions by consulting psychiatrists; and review options for a physician who seeks advice regarding a patient with whom a sexual boundary has been crossed.

SUMMARY:

Dr. R, an Internal Medicine specialist, was referred by his attorney for psychiatric evaluation after a Board of Medicine investigation of a complaint by a patient, Ms. C. Ms. C alleged that during physical examinations he had sexually assaulted her over several visits. The investigation also revealed that he had prescribed injectable opiates continuously for two years for her fibromyalgia and migraines. Dr. R had followed Ms. C for almost 20 years and considered her his "favorite patient" because she presented a complex diagnostic picture that fascinated him as an internist. He had made some diagnoses that other physicians had missed. The patient had been correspondingly grateful, had felt he was the only physician who understood her, and declined his many attempts to refer her to other physicians for treatment. Dr. R's problem list for the patient included a very large number of symptoms and diagnoses, most of them medically unexplained.

Discussion of this case will focus on two sets of issues. One is disturbances in the doctor-patient relationship that occur with severely somatizing patients, and what psychiatrists can offer other physicians to better mange them. The other focus of discussion will be the smaller boundary violations that started this physician down a slippery slope into sexual misconduct.

REFERENCES:

1. Farber NJ, Novack DH, Silverstein J, Davis EB, Weiner J, Boyer EG: Physicians' experiences with patients who transgress boundaries. J Gen Intern Med. 2000 Nov; 15(11):770–50.
2. Schwartz RS, Olds J: A phenomenology of closeness and its application to sexual boundary violations: a framework for therapists in training. Am J Psychother. 2002; 56(4): 480–93.

2. ASSESSING AND TREATING PSYCHIATRIC SYMPTOMS IN INDIVIDUALS WITH CARDIOVASCULAR DISEASE

Christine E. Skotzko, M.D., *18 Amy Drive, Westfield, NJ 07090-261,* Lynnette Krueger, M.S.N., Maria A. Rueda-Lara, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants shall develop the following skills in working with individuals with cardiovascular illness: history taking in a chronically medically ill population; differential diagnosis of Anxiety symptoms; differential diagnosis of Depressive symptoms; approaches to medication management based on symptom control; and usefulness of screening tools in following symptom control.

SUMMARY:

As medical technology advances, there are increasing numbers of individuals who survive what would have been insurmountable cardiovascular events several years ago. The undeniable links between depression and anxiety in individuals who have had heart attacks, cardiac bypass surgery, and internal defibrillators are clearly documented in the literature.

As a result there are increasing numbers of individuals with comorbid Psychiatric disorders in need of care in the community. Case presentations of several individuals actually referred for treatment will be utilized to allow for clinical correlation of the information presented.

Cases will include: Primary Symptoms of Depression: Primary Symptoms of Anxiety; and Mixed Depressive and Anxiety Symptoms.

Participants will be introduced to appropriate techniques for assessing individuals who present in their offices, differentiating symptoms that result from the underlying cardiovascular illness, and approaches to treatment that are symptom driven. General guidelines for medication use will be presented, as well as approaches to working with the referring providers.

REFERENCES:

1. Carney RM, Freedland KE, Miller GE, Jaffe AS. Depression as a risk factor for cardiac mortality and morbidity: a review of potential mechanisms. J Psychosom Res. 2002 Oct; 53(4):897–902.
2. Kessler RC, Berglund P, Demler O, Jin R, Koretz D, Merikangas KR, Rush AJ, Walters EE, Wang PS; National Comorbidity Survey Replication. The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). JAMA. 2003 Jun 18; 289(23):3095–105.

3. PSYCHIATRIC ISSUES IN THE MANAGEMENT OF PATIENTS WITH HIV INFECTION

Glenn J. Treisman, M.D., *John Hopkins University, 600 North Wolfe Street, Meyer 4-119, Baltimore, MD 21287,* Andrew F. Angelino, M.D., Heidi E. Hutton, Ph.D.

EDUCATIONAL OBJECTIVES:

Participants will be able to demonstrate an understanding of the impact of psychiatric illness on HIV infection. Participants will be able to demonstrate an understanding of the impact of HIV infection on psychiatric illness. Participants will be able to demonstrate an understanding of the principles of treatment of psychiatric illmesses in patients with HIV infection.

SUMMARY:

Psychiatric disorders are a common problem in the HIV clinic. Psychiatric disorders are linked to a number of the behaviors that place patients at risk for HIV, and the virus causes a variety of neuropsychiatric consequences that may cause or worsen psychiatric disorders. The epidemic transmission of HIV may in part be driven by psychiatric disorders. Depression, personality disorders, substance abuse, cognitive impairment and a variety of psychological states all have been shown to increase the risk of HIV infection. Survey reports suggest high rates of psychiatric disorders in HIV clinics, and chronically mentally ill patients have been shown to have an increased risk for HIV infection. Additionally, patients with HIV infection have been shown to have a delay in receiving treatment with Highly Active Antiretroviral Therapy (HAART), a decreased likelihood of a complete response, a decreased likelihood of staying on treatment, and an increased risk of death. Data from our clinic suggests this risk is reversed with psychiatric treatment. A case of a HIV infection in a person with many psychiatric disorders will be presented with a discussion of the issues of treatment of mood disorders, personality disorders, substance abuse, and problems of life encounters.

REFERENCES:

1. Angelino AF, Hutton HE, Treisman GJ: Psychiatric issues in the management of patients with HIV infection. JAMA 2001; 286:2857–2864.
2. Kaplin AI, Treisman GJ: Neurologic and psychiatric complications of antiretroviral agents. AIDS 2002; 16:1201–1215.

CONTINUOUS CLINICAL CASE CONFERENCE

1. HELPING PATIENTS COUNTER DEMORALIZATION WHILE LIVING WITH A CHRONIC OR RECURRENT PSYCHIATRIC ILLNESS: PARTS 1 AND 2

James L. Griffith, M.D., *Department of Psychiatry, George Washington University Medical Center, 2150 Pennsylvania Avenue, N.W., Washington, DC 20037*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to: (1) distinguish demoralization from depression or other Axis I symptoms of psychiatric disorders; (2) discern when demoralization contributes to non-adherence to treatment or other harmful health behaviors; and (3) demonstrate interviewing methods and use of psychosocial interventions that counter demoralization.

SUMMARY:

Demoralization, as a sense of incompetence, despair, helplessness, isolation from others, or meaninglessness, can undermine coping when patients grasp the significances for their lives of such diagnoses as schizophrenia, bipolar disorder, dissociative disorder, or personality disorder. Often under-appreciated by clinicians, demoralization is commonly misdiagnosed as depression, other Axis I symptoms, or an indicator of character pathology.

During this program, we will review the concept of demoralization, its diagnostic features, and systematic methods for building resilience by identifying and addressing each of the existential components of demoralization. Over the course of two days, four different cases will be presented in which audience participants with interact with faculty discussants in: (1) distinguishing signs of demoralization and their effects upon course of treatment; (2) noting how these signs of demoralization can be distinguished from Axis I or Axis II symptoms; and (3) proposing a range of methods that can help patients build resilience against its effects. An interactive dialogue will be encouraged.

REFERENCES:

1. Frank JD, Frank JB: Persuasion and Healing: A Comparative Study of Psychotherapy. Baltimore: Johns Hopkins University Press, 1991.
2. Griffith JL, Griffith ME: Encountering the Sacred in Psychotherapy: How to Talk with People about their Spiritual Lives. New York: Guilford Press, 2002.
3. Slavney PR: Diagnosing demoralization in consultation psychiatry. Psychosomatics 1999; 40: 325–329.

2. TWO HOSPITALIZED PATIENTS WITH REFRACTORY MOOD DISORDER AND COGNITIVE IMPAIRMENT: PART 1 AND 2

Stuart C. Yudofsky, M.D., *Department of Psychiatry, Baylor University School of Medicine, One Baylor Plaza, Houston, TX 77030*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will understand how to conduct a neuropsychiatric work-up of patients with mood disorders and concomitant cognitive impairment. Special attention will be placed on the diagnosis and treatment of primary brain disorders that contribute to both mood and cognitive disorders.

SUMMARY:

This conference will present two cases of patients who were treated at the Menninger Clinic, Houston for intensive inpatient treatment of refractory mood disorders. One patient suffered from severe Manic Depressive Illness, long-standing alcohol dependency, and severe interpersonal difficulties, in addition to cognitive impairment. A second patient was admitted with Major Depression and known HIV infection. During his hospitalization, cognitive impairment and parkinsonian symptoms were also observed. The workup of these two patients will be carefully reviewed, with special emphasis on brain findings. Utilizing a biopsychosocial model, treatment approaches to these patients and others with mood disorders and cognitive impairment will be presented.

REFERENCES:

1. Mayberg HS, Keightley M, Mahurin RK, Brannan SK: Neuropsychiatric Aspects of Mood and Affective Disorders, in The Textbook of Neuropsychiatry and Clinical Neurosciences, Fourth Edition, edited by Yudofsky SC, Hales RE. American Psychiatric Publishing, Washington, DC, 2003.
2. Duman RS, Malberg J, Nakagawa S, et al: Neuronal plasticity and survival in mood disorders. Biol Psychiatry 48:732–739, 2000.
3. Koutsilieri E, ter Meulen V, Riederer P: Neurotransmission in HIV-associated dementia: a short review. J Neural Transm (108:767), 2001.

DEBATE

RESOLVED: THE RRC SHOULD CONTINUE TO REQUIRE THAT PSYCHIATRIC RESIDENCY PROGRAMS MUST DEMONSTRATE THAT THE RESIDENTS HAVE ACHIEVED COMPETENCY IN PSYCHODYNAMIC PSYCHOTHERAPY

Moderator: Sheila Judge, M.D.
Affirmative: Allan Tasman, M.D., Lisa A. Mellman, M.D.
Negative: Joel Yager, M.D., Eugene H. Rubin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will be able to describe and discuss the principal arguments for retaining, modifying, or eliminating the current RRC requirements concerning achieving competency in psychodynamic psychiatry.

REFERENCES:

1. Rubin EH, Zorumski CF. Psychiatric education in an era of rapidly occurring scientific advances. Acad Med. 2003 Apr;78(4): 351–4
2. Yager J, Bienefield D. How competent are we to assess psychotherapeutic competence in psychiatric residents? Acad Psychiatry 2003. Fall;27(3): 174–81
3. Mellman LA, Beresin E. Psychotherapy competencies: development and implementation. Acad Psychiatry. 2003 Fall;27(3): 149–53

FOCUS LIVE

1. FORENSIC AND ETHICAL ISSUES IN PSYCHIATRY

Laura W. Roberts, M.D., *Department of Psychiatry, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226,* Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worchester, MA 01655,* Deborah J. Hales, M.D., Mark H. Rapaport, M.D.

EDUCATIONAL OBJECTIVES:

As a result of participation in this interactive workshop, participants will have the opportunity to review many aspects of current thought about ethical issues in psychiatry. Participants will engage in a self-assessment activity designed to help them identify areas where they might benefit from more study.

SUMMARY:

In FOCUS Live! sessions, expert clinicians, who served as the guest editors of *Focus* will lead lively multiple choice question-based discussions. Participants will test their knowledge with an interactive audience response system, which instantly presents the audience responses as a histogram on the screen, allowing private comparison to other clinicians in the audience. Questions will cover existing knowledge on a topic important to practicing general psychiatrists.

As psychiatrists we are called upon each day to make ethically important decisions in the service of our patients, our communities, our students, our colleagues, and our profession. Many of these decisions are so routine and so subtle as to be unnoticed within the course of our work. Making a diagnosis, recommending one medication over another, obtaining consultation, supervising trainees, and documenting clinical information are ordinary practices involving ordinary choices. Other decisions rivet our attention, however, causing us to be uneasy, to question, and to seek clarity. These decisions—involuntarily hospitalizing a suicidal elder, reporting suspected child abuse, dealing with a serious clinical mistake made by a colleague—are more recognizably ethical because they overtly challenge our understanding of what is good and right and require us to use, purposely, the power that is entrusted to us by virtue of our professional role. Nevertheless all of these decisions are intrinsically ethical. And applying insights derived from the field of psychiatric ethics may help us to make them well or, at least, better than we might.

A central aim of psychiatric ethics is analyzing morally-important, value-laden aspects of the care of people with mental illness and then making choices that reflect our best judgment and are true to our hearts. Psychiatric ethics is a growing field of multidisciplinary scholarship informed by conceptual work and empirical evidence. It encompasses abstract questions of humanness, humanity, moral agency, empathy, and spirituality; it also has taken on concrete questions related to measures of decisional capacity and voluntarism, construction of optimal confidentiality practices, efforts to establish and maintain therapeutic boundaries, assessments of harm-reduction strategies in the treatment of coexisting illnesses, and effectiveness of various research safeguards.

REFERENCES:

1. FOCUS: The Journal of Lifelong Learning in Psychiatry, Volume 1, Number 4, Forensic and Ethical Issues in Psychiatry.
2. Simon RI: Concise Guide to Psychiatry and Law for Clinicians, 3rd Edition, American Psychiatric Press, 2001.

2. PTSD AND ANXIETY DISORDERS: TEST YOUR KNOWLEDGE

Jonathan R.T. Davidson, M.D., *Department of Psychiatry, Duke University, P.O. Box 3812, Trent Drive, 4th Floor, Room 4082B, Durham, NC 27710,* Deborah J. Hales, M.D., Mark H. Rapaport, M.D.

EDUCATIONAL OBJECTIVES:

As a result of participation in this interactive workshop, participants will have review aspects of current clinical knowledge and increase their understanding of current diagnosis and treatment of anxiety disorders and PTSD. Participants will engage in a self-assessment activity designed to help them indentify areas where they might benefit from more study.

SUMMARY:

In FOCUS Live! sessions, expert clinicians, who served as the guest editors of *Focus* will lead lively multiple choice question-based discussions. Participants will test their knowledge with an interactive audience response system, which instantly presents the audience responses as a histogram on the screen, allowing private comparison to other clinicians in the audience. Questions will cover existing knowledge on a clinical topic important to practicing general psychiatrists, including diagnosis, treatment, and new developments.

Just as we regard schizophrenia and bipolar as being serious mental illnesses, so we should be commanded to regard posttraumatic stress disorder (PTSD), a condition whose prevalence in the US exceeds the combined prevalence of these other two disorders. A person with PTSD can expect, on average, to endure over two decades of active symptoms, to miss almost one day of work per week, and to have a 20% chance of attempting suicide, an outcome which is not fully explained by the presence of comorbid depression (Kessler, 2000; Davidson et al, 1991). The heavy burden of PTSD has been described elsewhere as far as its impact on health seeking is concerned (Davidson, 2002), and its destructive effect on intimate attachments and sources of support is also recognized.

Can PTSD be effectively treated? Until about five years ago, we had only a very limited appreciation as to how effective treatment could be. What little we knew led us to believe that gains were only modest, and treatment largely palliative. More recent reports of trials assessing SSRI drugs and exposure-based psychosocial therapies have fortunately painted a much brighter picture, and it is now justifiable, indeed best practice, to think of remission as being the desired outcome (Connor et al, 1999; Foa and Hembree, 2000). It is also important to keep in mind that, following trauma, most survivors do not develop PTSD. Could innate human resilience have a protective effect here? Is it possible to promote resilience with our known effective treatments? Evidence suggests this is so (Connor et al, 1999).

REFERENCES:

1. FOCUS: The Journal of Lifelong Learning in Psychiatry, Volume 1, Number 3, Posttraumatic Stress Disorder.
2. Hollander E, Simeon D: Concise Guide to Anxiety Disorders, American Psychiatric Press Inc, 2003.

3. SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

John Lauriello, M.D., *Department of Psychiatry, University of New Mexico, 2400 Tucker NE, Albuquerque, NM 87131,* Deborah J. Hales, M.D., Mark H. Rapaport, M.D.

SUMMARY:

In FOCUS Live! sessions, expert clinicians, who served as the guest editors of *Focus* will lead lively multiple choice question-based discussions. Participants will test their knowledge with an

interactive audience response system, which instantly presents the audience responses as a histogram on the screen, allowing private comparison to other clinicians in the audience. Questions will cover existing knowledge on a clinical topic important to practicing general psychiatrists, including diagnosis, treatment, and new developments.

Schizophrenia is a chronic, debilitating psychotic disorder affecting 1% of adults. Symptoms of the illness are highly variable from person to person, but typically include "positive" symptoms (delusions, hallucinations, thought disorganization), "negative" symptoms (blunted affect, social dysfunction, lack of motivation), cognitive impairments, and mood disturbance. Recurrence of active psychosis, progression of symptoms, and deterioration in all areas of life function are the rule. The combination of onset in early adulthood and persistent dysfunction create enormous financial and personal costs attributable to the disorder. The biological basis of schizophrenia is not clear, but is known to include genetic, environmental, and developmental factors. Recent research findings underscore the importance of dopamine systems and maturational changes in the brain. Treatment includes psychosocial interventions to address social deficits, family issues, and functional impairments. Medical treatment focuses on the use of atypical antipsychotic medications as first-line therapy, clozapine for treatment-refractory patients, and depot conventional antipsychotics for responsive, noncompliant patients. Optimal treatment is provided in community-based centers with expertise in the disorder, but to ensure adequate support for such treatment is a continuing challenge.

REFERENCES:

1. FOCUS: The Journal of Lifelong Learning in Psychiatry, Volume 2, Number 1, Schizophrenia.
2. Lauriello J, Bustillo J, Keith SJ: A critical review of research on psychosocial treatment of schizophrenia. Biol Psychiatry 1999; 46:1409–1417.

FORUMS

1. EVIDENCE-BASED PSYCHOTHERAPY

Chairperson: Darrel A. Regier, M.D.
Co-Chairperson: John S. McIntyre, M.D.
Participants: Myrna M. Weissman, Ph.D., Robert Michels, M.D., A. John Rush, M.D., David Barlow, Ph.D., Joshua E. Wilk, Ph.D., Lisa A. Mellman, M.D., Marsha M. Linehan, Ph.D., Anthony F. Lehman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the forum, the participant should be able to provide an overview of the empirical support for psychotherapies for major mental disorders.

SUMMARY:

Although several psychotherapies have been shown to be effective for some mental disorders, access to these treatments is limited. It's unclear if general acceptance of these treatments by the psychiatric community has been limited by factors such as lack of familiarity in training programs, skepticism about the evidence base, or discomfort in their use. This session will feature leading psychotherapy researchers who will provide an overview of the empirical support for psychotherapies for major mental disorders. They'll also highlight critical "treatment fidelity" issues affecting the effectiveness of these treatments in routine practice. John Rush, M.D. will provide an overview of evidence-based psychotherapies for mood disorders; David Barlow, Ph.D. will focus on anxiety disorders; Marsha Linehan, Ph.D. will review psychotherapy efficacy for personality disorders; and Anthony Lehman, M.D. will review evidence-based psychotherapeutic treatments for schizophrenia. Josh Wilk, Ph.D. will present national data from the APIRE Practice Research Network on patterns of evidence-based psychotherapies in routine psychiatric practice. Finally, Lisa Mellman, M.D. will review the state of psychotherapy training in psychiatric residency programs. Two discussants with expertise in the theory and practice of psychotherapy, Myrna Weissman, Ph.D. and Robert Michels, M.D. will comment on how current psychotherapy research and practice might be modified to improve treatment access.

REFERENCES:

1. Olfson M, Marcus SC, Pincus HA: Trends in office-based psychiatric practice. Am J Psychiatry 156:451–457.
2. Rush AJ, Thase MD, Psychotherapies for depressive disorders: A review. In Maj M, Sartorius N. (Eds), WPA Series. Evidence and Experience in Psychiatry, Vol. 1. Depressive Disorders. Chichester, UK: John Wiley & Sons, Ltd., pp. 161–206, 1999.

2. ETHICAL DILEMMAS IN PRACTICE AND RESEARCH

Chairperson: David M. McDowell, M.D.
Participants: David J. Hellerstein, M.D., David A. Lowenthal, M.D., Samuel C. Klagsbrun, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the forum, the participant will have a greater knowledge of the ethical dilemmas faced in practice today. The attendee will have a greater knowledge of the legal ramifications of clinical decisions made in regards to patients who use substances, but operate in the world.

SUMMARY:

Substance abuse throws a very large wrench into the heady conflagration of a physician's duties. The role the psychiatrist plays in terms of an individual with a substance abuse problem is a complex, and increasingly vexing one. On one hand a psychiatrist has a duty to maintain confidentiality in treating an individual patient. On the other hand there are limits in terms of the absolute inviolability that that privilege is held. This is most widely known with the Tarasoff case. It is clear, however that the law is anything but certain in terms of where a physicians duty to an individual patient ends, and his or her duty to society begins. It is a very indelicate balance.

REFERENCES:

1. Stevens NG. McCormick TR. What are students thinking when we present ethics cases?: an example focusing on confidentiality and substance abuse. [Journal Article] Journal of Medical Ethics. 20(2):112–7, 1994 Jun.
2. de Miranda S. The ethics of statutory coercion in the treatment of chemical substance abuse/dependence (addiction). [Journal Article] Medicine & Law. 7(5):427–32, 1989.

3. ABPN UPDATE: REQUIREMENTS FOR ABPN EXAMINATION

Chairperson: Stephen C. Scheiber, M.D.
Participants: Michael H. Ebert, M.D., Larry R. Faulkner, M.D., David A. Mrazek, M.D., Burton V. Reifier, M.D., Victor I. Reus, M.D., James H. Scully, Jr., M.D., Elizabeth B. Weller, M.D., Daniel K. Winstead, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assist resident members, young career psychiatrist members and other members in learning the policies and procedures of the ABPN for certification, recertification, and subspecialization.

SUMMARY:

An overview of the policies and procedures of the American Board of Psychiatry and Neurology will be presented followed by an active dialogue about the necessary conditions for admission to the certification examination, the examination process and the current status of recertification and subspecialization. Material will focus on the resident members and young career psychiatrists.

Resident and young career psychiatrists will be encouraged to attend and ask questions about certification, recertification and subspecialization in addition to the specifics of the Part I and Part II written and oral examinations for certification. Participants will be urged to discuss child and adolescent psychiatry, addiction psychiatry, forensic pschiatry, geriatric psychiatry, clinical neurophysiology, and pain management.

REFERENCES:

1. Shore, James and Scheiber, Stephen C. "Certification, Recertification and Lifetime Learning", APPI Press, Washington, D.C. 1994.
2. American Board of Medical Specialties: "Recertification for Medical Specialists", ABMS, Evanston, IL 1987.

4. JAILS OR TREATMENT? ALTERNATIVES TO INCARCERATION

Chairperson: Stephen M. Goldfinger, M.D.
Participants: Matthew D'Emic, J.D., Charles J. Hynes, J.D., Kenneth Linn Esq., Lisa Schreibersdorf, J.D., Anne J. Swern, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the forum, the participant should be able to describe one model of pre- and post-trial diversion and discuss the benefits of each.

SUMMARY:

As our nations jails and prisons become increasingly more overcrowded, and as our recognition of the disproportionate representation of those with mental illnesses and substance abuse among inmates grows, localities around the country are searching for better alternatives for these "triply challenged" individuals. Kings County (Brooklyn, NY), under the leadership of District Attorney Charles J. Hynes, is recognized as one of the most forward-thinking counties in the nation on issues of alternatives to incarceration.

Specialized programs for pre-sentencing diversion of dually diagnosed defendants (including felons), a specialized Mental Health Court with a full-time judge, and other residential and case management programs provide models for how DA's, defense attorneys, clinicians and academics, and community providers can work together.

This forum will bring together individuals from widely varying parts of the city's legal and treatment system for an exploration of what works, what doesn't, for whom, and why. *Brief* presentations will be followed by interactive discussion between and among panelists and the audience.

REFERENCES:

1. Broner N, Nguyen H, Swern A, Goldfinger S: Adapting a substance abuse court diversion model for felony offenders with co-occurring disorders: initial implementation Psychiatric Quarterly 74(4): 361–385; Jan 2003.
2. Griffin PA, et al.: The use of criminal charges and sanctions in mental health courts, 53 Psychiatric Serv. 1285, 1287–89 (2002).

5. MUSIC AND THE MIND: BEETHOVEN

Chairperson: Richard Kogan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this forum, the participant should: 1) recognize the psychological factors that influenced Beethoven's artistic development; and 2) understand some fundamental concepts about creativity.

SUMMARY:

No composer exerts a more powerful hold on the imagination than Ludwig van Beethoven, and no one has surpassed his extraordinary ability to express dramatic conflict and resolution. But the full scope of Beethoven's genius was slow to emerge. As a young composer, he embraced the styles and conventions of his contemporaries. Eventually, however, his quest to discover a personal voice led him to reshape pre-existing musical language in order to express the full range of human experience-despair and aggression as well as triumph and transcendance.

Psychiatrist and award-winning concert pianist Dr. Richard Kogan (1st prize-Chopin Competition) will perform musical examples to illuminate the connection between Beethoven's psyche and his creative process. There will be an exploration of the impact of significant biographical factors (his brutal childhood, the onset of his deafness, his thwarted quest for the "Immortal Beloved") on his artistic development.

With his unruly appearance, his volatile temperament, and his turbulent music, Beethoven is for many the model for the image of the "mad genius". Dr. Kogan will discuss the relationship between mental illness and artistic inspiration and he will speculate on whether Beethoven suffered from bipolar disorder.

REFERENCES:

1. Solomon, Maynard: Beethoven.
2. Neumayr, Anton: Music & Medicine.

6. REVERSING THE CRIMINALIZATION OF THE SERIOUSLY MENTALLY ILL

Chairperson: Marcia Kraft Goin, M.D.
Co-Chairperson: Henry C. Weinstein, M.D.
Participants: H. Richard Lamb, M.D., Tom Hamilton, M.D., Erik J. Roskes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this forum, the participant should be able to appreciate the causes and the extent of the criminalization of the seriously mentally ill in the criminal justice system and the juvenile justice system, that it is more cost effective to treat the mentally ill in the community and the efforts that the APA in partnership with other advocacy groups is making to keep the mentally ill out of the criminal justice and juvenile justice systems and to reverse the trend of criminalization by programs of diversion, mental health courts and discharge planning and increasing financial support of the community mental health system.

SUMMARY:

The criminalization of the seriously mentally ill is a major public policy scandal which resulted from the rapid deinsitutionalization of the seriously mentally ill and the concomitant failure to adequately fund the community mental health system. The seriously mentally ill are now significantly overrepresented in jails, in prisons and in juvenile detention facilities. In addition to humanitarian concerns (APA, NAMI and other advocates see the criminalization of the seriously mentally as a major civil rights issue) there are economic issues. The seriously mentally ill are more expensive to incarcerate than other inmates and are better served—as a matter of economics (costs)—by treatment in their communities. Just as deinstitutionalization was, in large part, driven by state budgetary concerns—the APA, in partnership with NAMI and other advocacy organizations is compiling data to prove the economic, budgetary and business advantages of decriminalizing the mentally ill.

The presenters at this forum will first describe the development of this situation: "transinstitutionalization." How the precipitous closing of hospital beds, labeling and stigmatization resulted in many seriously mentally ill people—not true criminal offenders—became inmates in state prisons. Programs to "uncriminalize" the mentally ill—and prevent rearrest and recidivism—will be described including diversion programs, mental health courts and discharge into a system of mental health care that welcomes patients released from correctional facilities.

An advocacy effort by which legislators and their constituents—the taxpayers—will be persuaded that they can avoid misspent resources and it is more cost efficient to treat and maintain these patients in the community mental health system rather than in the juvenile justice or the criminal justice system will be presented.

REFERENCES:

1. NAMI and Public Citizen's Health Research Group (1992) "Criminalizing the Seriously Mentally Ill—The Abuse of Jails as Mental Hospitals".
2. American Psychiatric Association (2000). Psychiatric Services in Jails and Prisons, 2nd Edition: Task Force to Revise the APA Guidelines on Psychiatric Services in Jails and Prison (Rep. No. 2). Washington, DC: American Psychiatric Association.

7. UNCONSCIOUS PREDICTION, CONSCIOUS MONITORING, AND THERAPEUTIC CHANGE: IS THERE A MIND-BRAIN BARRIER?

Chairperson: Marian I. Butterfield, M.D.
Participant: Regina Pally, M.D.

EDUCATIONAL OBJECTIVE:

The educational objective of this forum is to present a new neurobiologic paradigm of brain function, which is relevant to the theory and practice of psychotherapy.

SUMMARY:

1. The brain automatically and non-consciously generates non-conscious predictions about changes in the environment.
2. Past learning about the regularities of which events tend to follow one another, contribute to predictions.
3. Predictions enable the brain to perceive events and respond to them rapidly and efficiently.
4. Even before events occur and we respond to them, the brain has already generated a prediction of what event is most likely and what action most likely will be taken in response.
5. As a result of predictions, the brain increases activity in perceptual, emotional and motor brain regions best adapted to what is predicted.
6. Predictions create a subjective bias. We react more to what we predict than to what is there.
7. Predictions are not always correct. The brain has a monitoring system, involving consciousness, which can detect and correct prediction errors.
8. Transference, and repetition of patterns of behavior from childhood, are the result of predictive mechanisms. Conscious reflection facilitates working through and therapeutic change.
9. Emphasis is given to the early relationship with caretakers as the basis for the predictive template of what to expect from others. We relate to people as we expect to be related to and are biased by our brain activity, to experience what we expect.

REFERENCES:

1. Freeman WJ. How Brains Make Up Their Minds. New York: Columbia University Press. 2000.
2. Fuster JM. Cortex and Mind. New York: Oxford University Press. 2003.

8. SHOULD SEX BE PREVENTED IN PSYCHIATRIC UNITS? ARGUMENTS AND NEW DIRECTIONS

Chairperson: Milton L. Wainberg, M.D.
Participants: Elizabeth B. Ford, M.D., Carol A. Bernstein, M.D., Marshall Forstein, M.D., Paulo E. Mattos, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this forum, the participant should be able to understand all issues pertinent to developing a comprehensive policy in how to approach sex behaviors in adult psychiatric inpatient units and training methods for ensuring all staff and patient participation in this process and adherence to it.

SUMMARY:

The debate over how to manage sexual behavior on adult acute care inpatient psychiatric units has implications on patient wellbeing, institutional policies and liabilities. Psychiatric hospitals must protect and safeguard persons with possible impaired decisional capacity. A de facto assumption in psychiatric inpatient care is that the acute care setting should prevent all sexual interactions between patients given the potential risks of such behavior. Concerns include the transmission of sexually transmitted diseases, reproductive issues, mental wellbeing, and the legal implications of nonconsensual activity. However, adult psychiatric inpatients should be granted as many rights as are possible without having an adverse effect on their treatment or recovery. There is currently no standard for a sexual behavior policy for psychiatric inpatients. This forum will debate the pros and cons of preventing sex in inpatients units. Debaters will present their positions utilizing published and ongoing research in this area both nationally and internationally.

REFERENCES:

1. Ford, Elizabeth; Rosenberg, Michele; Holsten, Margarita; Boudreaux, Tyson. Managing sexual behavior on adult acute care inpatient psychiatric units. [Journal Article] Psychiatric Services. Vol 54(3) Mar 2003, 346–350.
2. McKinnon, Karen; Carey, Michael P; Cournos, Francine. Research on HIV, AIDS, and severe mental illness: Recommendations from the NIMH National Conference.

9. I AM SAM

Chairperson: Marcia Kraft Goin, M.D.
Participants: Jesse Nelson, Daniel J. Siegel, M.D.

SUMMARY:

A New Line Production, "I Am Sam," is the heartfelt story of Sam Dawson (*Sean Penn*), a mentally challenged father who struggles with the trials and tribulations of parenthood. Sam has the intellectual capacity of a seven-year-old and the film explores the critical year his daughter turns seven and begins to eclipse him. Initially below the radar, their situation comes under scrutiny when Lucy (*Dakota Fanning*) enters school and a social worker intervenes to remove her from their home.

Faced with a seemingly unwinnable case, Sam stumbles upon Rita Harrison (*Michelle Pfeiffer*), a high-powered, self-absorbed divorce attorney who takes his case pro bono as a challenge from her colleagues. Their worlds collide. On the surface they appear to be drastically different when in reality they are subtly similar. Sam's compulsive need for order is judged harshly but mirrors Rita's more socially acceptable obsessive-compulsive nature. Their relationship, while unsuspecting and even unwilling, fuses a bond that results in an unlikely testament to the power of unconditional love.

10. BUPRENORPHINE: WHAT THE CLINICIAN SHOULD KNOW

Chairperson: Herbert D. Kleber, M.D.
Participants: David M. McDowell, M.D., Roberta Sales, R.N., Erik W. Gunderson, M.D., Patricia I. Ordorica, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will have an understanding of the pharmacological use and applicability of buprenorphine; and have an understanding of the history and current status of the regulation of buprenorphine.

SUMMARY:

This workshop will help participants understand the use of buprenorphine for opioid dependent patients. The Drug Addiction Treatment Act of 2000 permits physicians to prescribe buprenorphine, a partial opioid agonist, in their office practices for the treatment of opioid dependence. Buprenorphine can be prescribed by physicians who have the required certification, for detoxification and maintenance treatment of opioid dependence. Clinically relevant characteristics of the medication including induction and maintenance protocols will be discussed. The prerequisites for a physician to begin prescribing buprenorphine in office-based practices will be discussed.

REFERENCES:

1. Krantz MJ, Mehler PS: Treating opioid dependence: growing implications for primary care. Archives of Internal Medicine, 2004, Feb 9; 164(3) 277–88.
2. Gandhi DH, et al.: Short-term outcomes after brief ambulatory opioid detoxification with buprenorphine in young heroin users. Addiction, 2003, 98, 453–462.

11. 9/11 RESEARCH: A REVIEW AND REVIEWS

Chairperson: Anand Pandya, M.D.
Participants: Carol S. North, M.D., Craig L. Katz, M.D., Sandro Galea, M.D., Ezra S. Susser, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this forum, participants will be able to: (1) List 3 major psychiatric findings from 9-11-related research; and (2) identify two areas for future disaster psychiatry research.

SUMMARY:

The attacks on September 11th, 2001 were a devastating tragedy that profoundly affected many throughout the country including psychiatrists and researchers. Yet, this event also created a unique opportunity to study the psychological effects of disasters, the time course of these reactions, and the treatment for pathological reactions.

This panel will include leading researchers who responded to September 11th. These researchers will summarize their own findings and the findings of others that they feel have contributed substantially to our understanding of disaster psychiatry after September 11th. These panelists will then have an opportunity to respond to each others work and to field questions from the audience. The forum will conclude with a discussion of future directions in disaster psychiatry and the ongoing psychiatric research agenda for September 11th.

REFERENCES:

1. Katz C, Pellegrino L, Pandya A, Ng A, Delisi L: Research on psychiatric outcomes and interventions subsequent to disaster: a review of the literature. Psychiatry Research (2002) 110:201–217.
2. Galea S, Resnick H, Ahern J, Gold J, Bucuvalas M, Kilpatrick D, Stuber J, Vlahov D: Posttraumatic stress disorder in Manhattan, New York City, after the September 11th terrorist attacks. J Urban Health. (2002) 79:340–53.

12. APA AND THE PHARMACEUTICAL INDUSTRY: AN OPEN FORUM

Chairperson: Stephen M. Goldfinger, M.D.
Participants: Charles R. Goldman, M.D. Geetha Jayaram, M.D., David M. McDowell, M.D., Trevor R.P. Price, M.D., Nyapati R. Rao, M.D., Anand Pandya, M.D., David B. Mallott, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to describe the current policies and activities of the APA and the ACCME; members will have shared their thoughts about important future directions for the APA; and approaches on how best to shape and oversee the industry/organizational boundary will have taken place.

SUMMARY:

The interface between the pharmaceutical industry and medical/professional organizations has become an area of increasing scrutiny and controversy. From scholarly publications to tabloid media, attention is being focused on the nature, content, oversight, and potential abuse of industry involvement in research, academic departments, and medical societies. In response to leadership and member concerns about these issues, in 1999 the APA established the Committee on Commercial Support.

The Committee on Commercial Support is charged with developing policies and procedures to ensure that the interface between the APA and commercial/industry supported educational activities reflect the highest ethical and educational standards. Direct tasks of the group include monitoring the content of industry-supported presentations at the Annual Meetings, developing guidelines and policies for improving the quality and balance of these presentations, and establishing sanctions for members and organizations in violation of APA policy. Although many policies involve interpretation of the guidelines of the ACCME, others are newly developed by APA, which is now a leader for policymaking in this arena.

In this forum, members of the committee will briefly present an overview of our current activities and some of the more controversial issues and decisions we are facing. The bulk of the forum will be an open discussion among members and attendees on these issues, with hopes that valuable contributions which can be implemented for future meetings will emerge from the interchange.

REFERENCES:

1. Friedberg M, Saffran B, Stinson TJ, et al: Evaluation of conflict of interest in economic analyses of new drugs used in oncology. JAMA, 1999; 282:1453–1457.
2. ACCME's Essential Areas, Elements, and Decision-Making Criteria Accreditation Council for Continuing Medical Education, pp 7–10, July 1999.

LECTURES

SUNDAY, MAY 2, 2004

LECTURE 1
AAPL/APA'S MANFRED S. GUTTMACHER AWARD LECTURE
INFANTICIDE: THE HOPE OF PREVENTION AND THE PROMISE OF SAVED LIVES

Margaret G. Spinelli, M.D., *College of Physicians and Surgeons of Columbia University, The New York State Psychiatric Institute, 1051 Riverside Drive, Suite 123, New York, NY 10032*

SUMMARY:

Infanticide is a subject both compelling and repulsive. The killing of an innocent elicits sorrow, anger, horror. It is a crime. It demands retribution. That is the law. Yet the perpetrator of this act is often a victim, too, and that recognition makes for a more paradoxical response.

Maternal infanticide often occurs in the setting of postpartum illness. The fact that childbirth related psychiatric illness is precipitated by neurohormonal mechanisms provides the foundation for infanticide legislation in most western countries. This model provides for lenient sentencing and mandated psychiatric treatment, whereas "killer mothers" in the United States may face life in prison or execution. The law requires bright lines and clear boundaries. The absence of formal DSM-IV-TR diagnostic criteria for postpartum disorders promotes disparate treatment under the law. Furthermore, it discourages shared knowledge in the psychiatric community which could facilitate identification of mothers at risk. The likelihood that 21st century neuroscience can be applied to 19th century legislation is arguable. The insanity defense (M'Naghton 1843) used in approximately one half of the United States emphasizes cognitive capacity within a psychotic episode, a relatively unexplored domain. Furthermore, recent data on objective tests demonstrate cognitive impairment in puerperal psychosis and psychotic depression. We in psychiatry fail to educate the judicial system about mental illness. While we preserve fruitless attempts to fit our contemporary "square peg" into the obsolete "round hole" of the law, we abandon the mentally ill leaving room for doubt that the system is functioning justly or effectively or humanely.

REFERENCE:

1. Spinelli M: Infanticide: Psychosocial and Legal Perspectives on Mothers Who Kill. American Psychiatric Press, Washington DC, 2002.
2. Wisner KL, Peindl KS, Hanusa BH: Symptomatology of affective and psychotic illnesses related to childbearing. J Affect Disord 1994; 30:77–87.

MONDAY, MAY 3, 2004

LECTURE 2
FRONTIERS OF SCIENCE LECTURE SERIES
SIGNAL INTEGRATION IN THE BRAIN

Paul Greengard, Ph.D., *Laboratory of Molecular and Cellular Neuroscience, Rockefeller University, 1230 York Avenue, New York, NY 10021*

SUMMARY:

Nerve cells communicate with each other through two mechanisms, referred to as fast and slow synaptic transmission. Fast-acting neurotransmitters, e.g., glutamate (excitatory) and GABA (inhibitory), achieve effects on their target cells within one millisecond, by virtue of opening ligand-operated ion channels. In contrast, all of the effects of the biogenic amine and peptide neurotransmitters, as well as many of the effects of glutamate and GABA, are achieved over hundreds of milliseconds to minutes, by slow synaptic transmission. This latter process is mediated through an enormously more complicated sequence of biochemical steps, involving second messengers, protein kinases, and protein phosphatases. Slow-acting neurotransmitters control the efficacy of fast synaptic transmission by regulating the efficiency with which fast-acting neurotransmitters produce their effects on postsynaptic receptors.

REFERENCE:

1. Greengard, P. (2001). The neurobiology of slow synaptic transmission. Science 294:1024–1030.

LECTURE 3
APA'S BENJAMIN RUSH AWARD LECTURE
THE CHANGING FACE OF MENTAL HEALTH SERVICES

David Mechanic, Ph.D., *Health Care Policy and Aging Research, Institute of Health, 30 College Avenue, New Brunswick, NJ 08901*

SUMMARY:

This lecture will examine changing patterns of mental health services with a focus on how managed behavioral health has contributed to shaping service delivery and professional practice. The lecture will examine changes in access, service patterns, intensity of care and quality with particular attention to persons with serious mental illness and Medicaid behavioral health.

REFERENCE:

1. Mechanic D: Policy challenges in improving mental health services: some lessons from the past, Psychiatr Serv, September 2003; 54:1227–1232.

LECTURE 4
INTERNATIONAL PSYCHIATRIST LECTURE SERIES
PSYCHIATRY AND SPIRITUALITY: A HOLISTIC PERSPECTIVE

Sri Sri Ravi Shankar, *1134 11th Street, Suite 202, Santa Monica, CA 90403*

SUMMARY:

The quality of our minds determines the quality of our lives. Many people suffer from stress, but lack the energy and awareness to deal with the demands of life. The greatest stress comes from vacillation of the mind between anger about the past and worries about the future. Peace and joy are found when we bring our mind to the present—here and now. The Sudarshan Kriya breathing technique brings our mind completely into the present moment, relieves stress, and creates a sense of belonging.

The Basic Art of Living Course teaches yogic breathing, in the context of stress reduction and human connection. This is particularly beneficial for psychiatrists, who are exposed to negative emotions, human suffering, and difficult work demands. Many course graduates describe increased relaxation and energy and a better perspective on "what really matters." The Art of Living also offers courses that can help those who suffer from mental illness. By taking the Basic Course, mental health providers will learn how to select patients for referral or they may take further training to teach inexpensive, non-stigmatizing programs to children and adults in public health care settings, schools, hospitals, addiction programs, and the criminal justice system.

When the breath links the outer world of activity with inner peace, energy rises, humor and creativity return, our heart opens and service

to humanity is its natural expression. The only true security in this world is in the process of giving love. In this time together, we will journey from the head back to the heart.

REFERENCE:

1. Brown, R. P. & Gerbarg, P. L. *Yogic Breating, Sudarshan Kriya for Treatment of: Depression, Anxiety, Stress, PTSD, Aggression, and Violence* in Chapter 104 Complementary Alternative Treatments in Psychiatry by Dr. Richard P. Brown, Dr. Patricia L. Gerbarg, and Dr. Philip R. Muskin in *Psychiatry 2nd Edition*, ed. by Allen Tasman, Jeffrey Lieberman and Jerald Kay, Published by Wiley & Sons, Ltd., London, UK, 2003, pp. 2147–2183.

LECTURE 5
SURVIVING JOCK CULTURE

Robert Lipsyte, *163 3rd Avenue, Suite 137, New York, NY 10003*

SUMMARY:

Jock Culture, the values of America's elite athletes and their coaches and fans, has become a dominant strain in our national life. Machismo, entitlement, generosity, bullying, self-absorption, loyalty, bravery, emotional constriction, and sheer joy are also the values of Wall Street, the Pentagon, the operating room, the fire house, the factory floor. Women are devalued in this culture and outsiders—anyone not 'on the team'—are potential enemies. Humiliation and shame are common coaching tools. Winning is often not enough; the opposition needs to be dominated. These values are learned in youth sports and reinforced by the college and professional sports entertainment industry. It would be an area ripe for important investigation by the psychiatric community, except that too many psychiatrists either dismiss sports as mere fun and games or have begun to feed off it by promising athletes enhanced performance through mental "coaching." Our challenge is to find a way to de-emphasize the most destructive aspects of competitive sports and emphasize the enormous good that comes from healthful collective play. If we don't, we can expect only more episodes of high school sodomy hazing and pro athlete sexual assaults.

REFERENCE:

1. Sports World: An American Dreamland by Robert Lipsyte, Quadrangle/The New York Times Book Company, 1976.

LECTURE 6
INTERNATIONAL PSYCHIATRIST LECTURE SERIES
THE SEARCH FOR GENES OF BIPOLAR DISORDER: FROM CLASSICAL GENETICS TO NOVEL MOLECULAR TARGETS

Julien Mendlewicz, M.D., Ph.D., *Department of Psychiatry, Free University, Route de Lennik 808, Brussels, Belgium 1070*

SUMMARY:

Manic depressive (bipolar) illness is a common and complex disorder characterized by the alternance of depressive and manic episodes, and a rather high mortality rate mainly due to suicide. The bipolar phenotype is most probably determined by the interaction of susceptibility genes and psychosocial vulnerability factors.

Classical studies on human genetics of bipolar illness will be reviewed. These include adoption, twin and family studies of bipolar patients. Modern methods using molecular genetic strategies as they apply to psychiatric genetics will be discussed.

Several susceptibility genes have been proposed to be related to the bipolar phenotype, among them, candidate genes of interest for the understanding of the pathophysiology of bipolar disorder.

Nosological, therapeutic and ethical implications of molecular genetic approaches in psychiatry will be emphasized.

REFERENCE:

1. Baron, M: Manic-depression genes and the new millennium: poised for discovery. Molecular Psychiatry, 7 (4), 342–358, 2002.

LECTURE 7
APA'S ADOLF MEYER AWARD LECTURE
MIND, BRAIN, AND PERSONALITY DISORDERS

Glen O. Gabbard, M.D., *Department of Psychiatry, Baylor College of Medicine, 6655 Travis, Suite 500, Houston, TX 77030*

SUMMARY:

The mind-brain relationship has vexed philosophers for centuries and continues to be the subject of controversy within psychiatry. In psychiatric discourse, we often refer to "mind" and "brain" as separate entities, even though virtually all psychiatrists in our post-Cartesian era regard the mind as the activity of the brain. The persistence of these terms in contemporary psychiatric discussions reflects the fact that references to "mind" and "brain" have become a form of code for different ways to think about our patients and their treatment.

Polarities such as genes vs. environment, medication vs. psychotherapy, and biological vs. psychosocial, are often glibly subsumed under categories of "brain" and "mind." Relying on what we know about personality disorders, we can begin to deconstruct these false dichotomies, while still preserving the broadly psychosocial framework of diagnosis and treatment that is essential to the provision of comprehensive and effective intervention for these patents. The growing interest in the theory of mind, or mentalization, serves as a useful bridge between the two constructs. Advances in neuroscience have led to a greater appreciation of the value of psychotherapy in altering the brain.

REFERENCE:

1. Gabbard GO. *Psychodynamic Psychiatry in Clinical Practice: Third Edition.* American Psychiatric Press, Inc., Arlington, VA, 2000.

LECTURE 8
FRONTIERS OF SCIENCE LECTURE SERIES
SOCIAL NEUROSCIENCE: A NEW BASIC SCIENCE FOR PSYCHIATRY

Thomas Insel, M.D., *Office of the Director, National Institute of Mental Health, 6001 Executive Boulevard, Room 8235, MSC 9669, Bethesda, MD 20892*

SUMMARY:

In the past 5 years a series of studies spanning invertebrates to humans have begun to define the neurobiology of social behavior at the molecular, cellular, and systems levels. As social behavior is critical to survival and reproduction many of the neural mechanisms appear to be conserved across phylogeny. For instance, comparative studies have demonstrated that members of a nine amino acid neuropeptide family influence sociosexual behaviors in species as diverse as snails, newts, and rats. The members of this neuropeptide family in mammals, oxytocin and vasopressin, have profound effects on social memory, maternal care, pair bonding, and aggression. This presentation will describe several approaches to understanding the neurobiology of social behavior from knockouts of the oxytocin gene in mice to imaging studies in humans. One conclusion is that specific pathways appear to convey information about the social world, whether in the olfactory domain of rodents or the visual domain of primates. Another implication of this work is that we can now begin to define a "social brain" with likely candidates for "where to look" and "what to look for" in disorders of social behavior, including autism and schizophrenia.

REFERENCE:

1. Insel, TR and Young, LJ: Nature Neuroscience,"The Neurobiology of Attachment" 2:129–136, 2001.

LECTURE 9
APA'S SOLOMON CARTER AWARD LECTURE
I AM A FACT, NOT A FICTION

Phyllis Harrison-Ross, M.D., *41 Central Park West, New York, NY 10023*

SUMMARY:

This lecture will address the challenge of practicing culturally balanced, technologically pertinent psychiatry while reconciling restraints, constraints, dwindling resources, and a withering Hippocratic Oath.

REFERENCE:

1. Harrison-Ross, PA, L James: "Health Care For Women Offenders", "Turnstyle Justice", Edited by Guido et al, Prentiss Hall Publishers, 2002.

LECTURE 10
DISTINGUISHED PSYCHIATRIST LECTURE SERIES
LANGUAGE, PSYCHOSIS, AND THE SPECIATION EVENT

Timothy Crow, M.B., *Prince of Whales Centre, Warneford Hospital, Oxford OX3 7JX*

SUMMARY:

From the universality in all populations and absence of significant environmental causation, an evolutionary explanation of the persistence of the genetic predisposition to psychosis is required. Of the balancing advantages suggested the most cogent is the human capacity for language. According to this theory schizophrenia is the price that *Homo sapiens* pays for language. How old is the genetic predisposition? Perhaps as old as, but no older than, the origin of the species. As Broca suggested, it now seems that cerebral asymmetry is the feature that defines the human brain. Evidence for anomalies of asymmetry will be reviewed as well as the case that the core schizophrenic symptoms are disorders of language. The genetics of asymmetry will be outlined, including the evidence for a locus in a region of homology on the X and the Y chromosomes. The gene pair ProtocadherinX and Y has been under domain-specific positive selective pressure in the course of hominid evolution. The chromosomal rearrangements that provoked these changes are putative speciation events. It is argued that psychosis and language have a common origin in the genetic event that defined *Homo sapiens* as a species.

REFERENCE:

1. Crow TJ (Ed): The Speciation of Modern Homo Sapiens (2002) Oxford University Press: Oxford.
2. Crow TJ: Schizophrenia as the price that *Homo sapiens* pays for language: a resolution of the central paradox in the origin of the species. Brain Research Reviews 2002; 31:118–129.

LECTURE 11
WILLIAM C. MENNINGER MEMORIAL LECTURE
BODY AND SOUL

Tom Wolfe, *437 5th Avenue, 7th Floor, New York, NY 10016*

SUMMARY:

Tom Wolfe is recognized around the world as the pre-eminent social commentator of our time. For over three decades he has chronicled and forecast American mass culture with a wit and insight that eludes most futurists. His runaway best seller *The Bonfire of the Vanities* stands as a brilliant evocation of both the peculiar class structure and politics of New York City, and the economic excesses of the 1980s. His most recent novel, *A Man in Full,* has received both outstanding, critical, and popular success. Hailed by *Time* and *The Wall Street Journal* as even better than its phenomenally successful predecessor, it had an unprecedented first-run printing of 1.2 million copies and was nominated for the National Book Award four weeks prior to publication. As *Newsweek* states, "no writer—reporter or novelist—is getting our world on paper better than Tom Wolfe." Called the father of "New Journalism," Wolfe is the author of twelve books, including the national best sellers *The Right Stuff, The Electric-Kool Aid Acid Test, Radical Chic and Mau-Mauing the Flak Catchers,* and *The Bonfire of the Vanities.* In 1979, Wolfe won the American Book Award for general nonfiction for *The Right Stuff.* In 1980, he was named recipient of the Harold D. Vursell Memorial Award by The American Academy and Institute of Arts and Letters and received the Columbia Journalism Award for distinguished service in the field of journalism that same year. Raised in Richmond, Virginia, Wolfe received his bachelor's degree from Washington and Lee University and his doctorate in American Studies from Yale University. Afterward, he went to work as a reporter for *The Springfield Union* (in Massachusetts), *The Washington Post,* and *The New York Herald Tribune,* where he first began to push the envelope of conventional journalistic license. Since then, his writing has appeared in *New York Magazine, Rolling Stone, Esquire,* and *Harper's.*

TUESDAY, MAY 4, 2004

LECTURE 12
APA'S RESEARCH IN PSYCHIATRY AWARD LECTURE
ADVENTURES IN PSYCHIATRIC RESEARCH: NEUROBIOLOGY TO PUBLIC POLICY

Jack D. Barchas, M.D., *Department of Psychiatry, Cornell University Medical College, 525 East 68th Street, New York, NY 10021*

SUMMARY:

This presentation permits me an opportunity to provide some perspectives on the growth of knowledge, to discuss some of the lessons learned, and to acknowledge a few of the many individuals who as mentors, colleagues, and friends influenced my efforts.

The theme that underlies my passion in psychiatry and its sciences is that behavior influences neurobiology and that the resultant neurobiological changes alter future behavior. That the relationships are reciprocal and that both directions are important is central to the theme. Early on it was clear that substances that are neurotransmitters or neuromodulators, which we collectively termed neuroregulators, would be important in severe mental illness. Further, I had seen many individuals whose depressive or psychotic state had seemed initiated or made far worse by stress, frequently social and interpersonal stress of various types—interest in those relationships was encouraged by my late, first wife, Patricia Barchas, a pioneer in sociophysiology.

To study changes with stress and to understand the sequential processes that control neuroregulator systems was of the highest priority and was encouraged by the nature of Stanford and its Chair of Psychiatry, David Hamburg. Gaining knowledge of the regulatory processes could be expected to yield perspectives and hypotheses on differential vulnerability. Working with an extraordinary group of trainees and colleagues in the Nancy Pritzker Laboratory of Behavioral Neurochemistry, we studied the molecular biology of neuroregulators, from their genetics to enzymes involved in their formation, processes of utilization, localization, and inactivation. We improved

and developed new assays and identified some of the previously unrecognized neuroregulators. For each neuroregulator system we studied, from biogenic amines to peptides such as endorphins, we also looked at behavioral aspects, using a multi-pronged and cross-disciplinary approach.

Throughout my career, past and present, I have encouraged (and fought for) intellectual heterogeneity for psychiatric research. That, and a concern for the intersection of health and social policy matters, was an important factor in my agreeing to chair for 12 years the Institute of Medicine's Board on Biobehavioral Science and Mental Disorders and for an 8 year stint as the editor of *Archives of General Psychiatry*. The policy concerns led to my current role as Chair of the Board of Trustees of the New York Academy of Medicine.

My continuing interest in career development of researchers and clinicians has led me to a number of questions dealing with some of the practical aspects of individual success and failure in academics. Consideration of such issues has become a new focus of my efforts, with my wife, Rosemary Steens, a social historian of medicine.

LECTURE 13
DISTINGUISHED PSYCHIATRIST LECTURE SERIES WHY DOES THE HUMAN BRAIN BECOME ADDICTED?

Nora D. Volkow, M.D., *Department of Medicine, National Institute on Drug Abuse, 6001 Executive Boulevard, Room 5274, Bethesda, MD 20892*

SUMMARY:

Addiction is a disorder that involves complex interactions between a wide array of biological and environmental variables. Strategies for its prevention and treatment therefore, necessitate an integrated approach incorporating systems of analysis that span the molecular to the social. Pairing rapidly evolving technologies such as neuroimaging with sophisticated behavioral measurement paradigms has allowed extraordinary progress in elucidating many of the neurochemical and functional changes that occur in the brains of addicts. Although large and rapid increases in dopamine have been linked with the rewarding properties of drugs, the addicted state, in striking contrast, is marked by significant decreases in brain dopamine function. Such decreases are associated with dysfunction of prefrontal regions including orbitofrontal cortex (involved in salience attribution) and cingulate gyrus (involved in inhibitory control). In addition, disturbances in salience attribution result in enhanced value given to drugs and drug-related stimuli at the expense of other reinforcers. Dysfunction in inhibitory control systems, by decreasing the addict's ability to refrain from seeking and consuming drugs, ultimately results in the compulsive drug intake that characterizes the disease. Discovery of such disruptions in the fine balance that normally exists between brain circuits underling reward, motivation, memory and cognitive control have important implications for designing multi-pronged therapies for treating addictive disorders.

REFERENCE:

1. Volkow ND, Fowler JS, Wang G-J: The addicted human brain: insights from imaging studies. Journal of Clinical Investigation, 111(10), pp. 1444–1451, May 2003.
2. Volkow ND, Fowler JS, Wang G-J: Role of dopamine in drug reinforcement and addiction in humans: results from imaging studies. Behavioral Pharmacology, 13, pp. 355–366, 2002.

LECTURE 14
APA'S OSKAR PFISTER AWARD LECTURE DIALOGUE FROM THE RIMS OF THE GRAND CANYON: ON BRIDGING THE POST-FREUDIAN CHASM BETWEEN RELIGION AND PSYCHIATRY

Elizabeth S. Bowman, M.D., *Indiana University, 550 University Boulevard, #1711, Indianapolis, IN 46202*

SUMMARY:

Freud's theories on religion were a boon and a bane. Freud vastly advanced psychiatric understanding of religion, but his dismissive reductionism created a Grand Canyon of eroded trust between psychiatrists and clergy. Seventy-six years after *The Future of an Illusion* (Freud, 1927) this Canyon remains largely un-bridged. Religion and mental health professionals lack a comprehensive synthesis of spiritual and psychological life. Religious practitioners and scientists stand on opposite rims of a theoretical Grand Canyon, attempting communication from viewpoints too disparate for dialogue. Those we treat suffer. This lecture addresses this dilemma, critiques some post-Freudian attempts to bridge this gap, proposes reasons for the gap, and a proposal to enable bridging it.

Freud depicted religion as inherently pathological and incompatible with psychological maturity. For him, the mentally healthy solution was to abandon belief in God. Despite this, for personal reasons, he and the Rev. Oskar Pfister remained warm friends for 30 years. This lecture highlights subsequent revisions of Freud's religious theories, which I believe represent Freud's personal "theology" rather than scientific theory. The work of D.W. Winnicott, psychoanalyst and priest William Meissner (1984), psychoanalyst Ana-Maria Rizzuto (1979), and others discussed in this lecture opened the door for psychologically healthy religious belief. Yet, theoreticians, including clergy clinicians propose syntheses while writing from only one perspective or language, usually the scientific one, avoiding religious language. This raises the issue: *Can* we bridge this chasm if we can't leave the language of our respective rims?

Answers to bridging the religion-psychiatry chasm lie in the philosophies of science and of religion. Using the work of theologian/philosophers Langdon Gilkey (1985) and James Loder (1989), this lecture explores how psychiatry (science) and religion have difficulty meeting because they operate on two different levels or realms of experience, address different levels of causality, and have different aims, language, methods, scopes and limitations. For productive dialogue, it is essential that we acknowledge these differences and observe the limits, language and methods of each discipline. Psychological sciences, like Freud, have taken on a religious function in Western culture (offering their answers as ultimate causality and meaning) rather than respecting the boundaries of science (studying processes of material reality). Western religions (e.g., creation science movement) have sometimes clothed themselves in the language and methods of science to present theology (matters of ultimate causality) disguised in the methods and language of science (secondary causality). We can build a bridge for discussion at an intermediate level of philosophy by recognizing that science and religion answer different *kinds* of questions. Religion and psychiatry can support and critique each other. Religion can confront psychiatry when it masquerades as religion by making statements beyond the limits of the scientific method, and can provide moral commentary on how psychiatry functions. Psychiatry can provide support for healthy religious structures and critical explanations of the dynamics of evil manifestations of religion. Both disciplines can remind each other of their limits and encourage full expression within their respective scopes. Thus, we can move from competition and conflict to cooperation and complementarity (Loder, 1989).

REFERENCE:

1. Gilkey, L: *Creationism on Trial. Evolution and God at Little Rock*, Minneapolis: Winston Press, 1985.
2. Meissner, W: *Psychoanalysis and Religious Experience.* New Haven, CT, Yale Univ. Press, 1984.

LECTURE 15
FRONTIERS OF SCIENCE LECTURE SERIES ANTICRAVING MEDICATION: A NEW CLASS OF PSYCHOACTIVE MEDICATION?

Charles P. O'Brien, M.D., *Department of Psychiatry, University of Pennsylvania, 3700 Chestnut Street, Philadelphia, PA 19104*

SUMMARY:

Three decades of basic neuroscience has led to the development of animal models that predict drug abuse liability in human subjects. Using these animal models, effective medications have been developed for some of the major addictions. Basic and clinical data show that repeated drug use produces changes in the brain that are represented by learned responses to drug-related cues. This learning persists long after drug use has stopped and the patient is completely detoxified. Relapse, even after the best psychosocial treatment, is very common. Numerous studies have shown that cues previously associated with drug taking can act as conditioned stimuli and produce reflexive changes in former drug users. Many of these changes are perceived as compulsive drug craving. Medications have now been discovered that suppress craving and lead to an improved treatment outcome, although the mechanism of this compulsive drug craving is poorly understood. The empirical finding from clinical trials of craving-suppression by specific medications may signal a new class of medications available to the psychiatrist.

REFERENCE:

1. O'Brien CP: A range of research-based pharmacotherapies for addiction. Science 278:66–70, 1997.

LECTURE 16
DISTINGUISHED PSYCHIATRIST LECTURE SERIES HOW MANY PSYCHIATRISTS DO WE NEED?

James H. Scully, Jr., M.D., *American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*

SUMMARY:

The estimate of the proper number of psychiatrists to care for the U.S. population is influenced by historical, political and economic factors. Both "needs-based" and "demand-based" models will be discussed. Geographic distribution of the workforce also plays a major role in access to psychiatric services. Economic forces influence non-psychiatrist roles. These include both non-psychiatrist physicians as well as non-physician mental health providers and scope of practice conflicts.

REFERENCE:

1. Scully, J: "The Psychiatry Workforce", *Psychiatry in the New Millennium,* Sidney Weissman, Melvin Sabshin, Harold Eist (eds), 273–284, *American Psychiatric Press,* Washington, DC. 1999.

LECTURE 17
APA'S JUDD MARMOR AWARD LECTURE FEELING AND HEALING: BIOPSYCHOSOCIAL TREATMENTS AND THEIR EFFECTS ON MEDICAL ILLNESS

David Spiegel, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 2325, Stanford, CA 94305*

SUMMARY:

As modern medicine converts many previously terminal illnesses into chronic ones, there is more need than ever for techniques that provide comfort, social support, and stress management skills to those with cancer, heart disease and other serious medical illnesses. The increased need for such approaches is evidence by the growing public appetite for complementary treatments, now utilized by 42% of Americans who pay more out of pocket for such approaches than they do for conventional medical care. A growing body of evidence demonstrates that psychotherapeutic techniques such as group therapy and hypnosis reduce distress, pain, and social isolation, and may even improve survival time. Therapeutic domains include building new networks of social support, encouraging the expression of emotion related to the stress of illness, detoxifying fears of dying and death, restructuring life priorities, improving relationships with family and friends, and clarifying communication with physicians. In addition, specific stress management techniques such as training in self-hypnosis can effectively alter perception of pain and anxiety and facilitate medical procedures. Techniques such as hypnosis work by altering the function of specific parts of the brain involved in perceptual processing. New mind/body pathways linking stress and emotion management to diurnal patterns of stress hormones such as cortisol and immune function and to cancer progression will be reviewed. Evidence regarding effects of biopsychosocial interventions on cancer progression will be presented. The modulation of perception, emotion, cognition and social support are critical elements in managing the stress of medical illness: feeling may lead to healing.

REFERENCE:

1. Spiegel D: A 43-year-old woman coping with cancer. [see comments.]. JAMA 1999; 282(4):371–8.
2. Spiegel D: Healing Words: Emotional Expression and Disease Outcome. Journal of the American Medical Association 1999; 281:1328–1329.

LECTURE 18
FRONTIERS OF SCIENCE LECTURE SERIES CONCEPTUAL AND METHODOLOGICAL FLAWS IN THE EVALUATION OF ADDICTION TREATMENT

A. Thomas McLellan, Ph.D., *Treatment and Research Institute, 600 Public Ledger Boulevard, Philadelphia, PA 19104*

SUMMARY:

Some clinicians and researchers have argued that addiction is a "chronic illness." Implicit within that "chronic" concept are the expectations that there is no cure; that sustained improvement requires some form of continuous treatment and/or monitoring; and that relapse is a continuing threat. Yet addiction treatments have typically not been delivered or evaluated under those expectations. The presentation argues that this disconnect between the realistic limits of addiction treatments effects and the traditional methods used to evaluate those effects—has produced a significant underestimate of the potential effectiveness of addiction treatments and has restricted the clinical and policy relevance of the exiting research data on addiction treatment.

To illustrate, the presentation re-considers three of the more perplexing sets of findings from prior addiction treatment studies: 1) Few outcome differences between more intensive, inpatient or residential forms of treatment; and less intensive, outpatient treatments; 2) Little outcome enhancement from efforts to "match" patients to treatments; and 3) Lack of robust findings in medication trials.

These perplexing findings are explained by the explicit acute care assumption that some finite amount, duration or intensity of services will sustain symptom remission and enhanced functional status 6–12 months following the cessation of the intervention. These expectations are not consistent with a chronic care approach and may have limited understanding and development of more appropriate approaches.

The presentation concludes with an illustration of a more appropriate treatment and evaluation model derived from contemporary work in the treatment of hypertension and diabetes. Some of the clinical suggestions from this context include patient-practitioner contracting for pre-defined, time-limited clinical objectives; efforts to make treatments more attractive; and emphasis upon continued patient monitoring for relapse risk. Some research suggestions from this perspective include the use of adaptive evaluation designs and the measurement of treatment effectiveness during the course—not following the termination—of addiction treatment.

REFERENCE:

1. McLellan AT, O'Brien CP, Lewis DL, Kleber HD: Drug addiction as a chronic medical implications for treatment, insurance and evaluation. *JAMA 284:1689–1695,* 2000.

WEDNESDAY, MAY 5, 2004

LECTURE 19
DISTINGUISHED PSYCHIATRIST LECTURE SERIES THE ROLE OF GLUTAMATE IN THE PATHOPHYSIOLOGY OF SCHIZOPHRENIA

Joseph T. Coyle, Jr., M.D., *115 Mill Street, Belmont, MA 02478*

SUMMARY:

Glutamate is the major excitatory neurotransmitter in brain, utilized by more than 40 percent of synapses. A subtype of glutamate receptors—the NMDA receptor—plays a major role in synaptic plasticity including use dependent enhanced synaptic efficacy known as long term potentiation (LTP). LTP has been linked to memory and cognition. Numerous clinical studies have demonstrated that subanaesthetic doses of dissociative anaesthetics such as phencyclidine (PCP) and ketamine, which are non-competitive antagonists at the NMDA receptor, replicate in normal subjects the cognitive impairments, negative symptoms and brain functional abnormalities observed in individuals with schizophrenia. Post-mortem and genetic studies have identified abnormalities associated with schizophrenia that would interfere with NMDA receptor function. Placebo controlled trials of agents that enhance NMDA receptor function consistently reduce negative symptoms and frequently improve cognition in schizophrenic patients receiving typical antipsychotics. In aggregate, these findings suggest that NMDA receptor hypofunction may account for the endophenotype of schizophrenia and that the NMDA receptor is a novel pharmacologic target for developing more effective treatments for schizophrenia.

REFERENCE:

1. Coyle JT, Tsai G, Goff DC: Converging evidence of NMDA receptor hypofunction in the pathophysiology of schizophrenia. In: Glutamate and disorders of cognition and motivation (Moghaddam B and Wolf ME, eds.) Ann NY Acad Sci 1003:318–327, 2003.

LECTURE 20
APA'S SIMON BOLIVAR AWARD LECTURE LATINO YOUTH IN THE U.S.: DEVELOPMENTAL AND MENTAL HEALTH CHALLENGES

Andres J. Pumariega, M.D., *Department of Psychiatry, East Tennessee State University, 204 McWherter, P.O. Box 70567, Johnson City, TN 37614*

SUMMARY:

The latest Census figures have designated the Latino population not only as the largest ethnic/cultural minority group within the United States, but also the youngest such population in our nation, with 34.4 percent under the age of 18. Unfortunately, Latino youth are at higher or increasing risk for a number of adverse psychiatric and psychosocial outcomes, such as higher rates of depression, anxiety, substance abuse, and eating disorders; higher rates of teen pregnancy and school drop-out; and increasing rates of suicide (particularly amongst Latina youth). These findings are concerning given how closely linked the future of Latino youth is to the social and economic health and future of the United States. Dr. Pumariega will focus on the mental health challenges faced by Latino youth. This will include challenges from socioeconomic stressors, the stressors related to acculturation and discrimination, and stressors arising from their prior histories and those of their immigrant parents and forbears. The impact of these stressors on the process of child and adolescent development within a Latino cultural context will be discussed. Recommendations for clinical, service system, and public policy approaches to more effectively meet the needs of Latino youth will be presented.

REFERENCE:

1. Pumariega AJ, Pumariega JB, Factores de Riesgo de los Trastornos Mentales y de Adiccion entre Ninos Adolescentes Inmigrantes Hispanos. (Risk Factors for Mental and Substance Abuse Disorders for Immigrant Hispanic Youth.) *Psychline (Journal of Hispanice Mental Health),* 4(2): 17–21, 2002.
2. Pumariega,AJ: Cultural Competence in Systems of Care for Children's Mental Health. In: Pumariega, A.J. & Winters, N.C. *Handbook of Community Systems of Care: The New Child & Adolescent Community Psychiatry.* San Francisco: Jossey Bass Publishers, 2003, p. 82–106.

THURSDAY, MAY 6, 2004

LECTURE 21
DISTINGUISHED PSYCHIATRIST LECTURE SERIES STRESS AND RELAPSE TO SUBSTANCE USE DISORDERS

Kathleen T. Brady, M.D., *Institute of Psychiatry, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29401*

SUMMARY:

Most major theoretical models of addiction postulate that stress plays an important role in the initiation and continuation of substance use, as well as in relapse. The notion that exposure to stress-inducing factors in everyday life (i.e., life stressors) can cause susceptible people to initiate or relapse to substance use has intuitive appeal. A number of animal studies as well as human laboratory studies support the positive relationship between stress and substance use, abuse and relapse. Research investigating the organism's response to stress and the consequences of substance use at the level of biological processes in the brain has identified several neurobiological connections between the changes produced by stress and the changes produced by stress and the changes produced by both short-term (i.e., acute) and long-term (i.e., chronic) substance use.

In the clinical arena, the relationship between stress and substance has been more difficult to study. It is likely, however, that stress and the body's response to it play a role in the vulnerability to initial substance use, initiation of treatment, and relapse in recovering users. This relationship probably is mediated, at least in part, by common neurochemical systems, such as the serotonin, dopamine, and opiate peptide systems, as well as the HPA axis. Further exploration of these connections should lead to important pharmacological developments in the prevention and treatment of substance use disorders.

Psychosocial approaches to relapse prevention with established efficacy often contain elements aimed at reducing and managing stress. It is difficult, however, to separate the effects of such specific stress-reduction techniques from the effects of other effective treatment components. Nevertheless, studies indicate that treatment components fostering coping skills, problem-solving skills, and social support play a pivotal role in successful treatment. In the future, individualized treatment approaches that emphasize stress management strategies in those patients in whom a clear connection between stress and relapse exists will become particularly important.

REFERENCE:

1. Sinha R. How does stress increase risk of drub abuse and relapse? Psychopharmacology 2001, 158, 343–359.

LECTURE 22
APA'S ADMINISTRATIVE PSYCHIATRY AWARD LECTURE
PUBLIC ACADEMIC LIAISON: PURSUIT OF BEST PRACTICES IN A TIME OF ECONOMIC ENTRENCHMENT

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

SUMMARY:

Public academic liaison has been an enduring and successful collaboration between academic medical centers and state departments of mental health. These relationships have flourished in several states, contributing to successive generations of both academic-oriented psychiatrists and psychiatrists serving in the public sector. The needs and directions of both organizations can be complementary and synergistic. The pursuit of "Best Practices" in the public mental health system now provides a common focus for development and collaboration. Paradoxically, there is the chance that such partnerships may be advanced further during an era of economic entrenchment.

REFERENCE:

1. The President's New Freedom Commission. Transforming America's mental health system. Washington, D.C. 2003.
2. Talbott JA, Hales RE: Textbook of administrative psychiatry: New concepts for a changing behavioral health system. American Psychiatric Press 2002.
3. Drake RE, Goldman HR, Leff HS, Lehman AF, Dixon L, Mueser KT, Torrey WC: Implementing evidence-based practices in routine mental health service settings. Psychiatric Services 2001.

LECTURE 23
THE BRAIN IN LOVE

Helen E. Fisher, Ph.D., *Department of Anthropology, Rutgers University, 4 East 70th Street, New York, NY 10221*

SUMMARY:

An fMRI study of romantic love and the role this brain system plays in worldwide patterns of marriage and divorce, crimes of passion and the depression associated with rejection in love.

Romantic love, I propose, is a developed form of mammalian mating drive designed to motivate men and women to focus their courtship energy on preferred reproductive partners. I and my colleagues have put 17 men and women who had "just fallen madly in love" into a functional Magnetic Resonance Imaging (fMRI) scanner to identify the brain circuitry of this universal phenomenon. Participants alternately viewed a photo of a beloved and a photo of a familiar, emotionally neutral individual, interspersed with a distraction task. Dopamine pathways associated with reward and motivation were activated; regions of activation changed as the relationship endured; and men and women had some different brain responses. I will maintain that romantic love is largely distinct from the sex drive; that it evolved to facilitate mate choice; that gender differences in romantic passion reflect varied ancestral male and female reproductive strategies; that changes in romantic attraction across time are adaptations for child rearing; that this brain system is closely integrated with brain networks for hate/rage; and that romantic love can become a life-threatening addiction. Cross-cultural patterns of marriage and divorce, stalking and other crimes of passion, the clinical depression associated with romantic rejection, and much of world literature and the arts stem from this ancient drive to love.

REFERENCE:

1. Fisher H, Aron A, Mashek D, Strong G, Li H, Brown LL: The Neural Mechanisms of Mate Choice: A Hypothesis. Neuroendocrinology Letters. 23 (suppl. 4):92–97, 2002.

LECTURE 24
APA/NIMH VESTERMARK PSYCHIATRY EDUCATOR AWARD LECTURE
STRIKING ACCORD: TALES OF TEACHING AND THE HEART

Eugene V. Beresin, M.D., *Massachusetts General Hospital, 55 Fruit Street, Bulfinch 449, Boston, MA 02114*

SUMMARY:

Like the result of good parenting, the best outcomes with patients and students owe their success to the quality of a "good relationship." As healers and educators, our mission is to strike accord—to facilitate a harmonious, collaborative connection based on clear, contingent communication, mutually shared respectful interactions, enhanced security, emotional modulation, and assignment of attention and meaning.

Physicians have a social contract to heal, educate and discover. Each activity succeeds or fails through interpersonal relationships that transfer knowledge, skills and attitudes. While explicit knowledge may be formally taught, tacit knowledge, used by seasoned practitioners and investigators must be taught experientially through observation and practice in the context of a relationship. This form of knowledge includes personal experience, values, biases, intuition, heuristics, emotional intelligence and affective attunement, tolerance for ambiguity and uncertainty, and critical self-awareness. The combination of explicit and tacit knowledge with technical skills, creative problem solving, empathy, altruism, and a keen appreciation of the context of care enables expert practitioners to heal. While our master clinicians and researchers know this, medical educators have largely failed to develop a curriculum which describes or teaches the means of its acquisition.

Striking accord paves the way for secure attachments. And these provide the foundation for self-regulation, integration and coherent narratives. Narratives are the essential means by which our students integrate education and experience into personal and professional identities. Like musical performance, physicianship requires both forms of knowledge, active listening and responding, technical skills, critical self-reflection and self-correction.

Physician-educators must teach and demonstrate that human attachments are crucial for the learning process aws well as sound patient care.

We are at a critical juncture in medicine. Training programs from all specialties are newly required to demonstrate the attainment of professional competencies at all levels of training and practice. Medical education at undergraduate, graduate and post-traduate levels is under scrutiny and revision. Given the constraints of traditional educational methods, the blessing and curse of information technology, and the influence of managed care on our system of health care delivery and on our workforce of teacher-clinicians, how can we be most effective?

REFERENCE:

1. Siegel D: *The Developing Mind: Toward a Neurobiology of Interpersonal Experience.* New York: The Guilford Press, 1999.
2. Palmer PJ: *The Courage to Teach: Exploring the Inner Landscape of a Teacher's Life.* San Francisco: Jossey-Bass, Inc., 1998.

LECTURE 25
FRONTIERS OF SCIENCE LECTURE SERIES
THROUGH THE LOOKING GLASS: USES OF SIMULATION AND VIRTUAL REALITY IN CLINICAL PRACTICE AND BRAIN IMAGING RESEARCH

Godfrey D. Pearlson, M.D., *Institute of Living, 200 Retreat Avenue, Hartford, CT 06106*

SUMMARY:

The concept of "Virtual Reality" (VR) goes back almost forty years, but only recently have advances in computing and associated hardware (spurred by the videogame industry. NASA and the armed forces) allowed for clinical applicability. VR uses real-time 3-D computer graphics, body tracking devices, visual displays and other sensory input to immerse subjects in believable virtual environments. "Clinical Virtual Reality" is used mainly in phobia desensitization, with application also to eating disorders, social skills training, cognitive assessment and rehabilitation and pain control. In research settings, VR applications find uses in assessment of brain activation during performance of complex cognitive tasks (driving, 3-D maze navigation) and in examining problem behaviors (pathological gambling, substance abuse and other impulse control disorders). These allow examination of the brain in settings closer to the real world rather than a clinical laboratory in terms of ecological abuse, where setting is particularly important. Current achievements, caveats and future prospects of VR applications in psychiatry will be critically reviewed.

REFERENCE:

1. Riva G, Wiederhold BK, Molinari E (Eds.): Virtual Environments in Clinical Psychology and Neuroscience (Vol. 58). Amsterdam: IOS Press, 1998.

MEDICAL UPDATES

1. IRRITABLE BOWEL SYNDROME

Susan Lucak, M.D., *Department of Gastroenterology, Columbia-Presbyterian Medical Center, 161 Fort Washington Avenue, Room 3-301, New York, NY 10032*

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant should be able to: (1) recognize that the irritable bowel syndrome (IBS) is the most common gastrointestinal disorder in the U.S., having significant impact on quality of life; (2) understand current pathophysiologic mechanisms of IBS; (3) review new approaches to the diagnosis of IBS; and (4) review pharmacotherapy and psychological therapies in IBS.

SUMMARY:

Irritable bowel syndrome is a functional disorder characterized by abdominal pain or discomfort associated with bowel irregularities such as constipation or diarrhea or alternating constipation with diarrhea. It is the most common gastrointestinal disorder in the U.S. The ratio of female to male patients is 2-3 to 1. Symptoms of IBS may be exacerbated by stress or eating. IBS can have significant impact on quality of life.

Our understanding of pathophysiology of IBS has evolved over the past several decades. Key pathophysiologic features of IBS include: altered gastrointestinal (GI) transit time and increased motor GI reactivity to various stimuli; visceral hypersensitivity; the entire GI tract is involved, not just the colon; and dysregulation between the brain and the gut can lead to altered visceral sensation and motility.

The diagnosis of IBS is no longer a "diagnosis of exclusion". Standardized diagnostic criteria called ROME II Criteria are used. Absence of "red flag" symptoms and signs along with targeted work-up allow making a more positive diagnosis of IBS.

In recent years, novel therapies directed at the serotonin (5-HT) receptors in the enteric nervous system have emerged. Alosetron, a 5-HT 3 receptor antagonist, is used in severe IBS with diarrhea. Tegaserod, a 5-HT 4 partial agonist, is used in IBS with constipation. Low doses of tricyclic antidepressants have been useful in some patients with IBS. The role of selective serotonin reuptake inhibitors is being evaluated. Psychological treatments have been helpful and can be used in combination with pharmacotherapy.

REFERENCES:

1. Establishing Irritable Bowel Syndrome as a Clinical Diagnosis. Nicholas J. Talley, Ed., Reviews in Gastroenterological Disorders 2003;3 (suppl 3): S1-S42.
2. Brandt LJ et al. Systematic review on the management of irritable bowel syndrome in North America. Am J Gastroenterology 2002;97 (suppl): S7-S26.

2. HEPATITIS B AND C: WHAT'S NEW?

Robert S. Brown Jr., M.D., *Department of Psychiatry, Columbia Presbyterian Medical Center, 622 West 168th Street, New York, NY 10032*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: 1) understand the risk factors for hepatitis B and C; 2) review the natural history and prognosis of hepatitis B & C; and 3) understand the latest treatment options for hepatitis B & C.

SUMMARY:

Hepatitis B and hepatitis C are the most common causes of viral liver disease worldwide and are a major source of morbidity and mortality in the United States. Screening patients at high risk and those with abnormal liver function tests with serologic tests for these viruses will provide earlier diagnosis. At the current time, staging the disease requires liver biopsy, which provides important prognostic information, although the development of serum markers of fibrosis is a work in progress. Hepatitis B is transmitted sexually, intravenously, and perinatally. It is a major cause of liver disease worldwide, mainly due to perinatal transmission in endemic areas. Over time, it can progress to cirrhosis and hepatocellular carcinoma. Diagnosis is based on hepatitis B surface antigen in the serum, and the level of viral replication is determined by the presence of the hepatitis B antigen or by the level of HBV DNA. FDA-approved treatments include alpha interferon, lamivudine, and adefovir. Hepatitis C is the most common cause of viral liver disease in the United States. It has a high rate of chronicity, with 85% of acute infections becoming chronic. The major risk factors are parenteral, mainly through intravenous drug use. Blood transfusion prior to 1991 is also a risk factor. Hepatitis C can also lead to cirrhosis and hepatocellular carcinoma, and disease progression is enhanced by alcohol.

REFERENCES:

1. Brown RS, Jr, Gaglio PJ: Scope of worldwide hepatitis C problem. Liver Transpl 2003; 9:S10–13.
2. Fried MW, Shiffman ML, Reddy KR, Smith C, Marinos G, Concales FL, Jr, Haussinger D, et al.: Peginterferon alfa-2a plus ribavirin for chronic hepatitis C virus infection. N Engl J Med 2002; 347:975–982.

3. BETTER SEX: NATURALLY

Richard P. Brown, M.D., *Department of Psychiatry, Columbia University, 86 Sherry Lane, Kingston, NY 12401*

EDUCATIONAL OBJECTIVES:

1. To give clinicians an overview of what herbs and nutrients may be used in men and women to improve sexual dysfunction (desire, arousal and orgasm) due to aging, illness, or psychotropic medication; 2. To review what research exists in this area; and 3. To address questions of dosing, side effects, and brands

SUMMARY:

Research data on yohimbine, Asian ginseng, ginkgo, argenine, muira puama, Arginmax, maca, Rhodiola rosea, horny goat weed, and Ayurvedic preparations will be reviewed. For each herb or preparation, effects on different phases of sexual response, dosing, side effects, interactions, and brands will be discussed. Ample time for questions and discussion will be provided.

REFERENCE:

1. Brown RP, Gerbarg PG, Muskin PR: Chapter 104 Complementary and Alternative Treatments in Psychiatry in Psychiatry, 2nd Edition, ed. by Allen Tasman, Jeffrey Lieberman and Jerald Kay, Published by Wiley & Sons, Ltd., London, UK, 2003.

4. HOW TO SHRINK OBESITY

Judith Korner, M.D., *William Black Medical Research Building, Columbia University College of Physicians, 650 West 168th Street, Room 905, New York, NY 10032*

EDUCATIONAL OBJECTIVES:

At the conclusion of this medical update, the participant should be able to: (1) define obesity, its prevalence and comorbidities; (2) identify appropriate nonpharmacological, pharmacological and surgical obesity treatments; and (3) review the current understanding of the neurohormonal regulation of body weight and how this knowledge may lead to future therapies for weight control.

SUMMARY:

Obesity is a complex disorder characterized by the accumulation of excess adipose tissue. Almost one-third of the adult population in the U.S. is obese. Being overweight substantially increases the risk of developing other morbidities such as type 2 diabetes mellitus, cardiovascular disease, gallbladder, liver and kidney problems, many types of cancer and even death. Non-pharmacological treatments for obesity include behavior therapy, exercise, and calorie-restricted diets. Prescription drugs approved by the FDA for weight loss include sibutramine, orlistat and phentermine. Off-label therapies such as metformin and topiramate will be discussed. In certain individuals, surgery to produce weight loss may be considered. While obesity has long been considered a behavioral disorder, discovery of the hormone leptin in 1994 catalyzed the field of obesity research by demonstrating the existence of a hormone that regulates body weight. Since then other hormones have been identified that control appetite and may possibly be manipulated to devise effective weight loss therapies.

REFERENCES:

1. Korner J, Aronne LJ: The emerging science of body weight regulation and its impact on obesity treatment. Journal of Clinical Investigation, 2003, 111:565–570.
2. DeNino WF, Korner J, Aronne LJ: Central control of energy homeostasis. Curr Opin Endocrinol Diabetes, 2003, 10:330–333.

PRESIDENTIAL SYMPOSIUM

1. THE BIOPSYCHOSOCIAL MODEL: MYTH OR REALITY?

Chairperson: J. Pierre Loebel, M.D.
Co-Chairperson: Marcia Kraft Goin, M.D.

1. **Biopsychosocial Model: History**
   John D. Wynn, M.D.
2. **Biopsychosocial Integration in Residency Training**
   Deborah S. Cowley, M.D.
3. **The Biopsychosocial Model: Contribution of Research**
   Charles B. Nemeroff, M.D.
4. **Biopsychosocial Psychiatry in Clinical Practice**
   Glen O. Gabbard, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the background of the bio-psycho-social concept; its importance in modern psychiatry; and its application in the areas of training, research, and clinical practice.

SUMMARY:

Notwithstanding the immense advances in the neuro-sciences and especially neuropsychopharmacology we believe there is no more fundamental issue challenging psychiatry at this time than the one alluded to in this year's Presidential theme. It has been argued that the future of psychiatry depends upon a biopsychosocial approach to the human condition. This symposium will consider the belief that the most significant contribution of modern psychiatry needs to be the replacement of an outmoded mind-brain dualism by an integrative, biopsychosocial model. Yet one of the symposium speakers has asserted that the biopsychosocial model is now invoked only to pay "political lip service" instead of describing what psychiatrists should practice as the "ultimate integrators of the biological and psychosocial perspectives." The major aim of the symposium is to contend and demonstrate that the notion does indeed describe the core concept of modern psychiatry but is overdue for definition and detailed, empirical description. The symposium will therefore present the nature and value of the integrative approach in the domains of training, research and clinical practice.

REFERENCES:

1. Engel G: The need for a new medical model: a challenge for biomedicine. Science 1977;196:129–136.
2. Kandel ER: A new intellectual framework for psychiatry. Am J Psychiatry 1998;155:457–469.

2. WITHER GO THE STATES: THE IMPACT OF BUDGET CUTS

Chairperson: David A. Pollack, M.D.

5. **Overview of the Impact of State Budget Cuts: Problems and Solutions**
   Michael F. Hogan, Ph.D.
6. **Using Fiscal and Clinical Measures During Times of Limited Resources**
   Theodore C. Lutterman, Lucille Schacht, Ph.D.
7. **State Policy Choices for Children's Mental Health in Tough Budget Times**
   Chris Koyanagi
8. **The Impact of Budget Cuts on Rural Mental Health**
   Dennis Mohatt, M.A.
9. **Cuts Cutting Into the Possibility of Recovery**
   Tom Lane, Laura Lee Hall, Ph.D.
10. **After All This, Do You Still Want to Be a Public Psychiatrist?**
    Allison M. Wehr, M.D., Jennifer K. Coffman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the importance of sufficient resources in the development and maintenance of effective state mental health and substance abuse services.

SUMMARY:

Given the economic downturn of the past three years in the United States, state mental health and substance abuse treatment programs and their corresponding public sector provider organizations have been struggling to maintain an adequate level of funding and services. The impact has been enormous. In many states, entire programs have been eliminated or severely cut back. Eligibility for certain services has been dramatically tightened. Access to crisis services, hospitalization, general outpatient and psychosocial rehabilitation, as well as medications has become very difficult for many patients. In some cases, access has been limited to only those patients with the most severe needs, and the care for persons with severe and persistent mental illness has been cut back to a minimal level. In one state, the cuts were so severe that more than 50% of the persons in treatment for opiate addiction were withdrawn from methadone treatment. The cuts in services have resulted in the demand for services to be diverted to other, less preventative and directly effective sectors of the service system: emergency room visits and involuntary hospitalization rates have increased, criminal justice involvement of persons with mental illness and substance use disorders has increased, and some states are beginning to see increased rates of suicide.

The President's New Freedom Commission on Mental Health reported on the state of mental health services in this country, highlighting the fragmentation and gaps in services. This presentation will review how the states are responding to the budget crisis in relation to the President's Commission's recommendations. The presentations will be from a wide variety of perspectives, including the state mental health administrative leadership, child and adolescent programs, rural programs, consumers and advocates.

REFERENCE:

1. The President's New Freedom Commission on Mental Health, Final Report. (2003). Washington, D.C.

3. RECONSTRUCTING POSTWAR MENTAL HEALTH SERVICES

Chairperson: Marcia Kraft Goin, M.D.
Co-Chairperson: Rodrigo A. Munoz, M.D.

11. **Wars and Mental Health in Iraq**
    Abdul M. Al-Jadiry, M.D.
12. **Mental Health in Iraq and the U.S. Military**
    Elspeth C. Ritchie, M.D.
13. **Strategies for Post-War Rehabilitation of Mental Health Services: Focusing on Iraq**
    Ahmed Okasha, M.D.

EDUCATIONAL OBJECTIVES:

To recognize the public health principles used in reconstructing mental health services in a post-war setting, and appreciate the complex political for implementing recommendations.

SUMMARY:

Following the recent wars in Iraq and Afghanistan, it has been necessary to rebuild the health infrastructure of these countries. Responsibility for undertaking such reconstruction efforts has been shared by the Ministries of Health functioning under the provisional governmental authorities, the regional World Health Organization resources, U.S. and British governmental health authorities and their civilian contractors, academic and national/international professional associations, the U.S. military, and various non-governmental volun-

teer organizations. Although mental health services are rarely considered to be a high priority in such post-conflict situations, extensive experience with the aftermath of both natural and human-produced disasters has indicated a high level of need for mental health services. In order to understand the degree to which this disaster and post-trauma experience translates to post-war priorities, the recent experience with addressing these issues in the Middle East warrants some examination and preliminary evaluation. This symposium will address these issues by inviting participation from the Iraqi Ministry of Health (Requesting specific nomination from MOH)[1]: the Coalition Provisional Authority (CPA)—Mr. James K. Haveman[1], (CPA Senior Advisor to the MOH, Baghdad); the Iraqi Psychiatric Society—Dr. Abdul Monaf H.M. Al-Jadiry, (Chairman of the Scientific Council of Psychiatry, Baghdad); the WHO Eastern Mediterranean Regional Office—Dr. Ahmad Mohit, (Regional Mental Health Advisor, EMRO); the World Psychiatric Association—Dr. Ahmed Okasha, (WPA President); and the U.S. Military—Dr. E. Cameron Ritchie, (USUHS). Dr. Norman Sartorius, who served for over thirty years as Director, WHO mental health division and as past-president of the WPA, will serve as the discussant. Dr. Norwood Knight-Richardson, special mental health advisor to the Secretary of HHS will also discuss the role of Federal Governments in restructuring Health and Mental Health Systems in post-conflict situations.

REFERENCES:

Regional Office for the Eastern Mediterranean (EMRO), World Health Organization. *Report on the Consultation on mental health and rehabilitation of psychiatric services in post-conflict and complex emergency countries.* Cairo, Egypt, 28–30 July 2003. (web address to be supplied)

RESEARCH ADVANCES IN MEDICINE

THE EPIDEMIOLOGY AND TREATMENT OF PSYCHIATRIC COMORBIDITIES

Chairperson: Joel J. Wallack, M.D.
Co-Chairperson: Geetha Jayaram, M.D.
Participants: Kathleen Merikangas, Ph.D., Joseph Biederman, M.D., Paul Thuluvath, M.D., Joel Gallant, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will understand: 1) the interplay between Hepatitis C and depression; 2) the latest developments in the treatment of HIV and their complications; and participants will appreciate as well the complexity of antecedent psychopathology and subsequent addictive disorders in youth and the fundamentals of the epidemiology of comorbid addictive and psychiatric disorders

SUMMARY:

Increased prevalence in treatment with HCV infection may be related to the disease, or to patient characteristics that predispose them to HCV infection. Interferon based treatment may cause significant depression and other neuropsychiatric symptoms in up to thirty percent of patients. Pre-existing depression worsens during interferon treatment as well. Dr. Tuluvath will discuss how adequate treatment of depression enables successful completion of treatment and better outcomes.

Dr. Gallant, an Associate Professor of Medicine and a researcher in the field of HIV, will discuss the latest developments in the care of a) the primary infection and indications for treatment; b) will review current guidelines for care, c) will discuss initial regimen of medications, d) the complications of treatment and lastly the management of treatment failure. He will conclude by discussing anti-retroviral agents that are in the development phase and research approaches.

Dr. Joseph Biederman, Professor of Psychiatry at Harvard Medical School and an authority in the treatment of anxiety disorders in children, will cover the topic of antecedent psychopathological disorders to subsequent substance use disorders and smoking.

Dr. Kathleen Merikangas, Associate Director of Epidemiology and Chief of the Section on Developmental Genetic Epidemiology in the Mood and Anxiety Disorders Program at the NIMH, will discuss current research on the patterns of comorbidity between mental, addictive and medical disorders. Evidence from family studies using genetic epidemiology methods will be reviewed.

REFERENCES:

1. El-Serag HB, Kunik M, Richardson P, Rabeneck L: Psychiatric disorders among veterans with hepatitis C infection. Gastroenterology 2002: 123: 476–82
2. Moore News Quarterly. Summer 2003. Volume 4, Number 3. Johns Hopkins University

REVIEW OF PSYCHIATRY

SESSION I OF THE REVIEW OF PSYCHIATRY

NEUROPSYCHIATRIC ASSESSMENT

Section Editors: Stuart C. Yudofsky, M.D.; Florence Kim, M.D.

1. **Neuropsychiatric Physical Diagnosis in Context**
   Fred Ovsiew, M.D.
2. **Neurological and Neuropsychological Exam of the Psychiatric Patient**
   Mark Lovell, Ph.D., Glen Getz, M.A.
3. **Electrophysiological Testing**
   Nashaat N. Boutros, M.D., Struve Frederick, Ph.D.
4. **Neuropsychiatric Lab Testing**
   Florence Kim, M.D., Stuart C. Yudofsky, M.D.
5. **Selected Neuroimaging Topics in Psychiatric Disorders**
   Thomas E. Nordahl, M.D., Ruth E. Salo, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand the essential elements of the neuropsychiatric exam for the assessment of psychiatric and neurological disorders. This program will provide an overview of the bedside neuropsychiatric exam, the clinical significance of neuropsychological and psychological testing to the assessment of the neuropsychiatric patient, and the clinical utility of laboratory testing, electrophysiological testing, and neuroimaging in neuropsychiatric disorders.

SUMMARY:

Neuropsychiatry is an integrative and collaborative field that brings together brain and behavior. Neuropsychiatry attempts to bridge the artificial boundaries between neurology and psychiatry, in order to treat the multitude of clinical manifestations of the singular brain. Neuropsychiatry is primarily focused on the assessment and treatment of the cognitive, behavioral and mood symptoms of patients with neurological disorders. However, an equally important focus for neuropsychiatrists is the understanding of the role of brain dysfunction in the pathogenesis of primary psychiatric disorders. This program will provide an overview of the components of the neuropsychiatric approach to clinical assessment. The bedside neuropsychiatric exam will be presented in-depth, along with the differential diagnoses of neuropsychiatric disorders to entertain when faced with a particular constellation of signs and symptoms. The clinical utility of neuropsychological and psychological measures to the neuropsychiatric approach will also be discussed. This will entail an analysis of major cognitive domains that may be involved in neuropsychiatric disorders, and how a specific pattern of deficits in certain domains may help to determine a neuropsychiatric diagnosis. Methods of electrophysiological testing and laboratory testing, and their importance to the diagnosis and evaluation of some neuropsychiatric disorders will also be discussed. Finally, neuroimaging techniques integral to the neuropsychiatric approach, and the current research findings with these modalities in patients with schizophrenia, affective disorders, and obsessive-compulsive disorder will be presented.

REFERENCES:

1. Yudofsky SC, Kim HF, eds.: Neuropsychiatric Assessment, Review of Psychiatry Series, Volume 23. Arlington, VA: American Psychiatric Publishing, Inc., 2004.
2. Yudofsky SC, Hales RE, eds.: American Psychiatric Publishing Textbook of Neuropsychiatry and Clinical Neurosciences, 4th ed.. Arlington, VA: American Psychiatric Publishing, Inc., 2003.
3. Boutros N, Struve FA: Electrophysiological assessment of neuropsychiatric disorders. Sem Clin Neuropsychiat 7:30–41, 2002.
4. Lezak MD: Neuropsychological Assessment, 311rd ed. New York: Oxford University Press, 1995.

SESSION II OF THE REVIEW OF PSYCHIATRY

COGNITIVE-BEHAVIOR THERAPY

Section Editor: Jesse H. Wright, M.D.

6. **Cognitive Therapy for Schizophrenia**
   Jan L. Scott, M.D., David G. Kingdon, M.D., Douglas Turkington, M.D.
7. **Cognitive Therapy for Bipolar Disorder**
   Monica A. Basco, Ph.D., A. John Rush, M.D., Noelle McDonald, B.S., Megan Merlock, B.A.
8. **Computer-Assisted Cognitive-Behavior Therapy**
   Jesse H. Wright, M.D.
9. **Cognitive Therapy With Medical Patients**
   Thomas Sensky, M.B.
10. **Cognitive Therapy for Children and Adolescents**
    Anne Marie Albano, Ph.D., Amy L. Krain, Ph.D., Elizabeth Podniesinksi, M.A., Keith Ditkowsky, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: 1) recognize advances in cognitive-behavior therapy (CBT) research and practice; 2) describe CBT methods for schizophrenia and bipolar disorder; 3) apply computer-assisted CBT to improve the efficiency of treatment; 4) list core methods of using CBT to help patients cope with medical illnesses; and 5) describe modifications of CBT for children and adolescents.

SUMMARY:

This review focuses on some of the new, most exciting, and potentially useful developments in cognitive-behavior therapy (CBT). Recent research has shown that CBT has an additive effect to medication in treating severe mental disorders such as schizophrenia and bipolar disorder. Another advance is the production of innovative computer programs that offer considerable promise for enhancing the efficiency of CBT and improving access to treatment. Also, cognitive-behavior therapy has been shown to be a practical method of helping patients cope with medical disorders; and CBT has been applied with excellent results in the treatment of children and adolescents. The presenters describe core findings from research and explain how to implement CBT with severe mental disorders, medical patients, younger individuals, and in computer-assisted therapy.

REFERENCES:

1. Albano AM, Kendall PC: Cognitive behavioural therapy for children and adolescents with anxiety disorders: clinical research advances. *International Review of Psychiatry, 14,* 128–133, 2002.
2. Basco MR, Merlock M, McDonald N: Cognitive-behavioral strategies for the management of bipolar disorder. Primary Psychiatry, 10(5): 65–71, 2003.
3. Turkington D, Dudley R, Warman, et al: Cognitive-behavioral therapy for schizophrenia: A review. J of Psychiatric Practice, 10(1): 5–16, 2004.
4. Wright JH, Wright AS, Salmon P, et al: Development and initial testing of a multimedia program for computer-assisted cognitive therapy. American J. of Psychotherapy. 56(1):76–86, 2002.

SECTION III OF THE REVIEW OF PSYCHIATRY

DEVELOPMENTAL PSYCHOBIOLOGY

Section Editor: B.J. Casey, Ph.D.

11. **Developmental Psychobiology: An Overview**
B.J. Casey, Ph.D.

12. **Withdrawn**

13. **The Developmental Psychobiology of Early Attachment**
Myron Hofer, M.D.

14. **The Developmental Neurobiology of Face Perception**
Charleston Nelson, Ph.D., Lisa Scott, B.S.

15. **Developmental Psychobiology of Tourette's Syndrome**
Kathy A. Gallardo, M.D., James E. Swain, M.D., James F. Leckman, M.D.

EDUCATIONAL OBJECTIVES:

This presentation will cover three fundamental topics on understanding typical and atypical development that are particularly relevant to biological and child psychiatry: 1) the importance of both plasticity and stability in the development of behavioral and neural systems in humans; 2) establishment of typical and atypical developmental progressions in behavioral and neural systems; and 3) the impact of methodological advances on imaging and genetics in understanding typical and atypical behavioral and neural development.

SUMMARY:

Developmental psychobiology refers to a multidisciplinary field. In so far as a discipline impinges on or informs us about development, it is important to the field of developmental psychobiology. The presentation will provide a broad sampling of work that address three fundamental topics on understanding typical and atypical development that are particularly relevant to biological and child psychiatry: 1) the importance of both plasticity and stability in the development of behavioral and neural systems; 2) establishment of typical and atypical developmental progressions in behavioral and neural systems; and 3) the impact of methodological advances on imaging and genetics in understanding typical and atypical behavioral and neural development. Thus, learning, development and the methods for studying learning and development will be discussed.

REFERENCES:

1. Casey (2004) Developmental Psychobiology: An Overview. in J.M. Oldham & M.B. Riba (Editors) Review of Psychiatry Series, Volume 23, APA.
2. Munakata, Y, Casey, BJ & Diamond, A (2004) Developmental Cognitive Neuroscience: Progress and Potential. Trends in Cognitive Science.

SECTION IV OF THE REVIEW OF PSYCHIATRY

BRAIN STIMULATION IN PSYCHIATRIC TREATMENT

Section Editor: Sarah H. Lisanby, M.D.

16. **Transcranial Magnetic Stimulation in Depression**
Thomas E. Schlaepfer, M.D., Markus Kosel, M.D.

17. **Transcranial Magnetic Stimulation Studies of Schizophrenia and Other Disorders**
Ralph E. Hoffman, M.D.

18. **Deep Brain Stimulation in Psychiatry**
Benjamin D. Greenberg, M.D.

19. **Vagus Nerve Stimulation in Psychiatry**
Harold A. Sackeim, Ph.D.

20. **Magnetic Seizure Therapy: Development of a Novel Convulsive Technique**
Sarah H. Lisanby, M.D.

EDUCATIONAL OBJECTIVES:

The objective of this symposium are: 1) to introduce attendees to the basics of emerging brain stimulation techniques in psychiatry, 2) to educate attendees regarding the current role of brain stimulation methodologies in psychiatric treatment; and 3) to examine the future implications of brain stimulation techniques to the field.

SUMMARY:

This symposium reviews new developments in emerging brain stimulation techniques for the study and treatment of psychiatric disorders, including transcranial magnetic stimulation (TMS), magnetic seizure therapy (MST), deep brain stimulation (DBS), and vagus nerve stimulation (VNS). TMS uses rapidly alternating magnetic fields applied to the scalp to induce small electrical currents in superficial cortex. At high enough intensities, TMS can induce a seizure. This higher dosage form of TMS is called magnetic seizure therapy (MST). Both TMS and MST induce far less electricity in the brain than ECT, and are able to stimulate more focal regions of the cortex because magnetic fields pass through tissue without impedance. VNS consists of an implanted electrical stimulator that administers pulsed electrical stimulation to the vagus nerve, stimulating vagal afferents and activating brainstem nuclei. DBS is more invasive than the other modalities, but it has the advantage of being able to reach deeper structures in a highly focal fashion. The availability of focal brain stimulation modalities challenges the field to identify the circuitry that needs to be modulated to exert therapeutic effects, and at the same time represents a methodology for systematically testing that circuitry. The next 5–10 years will be critical in determining whether and where these interventions will fit into out treatment algorithms. Regardless of their ultimate clinical role, is it already clear that these modalities can yield important information regarding the pathophysiology of psychiatric disorders that will be of use in developing newer and even more targeted treatments.

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ROUNDTABLE

COERCION AND TREATMENT: MEDICAL, LEGAL, AND ETHICAL ISSUES

Moderator: Carol Fisler, J.D.
Participants: A. Sasha Bardey, M.D., Mary Zdanowicz, J.D., Heather Barr, J.D., Thomasetta Harper

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand the forms that coercion takes and the research on its impact on treatment outcomes; 2) gain an appreciation of the medical, legal and ethical concerns around coerced treatment; and 3) gain insight into the perspectives of consumers, advocates and medical professionals on this controversial topic.

SUMMARY:

Controversy over the use of coercion in treating mental illness continues, with no prospect of consensus in sight. This workshop will explore the medical, legal and ethical issues on all sides of this debate. The panel—which includes a consumer who has experienced coerced treatment, a forensic psychiatrist who has run a mandated outpatient treatment program, the director of a leading advocacy organization fighting for laws that favor mandated treatment, a civil liberties lawyer who has strongly opposed numerous forms of coerced treatment, and an administrator of a mental health court—will discuss questions for which there are no easy answers:

Why do we need or want mechanisms that coerce people into treatment?

What are the various forms that coercion takes, and what are the practical and ethical issues raised by these mechanisms? Which forms are effective? Which are ineffective?

Who is helped and who is hurt by coercion in treatment? When the concerns of a consumer, a family, a community and a society are in conflict, whose concerns should win out?

Does coercion contribute to the criminalization of mental illness? Or does coercion into treatment help prevent involvement in the criminal justice system?

The members of the audience will have an opportunity to ask questions of the panelists and to voice their own opinions on the issues raised in the workshop.

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1. Rain SD, Williams VF, Robbins PC, Monahan J, Steadman HJ, Vesselinov R: Perceived coercion at hospital admission and adherence to mental health treatment after discharge. Psychiatric Services 2003; 54(1):103–5.
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